

# 4

## THE THERAPEUTIC RELATIONSHIP

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Listening creates a holy silence. When you listen generously to people, they can hear the truth in themselves, often for the first time. And when you listen deeply, you can know yourself in everyone.

—Rachel Remen, *Kitchen Table Wisdom*

Let us act like Einstein and begin our journey into the therapeutic relationship with a thought experiment (*Gedankenexperiment*). Like Einstein riding a beam of light into the universe, ask yourself: What accounts for the success of psychotherapy? Ponder it quietly for a moment.

Now, consider a more personal question: What accounted for the success of your own personal therapy? More than 75% of mental health professionals have undergone personal psychotherapy, typically on more than one occasion (Geller, Norcross, & Orlinsky, 2005). What made it effective? Give that some thought.

Your probable answer is that many factors account for the success of psychotherapy, including the client, the therapist, their relationship, the treatment method, and the context. Yet, when pressed for a single response, in my experience, about 80% of psychotherapists will answer: “the relationship.” As every human knows intuitively in his or her bones, it is the nurture and comfort of the other human. Your probable answer matches the cumulative findings of psychotherapy research.

Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most

powerful phenomenon we should be studying, practicing, and teaching. Henry (1998) concluded that the panel

would find the answer obvious, and *empirically validated*. Across studies, the largest portion of outcome variance not attributable to preexisting client characteristics involves individual therapist differences and the emergent therapeutic relationship between client and therapist, regardless of technique or school of therapy. (p. 128)

That is the main thrust of 4 decades of empirical research. In more strident moments, one could adapt Bill Clinton's unofficial campaign slogan: "It's the relationship, stupid!"

Indeed, of the multitude of factors that account for success in psychotherapy, **clinicians of different orientations converge on this point: The therapeutic relationship is the cornerstone.** To be sure, some clinicians conceptualize the relationship as a precondition of change, others as the fertile soil that permits change, and still others as the central mechanism of change itself. Nonetheless, the most common of common factors, the most convergence amongst the professional divergence, is the therapeutic relationship (Grencavage & Norcross, 1990; Weinberger, 1995).

Highlighting the therapeutic relationship as a mechanism of change raises the proverbial temptation to devalue other change mechanisms, such as the client's contribution and the treatment method. This chapter, as does the present volume, avoids such simple dichotomies and archaic polarizations. Focusing on one area—the psychotherapy relationship—should not convey the impression that it is the only area of importance nor should it trivialize or degrade the others. I argue for the centrality, not the exclusivity, of the therapeutic relationship. **The treatment method, the individual therapist, the therapy relationship, the client, and their optimal combinations are all vital contributors to the success of psychotherapy.** All must be studied.

We can operationally define the *client–therapist relationship* as the feelings and attitudes that therapist and client have toward one another and how these are expressed (Gelso & Carter, 1994; also see Gelso & Hayes, 1998). This definition is general but concise, reasonably consensual, and theoretically neutral.

**My aim in this chapter is to traverse the empirical research on what works in the therapeutic relationship and to translate that research into clinical practices.** Decades of research can guide therapists in what to do, what not to do, and how to adapt to individual clients and contexts. The chapter begins with clients' voices: what research into their experiences reveals about the therapeutic relationship. Then, I review the research on what works in the therapeutic relationship in general. **The ensuing section covers the research on what works for particular clients, that is, how to responsively tailor the therapeutic relationship to enhance the efficacy of treatment.** The chapter concludes with a brief,

Relación terapeuta paciente

Objetivo

practice-friendly review of what **does not work in the therapeutic relationship** and offers final thoughts on integrating the relationship into the larger treatment context.

## WHAT WORKS ACCORDING TO CLIENTS

Before turning to sophisticated empirical research on the robust association between the therapy relationship and treatment outcomes, let us consider a large body of clinical experience and client reports attesting to the powerful, if not curative, nature of the therapy relationship (Norcross & Lambert, 2005). **When clinicians ask clients what was helpful in their psychotherapy, clients routinely identify the therapeutic relationship** (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). At least 100 such studies have appeared in the literature with similar conclusions. **Clients do not emphasize the effectiveness of particular techniques or methods.** Instead, they primarily attribute the effectiveness of their treatment to the relationship with their therapists (Elliott & James, 1989; Strupp, Fox, & Lessler, 1969).

### Representative Studies

In an illustrative study, researchers asked outpatients to list curative factors that they believed to be associated with their successful cognitive-behavioral therapy (Murphy, Cramer, & Lillie, 1984). The factors endorsed by the majority of clients were advice (79%), talking to someone interested in my problems (75%), encouragement and reassurance (67%), talking to someone who understands (58%), and instillation of hope (58%). The clients in the study were mainly from the lower socioeconomic class, whom past research has suggested expect more expert advice in therapy (Goin, Yamamoto, & Silverman, 1965).

In an investigation of psychodynamic therapy (Najavits & Strupp, 1994), 16 therapists were assigned clients with similar difficulty levels. After 25 sessions, therapists were evaluated according to outcome, length of treatment, and therapist in-session behavior. Therapists whose clients evidenced better outcomes used more positive and fewer negative behaviors than the less effective therapists, with the largest differences occurring in relationship behaviors rather than technical skills. Warmth, understanding, and affirmation were considered positive, whereas subtle forms of belittling, blaming, ignoring, neglecting, attacking, and rejecting were considered negative. From these results, the authors concluded that “basic capacities of human relating—warmth, affirmation, and a minimum of attack and blame—may be at the center of effective psychotherapeutic intervention. Theoretically based technical

interventions were not nearly as often significant in this study” (Najavits & Strupp, 1994, p. 121).

