Empirically Supported Therapy Relationships

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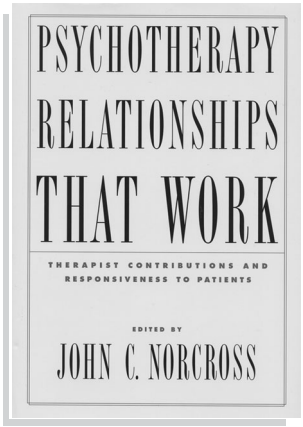

Health care professionals around the globe are increasingly promulgating practice guidelines and evidence-based treatments in mental health. Foremost among these initiatives in psychology was the Society of Clinical Psychology's (American Psychological Association, Division 12) Task Force efforts to identify empirically supported treatments (ESTs) for adults and to publicize these treatments to fellow psychologists and training programs. A succession of APA Division 12 Task Forces (now a standing committee) constructed and elaborated a list of empirically supported, manualized psychological interventions for adult disorders based on randomized controlled studies (Chambless et al., 1996; Chambless et al., 1998; Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Subsequently, ESTs were applied to both older adults and children (e.g., Gatz et al., 1998; Lonigan, Elbert, & Johnson, 1998).

In Great Britain, a Guidelines Development Committee of the British Psychological Society authored a Department of Health (2001) document entitled *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Practice Guidelines*. In psychiatry, the American Psychiatric Association has published a dozen or so practice guidelines, on disorders ranging from schizophrenia to anorexia nervosa to nicotine dependence.

These and other efforts to promulgate evidence-based psychotherapies have been noble in intent and timely in distribution. They are praiseworthy efforts to distill scientific research into clinical applications and to guide practice and training. They wisely demonstrate that, in a climate of increasing accountability, psychotherapy stands up to empirical scrutiny with the best of health care interventions. At the same time, as with any initial effort, the EST effort was incomplete and potentially misleading.

In particular, two important omissions detracted from these first-generation compilations of evidence-based practices. First, they neglected the therapy relationship, an interpersonal quality that makes substantial and consistent contributions to psychotherapy outcome, independent of the specific type of treatment. The therapy relationship accounts for as much treatment outcome as the specific treatment method (Lambert, 2003; Wampold, 2001).

Second, the initial efforts at ESTs and practice guidelines largely ignored matching the treatment and the relationship to the individual patient beyond his or her diagnosis. Virtually all were directed toward single, categorical disorders; DSM diagnoses have ruled the evidence-based roost to date. Although the research indicates that certain psychotherapies make better marriages for certain disorders, psychological therapies will be increasingly matched to people, not simply to diagnoses. As every clinician knows, different types of patients respond more effectively to different types of treatments and relationships. Clinicians strive to offer or select a therapy that accords to the patient's personal characteristics, proclivities, and worldviews—in addition to diagnosis.

Within this context, an APA Division of Psychotherapy Task Force was established to identify, operationalize, and disseminate information on empirically supported therapy relationships. We aimed to identify empirically supported (therapy) relationships rather than empirically supported treatments – or ESRs rather than ESTs. Specifically, the twin aims of the Division 29 Task Force were to: identify elements of effective therapy relationships, and to identify effective methods of tailoring therapy to the individual patient on the basis of his or her (nondiagnostic) characteristics. In other words, we sought to answer the dual pressing questions of "What works in general in the therapy relationship?" and "What works best for particular patients?"

The Task Force reviewed the extensive body of empirical research and generated a list of empirically supported relationship elements and a list of means for customizing therapy to the individual

client. For each, we judged whether the element was *demonstrably effective, promising and probably effective*, or whether there was *insufficient research to judge*. The evidentiary criteria for making these judgments were the number of supportive studies, the consistency of the research results, the magnitude of the positive relationship between the element and outcome, the directness of the link between the element and outcome, the experimental rigor of the studies, and the external validity of the research base.

The research reviews and clinical practices were compiled in *Psychotherapy Relationships That Work* (Norcross, 2002) and summarized in a special issue of *Psychotherapy* (Norcross, 2001). The following synopses are drawn from those documents.

