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Psychotherapy Relationships That Work II

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This article introduces the special issue of *Psychotherapy* devoted to evidence-based therapy relationship elements and traces the work of the interdivisional task force that supported it. The dual aims of the task force are to identify elements of effective therapy relationships (what works in general) and to identify effective methods of adapting or tailoring treatment to the individual patient (what works in particular). The authors review the structure of the subsequent articles in the issue and the multiple meta-analyses examining the association of a particular relationship element to psychotherapy outcome. The centrality of the therapy relationship, its interdependence with treatment methods, and potential limitations of the task force work are all highlighted. The immediate purpose of the journal issue is to summarize the best available research and clinical practices on numerous elements of the therapy relationship, but the underlying purpose is to repair some of the damage incurred by the culture wars in psychotherapy and to promote rapprochement between the science and practice communities.

Keywords: psychotherapy relationships, treatment outcomes, meta-analysis, alliance, treatment adaptation, evidence-based practice

The culture wars in psychotherapy dramatically pit the treatment method against the therapy relationship. Do treatments cure disorders or do relationships heal people? Which is the most accurate vision for researching, teaching, and practicing psychotherapy?

Like most dichotomies, this one is misleading and unproductive on multiple counts. For starters, the patient's contribution to psychotherapy outcome is vastly greater than that of either the particular treatment method or the therapy relationship (Lambert, 1992; Wampold, 2001). The empirical evidence should keep us mindful and a bit humble about our collective tendency toward therapist-centricity (Bohart & Tallman, 1999). For another, decades of psychotherapy research consistently attest that the patient, the therapist, their relationship, the treatment method, and the context all contribute to treatment success (and failure). We should be looking at all of these determinants and their optimal combinations (Norcross, Beutler, & Levant, 2006).

But perhaps the most pernicious and insidious consequence of the false dichotomy of treatment versus relationship has been its polarizing effect on the discipline. Rival camps have developed and countless critiques have been published on each side of the culture war. Are you on the side of the treatment method, the RCT (randomized controlled/clinical trial), and the scientific-medical model? Or do you belong to the side of the therapy relationship, the effectiveness and process-outcome studies, and the relational-contextual model? Such polarizations not only impede psychotherapists from working together but also hinder our attempts to provide the most efficacious psychological services to our patients.

We hoped that a balanced perspective would be achieved by the adoption of an inclusive, neutral definition of evidence-based practice. The American Psychological Association (APA, 2006, p. 273) did endorse just such a definition: "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." However, even that definition has been commandeered by the rival camps as polarizing devices. On the one side, some erroneously equate EBP solely with the best available research and particularly the results of RCTs on treatment methods, while on the other side, some mistakenly exaggerate the primacy of clinical or relational expertise while neglecting research support.

Within this polarizing context, in 1999, the APA Division of Psychotherapy commissioned a task force to identify, operationalize, and disseminate information on empirically supported therapy relationships. That task force summarized its findings in a 2001 special issue of this journal (Norcross, 2001) and detailed its results and recommendations in a lengthy book (Norcross, 2002). In 2009, the Division of Psychotherapy along with the Division of Clinical Psychology commissioned a second task force to update the research base and clinical practices on the psychotherapist-patient relationship. This special issue, appearing 10 years after its predecessor, does just that.

Our hope now, as then, was to advance a rapprochement between the warring factions and to demonstrate that the best available research clearly demonstrates the healing qualities of the therapy relationship. The work of the first task force brought renewed and corrective attention to the substantial research behind

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the therapy relationship and, in the words of one reviewer (Weiner, 2003, p. 532) "will convince most psychotherapists of the rightful place of ESRs (empirically supported relationships) alongside ESTs in the treatments they provide." Note the desired emphasis on "alongside" treatments, not "instead of" or "better than." We aimed then, as now, to identify evidence-based therapy relationships, as has been extensively done for particular treatment methods (e.g., Barlow, 2007; Gabbard, 2007; Nathan & Gorman, 2007; Research-Supported Psychological Treatments, 2010).

The work of the task force continues the application of psychological science to the identification and promulgation of effective psychotherapy. It does so by expanding or enlarging the typical focus of evidence-based practice to therapy relationships. Focusing on one area—in this case, the therapy relationships—may unfortunately convey the impression that this is the only area of importance. We review the scientific literature on the therapy relationship and provide clinical recommendations based on that literature in ways, we trust, without degrading the simultaneous contributions of the treatments, patients, or therapists to outcome.

Our immediate purpose in this special issue, then, is to summarize the best available research and clinical practices on numerous elements of the therapy relationship. We believe readers will benefit from the following reviews in that they convey the strength of evidence, its limitations, and implications for practice and training. We also hope this issue repairs some of the damage incurred by the culture wars in psychotherapy and promotes rapprochement between the science and practice communities.

The Purposes

The dual purposes of the interdivisional Task Force were to identify elements of effective therapy relationships and to identify effective methods of adapting or tailoring therapy to the individual patient on the basis of his or her (nondiagnostic) characteristics. In other words, we were interested in both what works in general and what works for particular patients. This special issue addresses the first purpose; another special journal issue will address the second (Norcross, 2011).