The massive National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program evaluated the effectiveness of interpersonal therapy, cognitive therapy, antidepressant medication plus clinical management, and a placebo plus clinical management (Elkin et al., 1989). Clients’ experiences on the helpful aspects of their psychotherapy experiences were examined as part of the research program. Their most frequent responses fell into the categories of “my therapist helped” (41%) and “learned something new” (36%). In fact, at posttreatment fully 32% of the clients receiving placebo plus clinical management wrote their therapists were the most helpful part of their “treatment” (Gershefski, Arnkoff, Glass, & Elkin, 1996).

As a final illustration, consider the studies on the most informed consumers of psychotherapy: psychotherapists themselves. In two studies, American ( $N = 727$ ) and British ( $N = 710$ ) psychologists were asked to reflect on their psychotherapy experiences and to nominate any lasting lessons acquired concerning the practice of psychotherapy (Bike, Norcross, & Schatz, 2009; Norcross, Dryden, & DeMichele, 1992). The most frequent responses all involved the interpersonal relationships and dynamics of psychotherapy: the centrality of warmth, empathy, and the personal relationship; the importance of transference and countertransference; the inevitable humanness of the therapist; and the need for therapist reliability and commitment. Conversely, a review of five published studies that identified covariates of harmful therapies received by mental health professionals concluded that the harm was typically attributed to distant and rigid therapists, emotionally seductive therapists, and poor client–therapist matches (Orlinsky & Norcross, 2005).

The tendency in psychotherapy research is to look past clients’ narrative reports of successful psychotherapy because they lack the precision and causation afforded by quantitative analysis. Although quantitative analysis surely provides an invaluable perspective, it often looks past the interpersonal experiences of our clients. Psychotherapy is an intensely relational and affective pursuit—that is what our clients tell us time and again.

### Practice Implications

- *Listen to clients.* What is missing in most psychotherapy journals and textbooks is the client’s voice (Gabbard & Freeman, 2006). The consumer movement in health care forcibly reminds therapists to listen to the client’s experiences, preferences, and realities. Their voices consistently, eloquently tell us to cultivate and customize the therapeutic relationship (Duncan, Miller, & Sparks, 2004).

- *Privilege the client's experience.* The empirical research on therapist empathy and the therapeutic alliance (to be reviewed shortly) repeatedly informs us that it is the client's experience of empathy and collaboration that best predicts treatment success (e.g., Bohart & Greenberg, 1997; Bedi, Davis, & Williams, 2005; Horvath & Bedi, 2002): the client's experience, not the therapist's experience. The practice imperative is to privilege the client's theory and experience of change, not the therapist's (Duncan & Miller, 2000).
- *Request feedback on the therapy relationship.* Psychotherapists are comparatively poor at gauging their client's experiences of their empathy and the alliance, although therapists frequently believe they are accurate (Hannan et al., 2005). A meta-analysis found that client and therapist alliance ratings only correlated an average of .33 (Tryon, Collins, & Felleman, 2006). The clinical upshot is to request real-time feedback from clients on their response to the therapy relationship. The benefits of doing so include empowering clients, promoting explicit collaboration, making mid-therapy adjustments as needed, and enhancing treatment success (Lambert, 2005). (Several methods of systematically gathering client feedback are provided in chap. 8, this volume.)
- *Avoid critical or pejorative comments.* Client reports and the empirical research converge in warning therapists to avoid negative communication patterns that detract from outcome, especially in treating more difficult clients (Lambert & Barley, 2002). These patterns include comments or behaviors that are critical, attacking, rejecting, blaming, or neglectful (Najavits & Strupp, 1994). Although this sounds like elementary advice, difficult clients who themselves attack, reject, and blame are likely to provoke negative communications from their therapists over time.
- *Ask what has been most helpful in this therapy.* If you have not yet tried it, ask your clients toward the conclusion of a successful course of therapy what has been most helpful to them. They are likely to be amazed by the ubiquity and centrality of the therapy relationship: "you listened carefully," "you respected and liked me," "I could tell you anything," "you believed in me," "we worked well together." You are also likely to receive responses that are representations or transitional objects for respect, listening, and support. In my practice, for example, many clients recall fondly my offering them a bottle of water, juice, or soda at the beginning of our sessions. The Diet Pepsi, a returned phone call,

or a sliding fee scale served as concrete symbols of the amorphous but genuine relationship.

## WHAT WORKS IN GENERAL

Hundreds upon hundreds of research studies convincingly demonstrate that the therapeutic relationship makes substantial and consistent contributions to psychotherapy outcome. These studies were efficiently summarized in a series of meta-analyses commissioned and published by an American Psychological Association Division 29 (Division of Psychotherapy) task force (Norcross, 2001, 2002) on empirically supported (therapy) relationships.

Two specific objectives informed the work of the task force: first, to identify elements of effective therapy relationships; second, to identify effective methods of tailoring therapy to the individual client on the basis of his or her (nondiagnostic) characteristics. Thus, we sought to answer the dual pressing questions of What works in general in the therapy relationship? and What works best for particular clients?

The task force reviewed the extensive body of empirical research and generated a list of effective relationship elements and effective means for customizing therapy to the individual client. The evidentiary criteria for making these judgments entailed number of supportive studies, consistency of the research results, magnitude of the positive relationship between the element and outcome, directness of the link between the element and outcome, experimental rigor of the studies, and external validity of the research base.

For each relationship element judged to be effective by that task force, I define the relationship element, describe the findings of an illustrative study, present the meta-analytic results, and most important, offer clinical practices predicated on that research.

### Empathy

Carl Rogers's (1957) definition of *empathy* has guided most of the research: "Empathy is the therapist's sensitive ability and willingness to understand clients' thoughts, feelings, and struggles from their point of view" (p. 98). Empathy involves entering the private, perceptual world of the other and, in therapeutic contexts, communicating that understanding back to the client in ways that can be received and appreciated.