General Elements of the Therapy Relationship

As noted, the first aim of the Task Force was to identify those relationship elements or behaviors, primarily provided by the psychotherapist, that are effective in general. For each of these relationship elements, we provide a brief definition, a summary of the research linking the element to therapy effectiveness, and a few clinical implications.

"...empathy involves entering the private, perceptual world of the other."

Demonstrably Effective

• *Therapeutic alliance.* The alliance refers to the quality and strength of the collaborative relationship between client and therapist, typically measured as agreement on the therapeutic goals, consensus on treatment tasks, and a relationship bond. Across 89 studies, the effect size (ES) of the relation between the therapeutic alliance and therapy outcome among adults was .21, a modest but very robust association. (A subsequent and independent meta-analysis of 23 studies of child and adolescent therapy found a weighted mean correlation between alliance and outcome of .20; Shirk & Karver, 2003). The alliance is harder to establish with clients who are: more disturbed, delinquent, homeless, drug abusing, fearful, anxious, dismissive, and preoccupied. On the therapist side, a stronger alliance is fostered by strong communication skills, empathy, openness, and a paucity of hostile interactions.

• *Cohesion in group therapy*. 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. Methods to increase cohesion include pre-group preparation, addressing early discomfort using structure, encouraging member-to-member interaction, actively modeling and setting norms (but not being overly directive). In addition, both feedback and establishing a good emotional climate contribute to cohesion.

• *Empathy*. Carl Rogers' definition, which has guided most of the research, is that empathy is the therapist's sensitive ability and willingness to understand clients' thoughts, feelings, and struggles from their point of view. In other words, empathy involves entering the private, perceptual world of the other. A meta-analysis of 47 studies (encompassing 190 tests of the empathy-outcome association) revealed an ES of .32. Furthermore, a causal link between empathy and outcome has been demonstrated, with suggestions that empathy is linked to outcome because it serves a positive relationship function, is a corrective emotional experience, promotes exploration and meaning creation, and supports clients' active self-healing efforts.

• *Goal consensus and collaboration*. The former refers to therapist-patient agreement on treatment goals and expectation; the latter is the mutual involvement of the participants in the helping relationship. 68% of the studies found a positive association between goal consensus and outcome, and 88% of the studies reported the same for collaboration and outcome. It is not concretely clear from the research how to build goal consensus or collaboration, but clinical experience suggests that clinicians should begin to develop consensus at intake, verbally attend to patient problems, address topics of importance to patients, resonate to patient attributions of blame regarding their problems, and frequently discuss or reevaluate goals.

Promising and Probably Effective

• *Positive regard*. This therapist quality is characterized as warm acceptance of the client's experience without conditions, a prizing, an affirmation, and a deep nonpossessive caring. The early research reviews were very supportive of the association between positive regard and therapy outcome, with 80% of the studies in the positive direction. More recent and rigorous reviews report 49% to 56% of the findings in the positive direction, with no negative associations between positive regard and outcome.

When treatment outcome and therapist positive regard were both rated by clients, the percentage of positive findings jumped to 88%. Clinically, results indicate that therapists cannot be content with feeling good about their patients, but instead should ensure that their positive feelings are communicated to them.

• *Congruence/genuineness*. The two facets here are the therapist's personal integration in the relationship (freely and deeply him or herself) 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 nonsignificant associations. The percentage of positive studies increased to 68% when congruence was tested in concert with empathy and positive regard, supporting the notion that the facilitative conditions 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.

"...effectively managing countertransference aids the process and probably the outcome of therapy."

• *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. To enhance the effects of feedback, therapists can increase their credibility (which makes acceptance of feedback more positive), give positive feedback (especially early to establish the relationship), and precede or sandwich negative feedback with positive comments.

• *Repair of alliance ruptures*. A rupture in the therapeutic alliance is a tension or breakdown in the collaborative relationship. The small body of research indicates that the frequency and severity of ruptures are increased by strong 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.