The aims of the original and the current task force remained the same, but our name, methodology, and scope did not. First, we retitled the task force *evidence-based psychotherapy relationships* instead of *empirically supported (therapy) relationships* to parallel the contemporary movement to the newer terminology. This title change, in addition, properly emphasizes the confluence of the best research, clinical expertise, and patient characteristics in a quality treatment relationship. Second, we expanded the breadth of coverage. New reviews were commissioned on the alliance with children and adolescents, the alliance in couple and family therapy, and collecting real-time feedback from clients. Third, we decided to insist on meta-analyses for the research reviews. These original meta-analyses enable direct estimates of the magnitude of association and the ability to search for moderators. Unfortunately, that also meant that a couple of relationship elements appearing in the first task force report (self-disclosure, transference interpretations) were excluded due to an insufficient number of studies. Fourth, we improved the process for determining whether a particular relationships element—say, the alliance or empathy—could be classified as Demonstrably Effective, Probably Effective, or Promising but Insufficient Research to Judge. We compiled expert panels to establish a consensus on the evidentiary strength of the relationship elements. Experts independently reviewed and rated the meta-analyses on several criteria: the 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.

The Therapy Relationship

For the purposes of our work, we again adopted Gelso and Carter's (1985, 1994) operational definition of the therapy relationship: The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed. This definition is quite general, and the phrase "the manner in which it is expressed" potentially opens the relationship to include everything under the therapeutic sun (see Gelso & Hayes, 1998, for an extended discussion). Nonetheless, it serves as a concise, consensual, theoretically neutral, and sufficiently precise definition.

We acknowledge the deep synergy between treatment methods and the therapeutic relationship. They constantly shape and inform each other. Both clinical experience and research evidence (e.g., Rector, Zuroff, & Segal, 1999; Barber et al., 2006) point to a complex, reciprocal interaction between the interpersonal relationship and the instrumental methods. Consider this finding from a large collaborative study: For patients with a strong therapeutic alliance, adherence to the treatment manual was irrelevant for treatment outcome, but for patients with a weak alliance, a moderate level of therapist adherence was associated with the best outcome (Barber et al., 2006). The relationship does not exist apart from what the therapist does in terms of method, and we cannot imagine any treatment methods that would not have some relational impact. Put differently, treatment methods are relational acts (Safran & Muran, 2000).

For historical and research convenience, the field has distinguished between relationships and techniques. Words like "relating" and "interpersonal behavior" are used to describe *how* therapists and clients behave toward each other. By contrast, terms like "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 (see Orlinsky, 2000, 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 our first research mentors, offered an analogy to illustrate the inseparability of these constituent elements. Suppose you want your teenager to clean his or her room. Two methods for achieving this are to establish clear standards and to impose consequences. A reasonable approach, but the effectiveness of these two evidence-based methods will vary on whether the relationship between you and the teenager is characterized by warmth and mutual respect or by anger and mistrust. This is not to say that the methods are

useless, merely how well they work depends upon the context in which they are used (Norcross, 2010).

We wish that more psychotherapists would acknowledge the inseparable context and practical interdependence of the relationship and the treatment. That can prove a crucial step in reducing the polarizing strife of the culture wars and in improving the effectiveness of psychotherapy (Lambert, 2010).

Scholarly and Practice Products

The interdivisional task force on evidence-based therapy relationships is generating numerous reports in an effort to disseminate widely our results and recommendations. We are publishing a synopsis of our work in this special issue as well as a second journal issue devoted to adapting or tailoring the therapy relationship to the individual patient (Norcross, 2011). The complete research reviews and detailed therapeutic practices are being published in a book, the second edition of *Psychotherapy Relationships that Work*. Members of the original and current task forces are presenting a series of addresses, workshops, and symposia on the conclusions and recommendations. We are also authoring summaries of our work for release in professional newsletters and interdisciplinary outlets. Last but not least, we are publishing layperson-friendly thumbsketches of the work as an online module in the National Registry of Evidence-based Programs and Practices (NREPP; www.nrepp.samhsa.gov/).

The goals of these products are identical: to disseminate evidence-based methods of improving the therapy relationship and effective means of adapting that relationship to the individual patient. The dissemination or uptake problem is a genuine concern. We aim to reach various stakeholders by distributing the results in their preferred communication formats: for researchers, a scholarly book, journal articles, and academic presentations; for practitioners, a practice journal, clinical workshops, and professional newsletters; and for students and early career professionals, online products that are free of charge. Our fervent hope is that the Task Force's multiple reports, and communication formats will enhance implementation.