Definición Rogers

A meta-analysis of 47 studies (encompassing 190 tests) revealed a median  $r$  of .26 between therapist empathy and psychotherapy outcome (Bohart, Elliott, Greenberg, & Watson, 2002). This translates into a conven-

tional effect size (ES) of 0.32. Empathy is linked to outcome because it serves a positive relationship function, facilitates a corrective emotional experience, promotes exploration and meaning creation, and supports clients' active self-healing.

In a classic study, W. R. Miller, Taylor, and West (1980) examined the comparative effectiveness of several behavioral approaches in reducing alcohol consumption. The authors also collected data on the contribution of therapist empathy to treatment outcome. At the 6- to 8-month follow-up interviews, client ratings of therapist empathy correlated significantly ( $r = .82$ ) with client outcome, thus accounting for 67% of the variance. Although there were methodological limitations to this early study, the results demonstrated that the importance of empathy was not restricted to person-centered or insight-oriented therapies. Moreover, this study provided impetus for W. R. Miller's development of *motivational interviewing*, a person-centered directive therapy that relies on expressing empathy and rolling with the resistance to help clients explore and resolve their ambivalence about change (W. R. Miller & Rollnick, 2002).

Of course, individual clients experience and interpret therapist behavior quite differently. In one interesting study of perceptions of empathy (Bachelor, 1988), 44% of clients valued a cognitive form of empathic response, 30% an affective form of empathy, and the remainder a nurturing and disclosing empathic response. These results lead to the following conclusions: No single, invariably facilitative empathic response exists, and clients respond according to their own unique needs (Bachelor & Horvath, 1999).

The most obvious practice implication is to convey empathy to all clients in all forms of psychotherapy. Therapists must make efforts to understand their clients, and this understanding must be communicated through responses that the client perceives as empathic. This stance contrasts with therapists responding primarily out of their own needs or agendas. Nor do empathic therapists parrot client's words or simply reflect the content of words. On the contrary, they understand and communicate the clients' moment-to-moment experiences and their implications. In helping clients access as much internal information as possible, empathic therapists attend to what is not said and is at the periphery of awareness as well as what is said and is in focal awareness (Bohart et al., 2002).

To highlight an earlier point, the primary means of ascertaining whether the psychotherapist is indeed empathic is to secure feedback from the client. Clinicians are inadequate judges of clients' experience of empathy (Bachelor & Horvath, 1999). Clinicians' intentions or efforts to be emphatic are insufficient; client reception of empathy is necessary.

Esforzamos por entender al paciente

## Alliance

The *alliance* refers to the quality and strength of the collaborative relationship between client and therapist. It is typically measured as agreement on the therapeutic goals, consensus on treatment tasks, and a relationship bond (Bordin, 1976; Horvath & Greenberg, 1994). This construct and its multiple measures go by several names: *working alliance*, *therapeutic alliance*, or simply, the *alliance*. And this construct is incontrovertibly the most popular researched element of the therapeutic relationship today. In fact, some people erroneously have begun to equate the alliance with the entire therapeutic relationship. Remember: The relationship is far broader and inclusive than the alliance alone.

Across 89 studies, the median correlation of the relation between the alliance and therapy outcome among adults was .21, a modest but very robust association (Horvath & Bedi, 2002). Across 23 studies of child and adolescent therapy, the weighted mean correlation between alliance and outcome was .20 (Shirk & Karver, 2003; see also chap. 11, this volume). A weighted mean correlation of .20 and .21 corresponds to an ES (*d*) of 0.45, a medium-sized effect. Nevertheless, this effect is large when one considers that the average ES for psychotherapy versus no treatment is 0.80, and the average ES for differences among treatments, when there are differences among bona fide treatments, is 0.20 (Wampold, 2001). Accordingly, the alliance is potent and amazingly consistent, certainly more than differences among treatments.

Individual studies provide clearer illustrations of the connection between the alliance and client outcome. Effect sizes and probability values, one must remember, translate into vital human statistics: happier and healthier people.

One early study (Gaston, Marmar, Gallagher, & Thompson, 1991) used hierarchical regression analysis to examine the alliance in older depressed clients who participated in behavioral, cognitive, or brief psychodynamic therapy. Clients completed the California Psychotherapy Alliance Scales after the 5th, 10th, and 15th sessions. The alliance uniquely contributed to outcome with increasing variance as therapy progressed. The alliance assessed at the 5th session accounted for 19% to 32% of treatment outcome and for 36% to 57% of outcome at the 15th session.

The salutary impact of the alliance is not restricted to psychotherapy. Several studies have examined the impact of the therapeutic alliance in pharmacotherapy. In the NIMH Collaborative Study, the therapeutic alliance in pharmacotherapy emerged as the leading force in reducing a client's depression (Krupnick et al., 1996). A perceived positive therapeutic alliance early in treatment predicted more rapid and better improvement in all four pharmacotherapy and psychotherapy conditions (Zuroff & Blatt, 2006). In a study of pharmacotherapy for bipolar disorder, the alliance (as rated by the client) with

the prescribing physician predicted long-term mood outcomes ( $r = .37$ ) and medication compliance ( $r = .48$ ) for up to 28 months following an acute episode (Gaudiano & Miller, 2006; see also chap. 7, this volume).

The meta-analytic results, combined with individual studies, point to a host of recommended clinical practices. First, develop a strong alliance early in treatment, probably within three to five sessions. If the alliance has not solidified by the fifth session, then the probability for success is jeopardized (Horvath & Bedi, 2002). Second, construct a thoughtful systemic plan for cultivating and maintaining the multiple alliances inherent in multiperson therapies (Kazdin, Marciano, & Whitley, 2005; Shelef, Diamond, Diamond, & Liddle, 2005). Third, recognize that an alliance is harder to establish with clients who are more disturbed, delinquent, homeless, drug abusing, fearful, anxious, dismissive, and preoccupied (Horvath & Bedi, 2002). Fourth, on the therapist side, foster a stronger alliance by using communication skills, empathy, openness, and a paucity of hostile interactions. Fifth, as noted in the following sections, strive to reach consensus on goals and respective tasks, which contributes to alliance formation and then to treatment success. The early sessions should always entail soliciting the client's goals and specifying the respective contributions of client and therapist alike. Sixth and finally, emphasize, particularly in the initial sessions, the relational bond, the special sense of understanding, safety, and trust.