• *Self-disclosure*. Therapist self-disclosure is defined as therapist statements that reveal something personal about the therapist. Analogue research suggests that nonclients generally have positive perceptions of therapist self-disclosure. In actual therapy, disclosures were perceived as helpful in terms of immediate outcomes, although the effect on the ultimate outcome of therapy is unclear. The research suggests that therapists should disclose infrequently and, when they disclose, do so to validate reality, normalize experiences, strengthen the alliance, or offer alternative ways to think or act. By contrast, therapists should generally avoid self-disclosures that are for their own needs, remove the focus from the client, or blur the treatment boundaries.

• *Management of countertransference*. Although defined in various ways, countertransference refers to reactions in which the unresolved conflicts of the psychotherapist, usually but not always unconscious, are implicated. The limited research supports the interrelated conclusions that the therapist acting out countertransference hinders psychotherapy, whereas effectively managing countertransference aids the process and probably the outcome of therapy. In terms of 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 interventions that 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 patient's behavior. The research correlating frequency of interpretations and outcome has yielded mixed findings; however, it appears that high rates of transference interpretations lead to poorer outcomes, especially for clients with low quality of object relations. By 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. The clinical 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 patient.

Customizing the Therapy Relationship to Individual Patients

Emerging research indicates that adapting the thera-

py relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment. Accordingly, the second aim of the Task Force was to identify those patient behaviors or qualities that served as reliable markers for customizing the therapy relationship

Demonstrably Effective as a Means of Customizing Therapy

• *Resistance*. Resistance refers to being easily provoked by external demands. Research confirms that high patient resistance is consistently associated with poorer therapy outcomes (in 82% of studies). But matching therapist directiveness to client level of resistance improves therapy efficiency and outcome (in 80% of studies). Specifically, clients presenting with high resistance benefited more from self-control methods, minimal therapist directiveness, and paradoxical interventions. By contrast, clients with low resistance benefited more from therapist directiveness and explicit guidance. The clinical implication is to match the therapist's level of directiveness to the patient's level of resistance.

"Most of the available studies (76%) found a significant, inverse relation between level of impairment and treatment outcome"

• *Functional impairment*. This complex dimension reflects the severity of the patient's subjective distress as well as areas of reduced behavioral functioning. Most of the available studies (76%) found a significant, inverse relation between level of impairment and treatment outcome. These results indicate that patients who manifest impairment in two or more areas of functioning (family, social, intimate, occupational) are more likely to benefit from treatment that is lengthier, more intense, and that includes psychoactive medication. Furthermore, patients who have little support from other people will more likely benefit from a lengthier psychotherapy that explicitly targets the creation of social support in the natural environment.

Promising and Probably Effective as a Means of Customizing Therapy

• *Coping style*. Although defined differently across theoretical orientations, coping style broadly refers to habitual and enduring patterns of behavior that characterize the individual when confronting new or problematic situations. In the research, attention has been devoted primarily to the externalizing (impulsive, action or task-oriented, stimulation seeking, extroverted) and internalizing coping styles (self-critical, reticent, inhibited, introverted). 79% of the studies investigating this dimension demonstrated differential effects of the type of treatment as a function of patient coping style. Hence, interpersonal and insight-oriented therapies are more effective among internalizing patients, whereas symptom-focused and skill-building therapies are more effective among externalizing patients.

• *Stages of change*. People progress through a series of stages—precontemplation, contemplation, preparation, action, and maintenance—in both psychotherapy and self-change. A meta-analysis of 47 studies found ESs of .70 and .80 for the use of different change processes in the stages; specifically, cognitive-affective processes are used most frequently by clients in the precontemplation and contemplation stages and behavioral processes most frequently by those in the action and maintenance stages. The therapist's optimal stance also varies depending on the patient's stage of change: a nurturing parent with patients in the precontemplation stage; a Socratic teacher with patients in the contemplation stage; an experienced coach with patients in the action stage; and a consultant during the maintenance stage. The clinical implications are to assess the patient's stage of change, match the therapeutic relationship and the treatment method to that stage, and systematically adjust tactics as the patient moves through the stages.