## Cohesion

Cohesion in group therapy—a parallel of the therapeutic alliance in individual therapy—also demonstrates consistent associations to client benefit. Cohesion refers to the forces that cause members to remain in the group, a “sticking togetherness.” Approximately 80% of the studies support positive relationships between cohesion (mostly member-to-member) and therapy outcome (Burlingame, Fuhrman, & Johnson, 2002; Tschuschke & Dies, 1994).

From this empirical research come a set of treatment principles for fostering cohesion and group outcomes (Burlingame et al., 2002). In particular, the leader or leaders of group therapy can

- Conduct pregroup preparation that sets treatment expectations, defines group rules, and instructs members in rules and skills needed for effective group participation.
- Establish clarity regarding group processes in early sessions (as higher levels of structure usually lead to higher levels of disclosure and cohesion).
- Model real-time observations, guide effective interpersonal feedback, and maintain a moderate level of control and affiliation.

- Time and deliver feedback to group members carefully so feedback is largely positive early on, feedback is balanced between positive and negative in later sessions, and the receiver is ready and open.
- Manage one's own emotional presence in the group because the leader not only affects the relationship with individual members but also all group members as they vicariously experience the leader's manner of relating.
- Facilitate group members' emotional expression, responsiveness of others to that expression, and shared meaning from such expression.

### Goal Consensus and Collaboration

*Goal consensus* refers to therapist–client agreement on treatment goals and expectations. *Collaboration* is the mutual involvement of the participants in the helping relationship. Although goal consensus and collaboration are frequently measured as part of the alliance, for clinical, research, and training purposes, they must be separated. We need to know, specifically, what in the therapy relationship (and the alliance) is effective. Fully 68% (17 of 25) of the studies found a positive association between goal consensus and outcome, and 89% (32 of 36) of the studies reported the same for collaboration and outcome (Tryon & Winograd, 2002).

In an interesting study, investigators explored the specific behavior of therapists contributing to a client's perception of a facilitative alliance (Creed & Kendall, 2005). Collaboration behaviors included the therapist presenting treatment as a team effort, helping set goals for therapy, encouraging specific feedback from the client, and building a sense of togetherness by using words like *we*, *us*, and *let's*. These collaborative behaviors predicted early client ratings of the alliance and therapist-rated alliances by the seventh session.

To promote treatment success, research and experience suggest that clinicians should begin to develop consensus at intake. In later sessions with their clients, they should encourage a process of shared decision making in which goals are frequently discussed, reevaluated, and agreed on. Collaborative therapists attend verbally to client problems, address topics of importance to them, and resonate to client attributions of blame regarding their problems. Collaboration involves the behaviors identified and validated in the Creed and Kendall (2005) study cited earlier. Therapists who mutually create homework assignments with clients achieve better therapy outcomes, particularly if they check on these assignments in the next session (Kazantzis, Deane, & Ronan, 2000). In short, the therapist and client journey together toward a mutual destination.

Therapist empathy, the alliance, cohesion in group therapy, goal consensus, and collaboration are demonstrably effective elements of the therapy relationship. The task force designated another set of seven relational elements as probably effective because of a less compelling body of extant research. These are summarized in less detail in the sections that follow.

## Positive Regard

This therapist quality is characterized as warm acceptance of the client's experience without conditions. It is understood as a prizing, an affirmation, and a deep nonpossessive caring. The early research reviews (e.g., Truax & Carkhuff, 1967; Orlinsky & Howard, 1978) were very supportive of the association between positive regard and therapy outcome, with approximately two thirds of the studies in the positive direction. Recent reviews of more rigorous studies published since 1990 found that 49% (27 of 55) of all associations were significantly positive and 51% (28 of 55) did not achieve significance. No studies reported negative associations between positive regard and outcome (Farber & Lane, 2002). When treatment outcome and therapist positive regard were both rated by clients, the percentage of positive findings jumped to 88% (Farber & Lane, 2002).

Clinically, the research results indicate, first, that the provision of positive regard or validation is strongly indicated in practice. Second, similar to empathy and the alliance, it is the client's perception of the therapist's positive regard that has the strongest association with outcome. At the risk of redundancy, supportive therapists should privilege their client's experience. Third, therapists cannot be merely content with feeling good about their clients but should ensure that their positive feelings are communicated to them. This does not require a stream of compliments or an outpouring of love. Rather, it speaks to the need for therapists to communicate a caring, respectful attitude that affirms a client's basic sense of worth (Duncan & Moynihan, 1994; Farber & Lane, 2002). Fourth, when working with challenging clients who tend to devalue others, therapists need to demarcate their support for the person of the client from their distaste of particular behaviors. Put differently, therapists can separate the "sinner from the sin" and thereby prize the client as whole.

## Congruence/Genuineness

The two facets here are the therapist's personal integration in the relationship and the therapist's capacity to communicate his or her personhood to the client as appropriate. Across 20 studies (and 77 separate results), 34% found a positive relation between therapist congruence and treatment outcome, and 66% found no significant associations (M. G. Klein, Kolden, Michels, &

Chisholm-Stockard, 2002). The percentage of positive studies increased to 68% when congruence was tested in concert with empathy and positive regard, supporting Roger's original conviction that the facilitative conditions (empathy, positive regard, congruence) work together and cannot be easily distinguished. Therapist congruence is higher when therapists have more self-confidence, good mood, increased involvement or activity, responsiveness, smoothness of speaking exchanges, and when clients have high levels of self-exploration/experiencing.

## Feedback

*Feedback* is defined as descriptive and evaluative information provided to clients from therapists about the client's behavior or the effects of that behavior. Across 11 studies empirically investigating the feedback–outcome connection, 73% were positive and 27% were nonsignificant (Claiborn, Goodyear, & Horner, 2002). Note that this research concerns therapist feedback to clients, not client feedback to therapists (for the latter, see chap. 8, this volume).

To enhance the clinical effectiveness of feedback, therapists can take the following steps (Claiborn et al., 2002):

- increase their credibility, which makes acceptance of feedback more positive;
- prepare the client to receive and make use of the feedback;
- structure the feedback and explain its goals in a clear way;
- give positive feedback, especially early to establish the relationship;
- precede or sandwich negative feedback with positive comments; and
- proceed cautiously with clients suffering from low self-esteem and negative mood, who are apt to bias processing of feedback in a negative direction.

## Repair of Alliance Ruptures

A *rupture* in the therapeutic alliance is a tension or breakdown in the collaborative relationship. Therapists should be aware that clients often have negative feelings about the treatment or the relationship. Additionally, they may be reluctant to broach their concerns for fear of the therapist's reactions. Many clients do not tell us about ruptures; they often "vote with their feet" and do not return. As such, therapists must be attuned to subtle indications of alliance ruptures and take the initiative in exploring their client's reactions (Safran, Muran, Samstag, & Stevens, 2002). Once more, here is where direct

monitoring of the client's experience of the treatment and the relationship pays dividends. Proactive monitoring can detect ruptures and improve the chances for therapy success. The small body of research indicates that the frequency and severity of ruptures are increased by rigid adherence to a treatment manual and an excessive number of transference interpretations. By contrast, the research suggests that repairs of ruptures can be facilitated by the therapist responding nondefensively, attending directly to the alliance, and adjusting his or her behavior (Safran et al., 2002).

### Self-Disclosure

*Therapist self-disclosure* refers to therapist statements and behaviors that reveal something personal about the practitioner. Analogue research suggests that nonclients commonly have positive perceptions of therapist self-disclosure. In actual therapy, disclosures are perceived as helpful for enhanced empathy and immediate outcomes, although the effect on the ultimate outcome of therapy is unclear (Hill & Knox, 2002). The research suggests that therapists should disclose infrequently and, when they do disclose, do so to validate reality, normalize experiences, strengthen the alliance, or offer alternative ways to think or act. Therapists should avoid self-disclosures that are for their own needs, remove the focus from the client, or blur the treatment boundaries.

### Management of Countertransference

Although variously defined, *countertransference* refers to reactions in which the unresolved conflicts of the psychotherapist, usually but not always unconscious, are involved. The limited research supports the interrelated conclusions that therapists acting out countertransference hinders psychotherapy. On the other hand, effectively managing countertransference aids the process and probably the outcome of therapy (Gelso & Hayes, 2002). In managing countertransference, five central therapist skills have been implicated: self-insight, self-integration, anxiety management, empathy, and conceptualizing ability.

### Quality of Relational Interpretations

In the clinical literature, *interpretations* are therapist interventions that attempt to bring material to consciousness that was previously out of awareness. In the research literature, interpretations are behaviorally coded as making connections, going beyond what the client has overtly recognized, and pointing out themes or patterns in the client's behavior. The research correlating frequency of interpretations and outcome has yielded mixed findings. However,

the evidence suggests that high rates of transference interpretations lead to poorer outcomes, especially for clients with low quality of object relations (Crits-Christoph & Gibbons, 2002). In contrast, other research has highlighted the importance of the quality of interpretations. Better outcomes are achieved when the therapist addresses central aspects of client interpersonal dynamics (Crits-Christoph & Gibbons, 2002; Luborsky & Crits-Christoph, 1998). The resulting practice implications are to avoid high levels of transference interpretations, particularly for interpersonally challenged clients, and to focus interpretations on the central interpersonal themes for each client.

Evitar sobre interpretar y focalizarse en temas interpersonales centrales

Taken together, this mass of empirical findings provides reliable evidence that therapists' relational contributions to outcome are identifiable and teachable. We do know what works! Further, these relational behaviors or qualities significantly and causally relate to psychotherapy success at a magnitude as high (or higher) than the particular treatment method (Norcross, 2002; Wampold, 2001).

## WHAT WORKS FOR PARTICULAR CLIENTS

The preceding section addressed relationship behaviors, primarily provided by the psychotherapist, that are effective: what works in general. This section addresses those client behaviors or qualities that may serve as reliable markers for customizing the therapy relationship: what works for particular clients.

The essential truth of behavioral science is that people differ. What works relationally for one person—say, a playful, good-natured tease for an adolescent boy—might be experienced as disrespectful or insensitive by another person. Person-centered therapists characterize these individual differences as idiosyncratic empathy modes.

Considerar diferencias individuales

Clinicians strive to offer or select a therapy that is responsive to the client's condition, characteristics, proclivities, and world views. This process goes by different names—responsiveness, customizing, attunement, tailoring, matchmaking, aptitude by treatment interaction—but the objective is to create a new therapy for each client. The saying “different strokes for different folks” aptly applies.

Objetivo es crear una nueva teoría para cada cliente

This position can be easily misunderstood as an authority figure therapist prescribing a specific form of psychotherapy for a passive client. Far from it, the goal is for an empathic therapist to arrange for an optimal relationship collaboratively with an active client on the basis of the client's personality and preferences. If a client frequently resists, for example, then the therapist considers whether she is pushing something that the client finds incompatible (preferences), or the client is not ready to make changes (stage of change), or the

client is uncomfortable with a directive style (reactance). Good clinicians pay attention to such matters.

The volume and precision of empirical research on what works best for particular clients pale in comparison with research on what works in general. The empirical research in this area, moreover, tends more toward the correlational and less toward the causal. Consequently, I tentatively summarize below the research on adapting the therapy relationship on just a few such client characteristics that, in the judgment of the Task Force, are demonstrably effective. When we say effective, we mean effective for customizing therapy to the individual client. Here then are three client dimensions—reactance, functional impairment, and stages of change—that may systematically guide therapists in adjusting the relationship to individual differences.