• *Anaclitic/sociotropic and introjective/autonomous styles*. In the psychoanalytic tradition, there are two broad personality configurations: a relatedness or anaclitic style that involves the capacity for satisfying interpersonal relationships, and a self-definitional or introjective style that involves the development of an integrated identity. Similar distinctions are made in cognitive therapy between sociotropic and autonomous styles. A small but growing body of research indicates that these two personality styles are differentially related to psychotherapy outcome. Specifically, anaclitic/sociotropic patients benefit more from therapies that offer more personal interaction and closer relatedness, whereas introjective/autonomous patients tend to do better in therapies emphasizing separation and autonomy. The identification of the patient's personality organization may enable therapists to adapt the degree of interpersonal closeness

to the individual patient.

• *Expectations*. Expectancy refers to client expectations of therapeutic gain as well as of psychotherapy procedures, the therapist's role, and the length of treatment. Of 24 studies on clients' outcome expectations, 12 found a positive relation between expectations and outcome, 7 found mixed results, and 7 found no relationship. Of 37 studies on clients' role expectation, 21 found positive relationships with outcome, 12 mixed support, and 8 found no association with outcome. The research literature encourages therapists to explicitly assess and discuss client expectations, address overt skepticism, arouse positive expectations, and activate the client's belief that he or she is being helped.

• A*ssimilation of problematic experiences*. The assimilation model suggests that, in successful psychotherapy, clients follow a regular developmental sequence of working through problematic experiences. The sequence is summarized in eight stages, from the patient being warded off/dissociated from the problem at the one end, to integration/mastery of the problem at the other end. A series of intensive case studies and two hypothesis-testing studies indicated that clients in the mid to late stages of assimilation prosper more from directive, cognitive-behavioral therapy. Furthermore, the research suggests that as the client changes, the therapist should change responsively, reflecting the evolving feelings, goals, and behaviors that represent therapeutic progress.

"...the research suggests that as the client changes, the therapist should change responsively..."

Insufficient Research

The state of the current research was insufficient for the Task Force to make a clear judgment on whether customizing the therapy relationship to the following patient characteristics improves treatment outcomes: Attachment style; gender; ethnicity; religion and spirituality; preferences; and personality disorders.

Practice and Research Recommendations

The Task Force reports (Norcross, 2001, 2002) close with a series of recommendations, divided into general, practice, training, research, and policy recommendations. The general recommendations encourage readers to interpret the findings in the context of the limitations of the Task Force's work (such as the modest causal connection between the relationship element and treatment outcome) and remind readers that the current conclusions represent initial steps in aggregating and codifying available research. Here, we conclude by highlighting several of the research and practice recommendations.

Research Recommendations

1. Researchers are encouraged to examine the specific mediators and moderators of the links between demonstrably effective relationship elements and treatment outcome.
2. Researchers are encouraged to progress beyond experimental designs that correlate frequency of relationship behaviors and outcome measures to methodologies capable of examining the complex associations among patient qualities, clinician behaviors, and therapy outcome.
3. Researchers are encouraged to avoid a "therapist-centric" view of the therapeutic relationship and to study both patients' and therapists' contributions to the relationship and the ways in which those contributions combine to impact treatment outcome.
4. Observational perspective (i.e., therapist, patient, or external rater) is a fundamental consideration that ought to be addressed in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for clinical practice.

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5. Since many of the important variables reviewed in the Task Force reports are not subject to randomization and experimental control, we recommend that standard research paradigms include the use of rigorous qualitative methods and statistically controlled correlational designs.

Practice Recommendations

6. Practitioners are encouraged to make the creation and cultivation of a therapy relationship characterized by the elements found to be demonstrably and probably effective in this report a primary aim in the treatment of patients.

7. Practitioners are encouraged to adapt the therapy relationship to specific patient characteristics in the ways shown in the report to enhance therapeutic outcome.

8. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, to improve the relationship, to modify technical strategies, and to avoid premature termination.

9. Concurrent use of empirically supported relationships and empirically supported treatments tailored to the patient's disorder and characteristics is likely to generate the best outcomes.□

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Other Resources

American Psychological Association Division of Psychotherapy Homepage (includes a link to the Task Force on Empirically Supported Psychotherapy Relationships). http://www.divisionofpsychotherapy.org

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