## Reactance

*Reactance* (or *resistance*) refers to being easily provoked and responding oppositionally to external demands. In session, reactance manifests itself in the client's clinical history of high defensiveness, his or her interpersonal style during the interview, response to early interpretations or homework assignments, psychological tests (such as the Minnesota Multiphasic Personality Inventory Paranoid, Defensive, and Hostility scales, for instance), and receptivity to early interpretations or homework assignments. Seasoned clinicians can typically spot highly reactant clients easily, as they can those with low reactance.

Of course, in an interpersonal perspective, we must acknowledge that the therapist's behavior itself may precipitate client reactance! A therapist's authoritarian behaviors, empathic failures, repeated confrontations, or pejorative interpretations may be the culprit for iatrogenic resistance. Let us be careful not to label and blame clients for responding in a reactant manner to resistance-causing therapists.

Varying therapist directiveness to the client's level of reactance improved therapy efficiency and outcome in 80% (16 of 20) of studies (Beutler, Moleiro, & Talebi, 2002). Specifically, clients presenting with high reactance benefit more from self-control methods, minimal therapist directiveness, and paradoxical interventions. By contrast, clients with low reactance benefit more from therapist directiveness and explicit guidance. Listening to the client and attending to his or her progress naturally lead experienced clinicians to similar conclusions. Direct guidance and confrontation with clients who dislike those styles are apt to fail.

In an illustrative study, researchers examined the impact of the interaction between 141 clients' reactance level and their therapists' directiveness on the effectiveness of psychotherapy (Karno & Longabaugh, 2005). Ratings of videotaped treatment sessions were used to measure client reactance and

Comportamiento del terapeuta puede generar reactancia.

+directivo a - reactancia

therapist directiveness. The results indicated that therapist directiveness had a negative impact on drinking outcomes for clients high in reactance, but not among clients low in reactance. The more therapists used interpretation and confrontation, the more the high reactant clients drank.

The practice implications entail attending to client interpersonal preferences, considering that stalled progress might result from a therapist pushing too fast or too directly for clients, and adjusting the therapist's level of directiveness to individual client differences. In the main, highly reactant clients do better with low directiveness and more self-control, whereas low reactant clients do better with high directiveness.

## Functional Impairment

This complex dimension reflects the severity of the client's subjective distress as well as reduced behavioral functioning. On the low end of the continuum are clients in little distress and functioning well. On the high end are those in severe and chronic distress, impaired in most areas of functioning (family, social, intimate, occupational). The client's Global Assessment of Functioning (GAF) score and the sheer number and complexity of the client's presenting problems provide a good estimate of functional impairment.

The majority of available studies (74%; 31 of 42) found a significant, inverse relation between level of impairment and treatment outcome. More functionally impaired clients have poorer outcomes (Beutler, Harwood, Alimohamed, & Malik, 2002). At the same time, the research also indicates that clients who manifest impairment in two or more areas of functioning are more likely to benefit from intensive therapy. Such treatment has five characteristics: It is lengthier, more intense, includes psychoactive medication, entails multiple formats (individual couple, family, group), and targets the creation of social support in the natural environment (Beutler, Harwood, et al., 2002; for another interpretation of this research, see chap. 3, this volume).

The research literature corresponds with client voices and preferences. Clients suffering high or chronic distress frequently request that they would profit from "more": more therapy, the addition of group or family therapy, the introduction of psychotropic medication, and greater support in their lives.

## Stages of Change

People progress through a series of stages—precontemplation, contemplation, preparation, action, and maintenance—in both psychotherapy and self-change. More formally, the stages of change can be assessed via a dozen inventories and algorithms (see <http://www.uri.edu/research/cprc/measures>).

htm). In session, I recommend asking clients a series of quick, discrete questions for each problem behavior:

Do you currently have a problem with \_\_\_\_\_?  
(If yes, then in contemplation, preparation, or action stage. If no, then in precontemplation or maintenance stage.)

If yes, when will you change it? (Someday: contemplation stage. In the next few weeks: preparation stage. Right now: action stage.)

If no, what leads you to say that? (Because it's not a problem for me: precontemplation stage. Because I have already changed it: maintenance stage.)

A meta-analysis of 47 studies found ESs of 0.70 and 0.80 for the use of different treatment processes in the stages of change (Rosen, 2000). Specifically, cognitive-affective processes are used most by clients in the precontemplation and contemplation stages. Behavioral processes are used most frequently and effectively by those in the action and maintenance stages. Those change processes and treatment methods effective for clients in one stage tend not to be as effective for clients in different stages. For instance, an empathic therapist would probably not request that a client tentatively contemplating ending a relationship do so immediately; the client is simply "not ready yet" to take that step.

The therapist's optimal stance also varies depending on the client's stage of change. Namely, the therapist assumes the position of a nurturing parent with clients in the precontemplation stage, a Socratic teacher with clients in the contemplation stage, an experienced coach with those in the action stage, and a consultant during the maintenance stage (Prochaska & Norcross, 2002). The practice implications encompass assessing the client's stage of change, aligning the therapeutic relationship to that stage, and adjusting tactics as the client moves through the stages. In short, the therapist leads by following the client.

### Additional Characteristics

Researchers are investigating several other, nondiagnostic client dimensions that may call for tailoring the therapy relationship to individual client differences. Among these are clients' preferences (Arkoff, Glass, & Shapiro, 2002), coping style (Beutler, Harwood, et al., 2002), attachment style (Meyer & Pilkonis, 2002), religious commitment (Worthington & Sandage, 2002), and cultural identification (Sue & Lam, 2002). However, the results of the outcome research on these factors are not yet robust or reliable enough to recommend that therapists routinely use them to tailor the therapeutic relationship.

The overarching lesson of this body of research is to be responsive to clients' requests and needs. This ethical and practical imperative translates into meeting the individual where he or she is, whether that be defined by stage of change, preference, functional impairment, or reactance level. A

client who does poorly in one type of relationship (e.g., directive) may do quite well with another. George Eliot (a pseudonym for Mary Ann Evans) wrote in her 1860 novel, *The Mill on the Floss*, “We have no master-key that will fit all cases.” Clinical decisions, like Eliot’s moral decisions, must be informed by “exerting patience, discrimination, and impartiality” and an insight earned “from a life vivid and intense enough to have created a wide, fellow feeling with all that is human.”

## WHAT DOES NOT WORK

Translational research is both prescriptive and proscriptive. It tells us what works and what does not. Seven caveats from the research literature now follow on what should be avoided.

### Confrontations

Controlled research trials, particularly in the addictions field, consistently find a confrontational style to be ineffective. In one review (W. R. Miller, Wilbourne, & Hettema, 2003), confrontation was ineffective in all 12 identified trials. By contrast, expressing empathy, rolling with resistance, developing discrepancy, and supporting self-efficacy—all characteristic of motivational interviewing—have demonstrated large effects with a small number of sessions (Burke, Arkowitz, & Dunn, 2002).

### Negative Processes

Client reports and research studies converge in warning therapists to avoid comments or behaviors that are hostile, pejorative, critical, rejecting, or blaming (Binder & Strupp, 1997; Lambert & Barley, 2002). Therapists who attack a client’s dysfunctional thoughts or relational patterns need, repeatedly, to distinguish between attacking the person versus his or her behavior. And, all therapists are advised to manage negative process by learning relational and self-soothing skills.

### Assumptions

Psychotherapists who assume or intuit their client’s perceptions of the alliance, empathy, relationship satisfaction, and treatment success are frequently inaccurate. Psychotherapists who specifically and respectfully inquire about their client’s perceptions frequently enhance the alliance and pre-

vent premature termination (Lambert, 2005; S. D. Miller, Duncan, Sorrell, & Brown, 2005).

### Therapist Centricity

A recurrent lesson from process–outcome research is that the client’s observational perspective on the therapy relationship best predicts outcome (Orlinsky, Rønnestad, & Willutzki, 2004). Psychotherapy practice and research that relies on the therapist’s observational perspective, although valuable, simply does not predict outcome as well. Therefore, privilege the client’s experiences.

### Rigidity

By inflexibly and excessively structuring treatment, the therapist risks empathic failures and inattentiveness to clients’ experiences. Such a therapist is then likely to overlook a breach in the relationship and mistakenly assume she has not contributed to that breach. Dogmatic reliance on particular relational or therapy methods, incompatible with the client, imperils treatment (Ackerman & Hilsenroth, 2001).

### Ostrich Behavior

The nascent research on alliance ruptures in psychotherapy indicate they are common, rarely addressed, and predict premature termination and poor outcomes. Many psychotherapists apparently prefer what we call *ostrich behavior*: burying their heads in the sand and hoping (against hope) that early signs of a rupture do not materialize into a negative outcome. Addressing ruptures in the working alliance is understandably challenging, especially for trainees, but is effective on many fronts.

### Procrustean Bed

As the field of psychotherapy has matured, using an identical therapy relationship (and treatment method) for all clients is now recognized as inappropriate and, in selected cases, even unethical. The efficacy and applicability of psychotherapy are enhanced by tailoring it to the unique needs of the client, not by imposing a *Procrustean bed* onto unwitting consumers of psychological services. (Procrustes, in Greek mythology, was the legendary giant and brigand of Attica, said to be the son of Poseidon. With hospitality, he lured strangers to his inn, and then tied his victims to an iron bed. If their limbs were too long, he would cut them to fit. If too short, he stretched them to the right size.)

Psychotherapists can optimize therapy relationships by simultaneously using what works *and* studiously avoiding what does not work (see Norcross, Koocher, & Garofalo, 2006, for a consensual list of what does not work).

## INTEGRATING RESEARCH AND PRACTICE, INTEGRATING THE RELATIONAL AND TECHNICAL

The research on the therapy relationship is vast, robust, and instructive. As in all pursuits, it is also evolving and not beyond cavil. Before closing, and without resorting to a hackneyed call for more research, allow me a few remarks of caution and constraint. First, current conclusions represent initial steps in aggregating and codifying available research. We all eagerly await updates. My own best guess is that client preferences and attachment styles will soon emerge in research as key guides to how therapists might construct a facilitative therapy relationship.

Second, all findings need to be interpreted within context, such as the modest causal connection between the relationship elements and treatment outcome. Because many facets of the relationship are not subject to randomization and experimental control, it is more difficult to determine a strong, causal relationship between relational elements and treatment outcomes. Nonetheless, dozens of lagged correlational, unconfounded regression, structural equation, and growth curve studies persuasively demonstrate that the therapy relationship causally contributes to outcome (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). For example, using growth-curve analyses (and after controlling for prior improvement and eight prognostically relevant client characteristics), D. N. Klein et al. (2003) found that the early alliance significantly predicted later improvement in 367 chronically depressed clients. Although researchers need to continue to parse out the causal linkages, the therapy relationship has already been shown to exercise causal association to outcome.

For historical and research convenience, we have made distinctions between relationships and techniques. Terms such as *relating* and *interpersonal behavior* are used to describe how therapists and clients behave toward each other. In contrast, terms such as *technique* or *intervention* are used to describe what is done by the therapist. In research and theory, we often treat the *how* and the *what*—the relationship and the intervention, the interpersonal and the instrumental—as separate categories. In reality, of course, what one does and how one does it are complementary and inseparable. To remove the interpersonal from the instrumental may be acceptable in research, but it is a fatal flaw when the aim is to extrapolate research results to clinical practice. Although this chapter has focused on key associations between outcome and

qualities of the therapeutic relationship, one must always remember that what the therapist does is also influential and inseparable (Orlinsky, 2000). (See also a 2005 special issue of *Psychotherapy* on the interplay of techniques and therapeutic relationship.)

In other words, the value of a treatment method is inextricably bound to the relational context in which it is applied. Hans Strupp, one of my first research mentors, offered an analogy to illustrate the inseparability of these constituent elements. Suppose a parent wants a teenager to clean his or her room. Two methods for achieving this are to establish clear standards and to impose consequences. It's a reasonable approach, but the effectiveness of these two evidence-based methods will vary on whether the relationship between the parent and the teenager is characterized by warmth and mutual respect or anger and mistrust. This is not to say that the methods are useless, but how well they work depends on the context in which they are used.

método y contexto relacional son inseparables

When all is said and done, when the thousands of empirical studies bearing on the therapeutic relationship are analyzed, here is what can be reliably stated about practice (Norcross, 2001, 2002):

- The therapy relationship makes significant and consistent contributions to psychotherapy outcome for all types of psychological treatments. Thus, practitioners should make the creation and cultivation of a facilitative therapy relationship a primary aim.
- Adapting or tailoring the therapy relationship to specific client needs and characteristics may enhance the effectiveness of treatment. Hence, practitioners are encouraged to adapt the therapy relationship to client characteristics in those ways shown to enhance therapeutic outcome.
- Actively monitoring the quality of the therapeutic relationship improves alliances and reduces negative outcomes. Practitioners should routinely monitor clients' responses to the therapy relationship and treatment.
- The therapy relationship acts in concert with treatment method, client characteristics, and clinician qualities in determining treatment effectiveness. Thus, a comprehensive understanding of effective (and ineffective) psychotherapy considers all of these determinants and their optimal combinations.
- In an era preoccupied with technology and materialism, mental health practitioners should advocate for the research-substantiated benefits of a facilitative and responsive human relationship in psychotherapy.

relación terapéutica como primer objetivo

Adaptar relación terapéutica a cada cliente

Monitorear relación terapéutica

Coming full circle, if we are to be like Einstein—or at least an interpersonally talented Einstein—what might we do? Cultivate the therapy relation-

ship. Customize the relationship (and treatment) to the particular client and context. Simultaneously use what works. Avoid what does not. Capitalize on what decades of research and millions of clients have told us: Nurture the therapeutic relationship.

## QUESTIONS FROM THE EDITORS

1. *Mindful of the consequence of a sound alliance to outcome and retention (some calling it the flagship) and the recent call by many to monitor/measure the alliance, what do you think it will take for the field to embrace alliance assessment as a necessary component of service delivery?*

Beats me. The extant body of research is robust and convincing to most practitioners (including me), and many of my colleagues have incorporated into their sessions various means of directly assessing their clients' experience of the relationship. However, others do not find the research sufficiently compelling or theoretically compatible to implement a formal assessment of alliance.

All psychotherapy innovations take many years to make it from science to service. Recent efforts to accelerate the translation of research into practice might help (Norcross, Hogan, & Koocher, 2008), as long as they do not focus exclusively on specific treatment methods for particular *DSM* categories. Other than that, I am at a loss to explain why more practitioners are not systematically monitoring the therapy relationship and soliciting feedback from their clients. It strikes me as bad science and as bad practice not to do so.

2. *Given the import of a strong therapy relationship to treatment outcome, what implications do you see in the training of graduate students?*

Three immediate implications spring to mind: graduate admissions, curriculum requirements, and competency training. First, we must select students for graduate training who are both academically qualified and interpersonally skilled. We have lost our collective way of late. On the one hand, PhD and MD/DOs programs are very competitive in admissions, but favor entrance examination scores, undergraduate grades, and research experiences over interpersonal skills. On the other hand, many master's programs do emphasize interpersonal skills in admissions decisions, yet are forced to accept the vast majority of applicants for economic survival. For this reason, some students with questionable preparation and mental health are admitted. We need to find a middle way, a way that commits us to selecting rigorously prepared and interpersonally adept people.

Second, every graduate program in mental health should provide explicit training in the effective elements of the therapy relationship and in adapting the relationship to the individual client. To do so will probably require some

accountability and accreditation “teeth.” Accreditation and certification bodies should develop criteria for assessing, in their evaluation process, the adequacy of training in the therapy relationship.

Third, we need to progress in graduate training from mere exposure to knowledge to demonstrated competence in skills. To know that the therapy relationship is a reliable contributor to outcome is far different from being skilled in creating and cultivating that relationship. I am a strong advocate of competency-based training.

3. *You discuss the important interplay of relationship and technique. It has been suggested that technique represents an instance of the alliance in action. How does such an interdependence of these factors, and the inevitable improvisations and ebb and flow of clinical interaction, help or hinder research about the relationship?*

Research on the effectiveness of the psychotherapy relationship is constrained by therapist responsiveness—the ebb and flow of clinical interaction, as you put it. *Responsiveness* refers to behavior that is affected by emerging context and occurs on many levels—including choice of an overall treatment, case formulation, strategic use of the self and method—and then adjusting those to meet the emerging, evolving needs of the client in any given moment (Stiles, Honos-Webb, & Surko, 1998). Effective psychotherapists are responsive to the different needs of their clients, providing varying levels of relationship elements in different cases and, within the same case, at different moments.

When this occurs, highly effective relational ingredients may have null (or even negative) correlations with outcomes in the cumulative research. Successful responsiveness can confound attempts to find naturalistically observed linear relations of outcome with therapist behaviors (e.g., self-disclosures, positive regard). Because of such problems, the statistical relations between the relationship and outcome cannot always be trusted. By being clinically attuned and flexible, as they should, psychotherapists make it more difficult in research studies to discern what works.

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