These task force products would not have been possible without organizational and individual support. The board of directors of the APA Division of Psychotherapy and the APA Division of Clinical Psychology commissioned and supported the task force. In particular, we are indebted to the presidents of the respective divisions: Drs. Jeffrey Barnett, Nadine Kaslow, and Jeffrey Magnavita of the psychotherapy division, and Drs. Marsha Linehan, Irving Weiner, and Marvin Goldfried of the clinical division. The authors of the meta-analyses, of course, were indispensible in generating the research conclusions and were generous in sharing their expertise. The Steering Committee of the first task force assisted in canvassing the literature, defining the parameters of the project, selecting the contributors, and writing the initial conclusions. We express our gratitude to them all: Steven J. Ackerman, Lorna Smith Benjamin, Larry E. Beutler, Charles J. Gelso, Marvin R. Goldfried, Clara E. Hill, David E. Orlinsky, and Jackson P. Rainer.

This Issue

Following this introduction are 11 articles presenting multiple meta-analyses on particular facets of the psychotherapy relationship and their relation to treatment outcome. The articles are intentionally clustered and ordered. We begin with broader, more inclusive relationship elements. The therapy alliance and group cohesion are composed, in fact, of multiple elements. Subsequent articles feature more specific elements of the therapy relationship (empathy, goal consensus, collaboration, positive regard, and congruence). The three articles after those review specific therapist behaviors—collecting client feedback, repairing alliance ruptures, and managing countertransference—that promote the relationship and favorable treatment results. The special issue concludes with an article that summarizes the research conclusions and practice recommendations of the task force.

Except the bookends, each article uses the same section headings and follows a consistent structure, as follows:

◆ Introduction (untitled). Introduce the relationship element and its historical context in several paragraphs.

◆ Definitions and Measures. Define in theoretically neutral language the relationship element. Identify any highly similar or equivalent constructs from diverse theoretical traditions. Review the popular measures used in the research and included in the ensuing meta-analysis.

◆ Clinical Example. Provide several concrete examples of the relationship behavior being reviewed. Portions of psychotherapy transcripts might help here.

◆ Meta-Analytic Review. Systematically compile all available empirical studies linking the relationship behavior to treatment outcome in the English language. Use the Meta-Analysis Reporting Standards (MARS) as a general guide for the information included in your chapter and report your effect size as weighted *r*.

◆ Moderators. Present the results of the moderator analyses on the association between the relationship element and treatment outcome. If available in the studies, examine the possible moderating effects of (1) rater perspective (assessed by therapist, patient, or external raters), (2) therapist variables, (3) patient factors, (4) different measures of the relationship element, (5) time of assessment (when in the course of therapy), and (6) type of psychotherapy/theoretical orientation.

◆ Patient Contribution. The meta-analyses pertain largely to the psychotherapist's contribution to the relationship; by contrast, this section will address the patient's contribution to that relationship and the distinctive perspective he or she brings to the interaction.

◆ Limitations of the Research. Points to the major limitations of both the meta-analysis and the available studies.

◆ Therapeutic Practices. The emphasis here should be placed squarely on what works. Bullet the practice implications from the foregoing research, primarily in terms of the therapist's contribution and secondarily in terms of the patient's perspective.

These research reviews are based on the results of empirical research linking the relationship element to psychotherapy outcome. Outcome was inclusively defined, but consisted largely of distal posttreatment outcomes. Authors were asked to specify the outcome criterion when a particular study did not employ a typical end-of-treatment measure of symptom or functioning. Indeed, the type of outcome measure was frequently analyzed as a possible moderator of the overall effect size.

Speaking of effect sizes, the meta-analyses reported herein all employed the weighted *r*. This decision improved the consistency among the meta-analyses, enhanced their interpretability among the readers (square *r* for the amount of variance accounted for),

and enabled direct comparisons of the meta-analytic results to one another as well as to *d* (the ES typically used when comparing the relative effects of two treatments). In all of these analyses, the larger the magnitude of *r*, the higher the probability of patient success in psychotherapy. By convention (Cohen, 1988), an *r* of .10 in the behavioral sciences is considered a small effect, .30 a medium effect, and .50 a large effect.

Given the large number of factors contributing to treatment outcome and the inherent complexity of psychotherapy, we do not expect large, overpowering effects of any single facet. Instead, we expect to find a number of helpful facets. And that is exactly what we find in the following articles—beneficial, small to medium-sized effects of several elements of the complex therapy relationship.

Limitations of the Task Force

A single task force can accomplish only so much work and cover only so much content. As such, we wish to acknowledge several necessary omissions and unfortunate truncations in our work.

The products of the Task Force probably suffer from content overlap. We may have cut the "diamond" of the therapy relationship too thin at times, leading to a profusion of highly related and possibly redundant constructs. Goal consensus, for example, correlates highly with parts of the therapeutic alliance, but these are reviewed in separate articles. Collecting client feedback and repairing alliance ruptures, for another example, may represent different sides of the same therapist behavior, but these too are covered in separate articles and meta-analyses. Thus, to some the content may appear swollen; to others, the Task Force may have failed to make necessary distinctions.

Another prominent limitation across these research reviews is the difficulty of establishing causal connections between the relationship behavior and treatment outcome. Only the article on collecting client feedback contains randomized clinical trials capable of demonstrating a causal effect. Causal inferences are always difficult to make concerning process variables, such as the therapy relationship. Does the relationship cause improvement or simply reflect it? The interpretation problems of correlational studies (third variables, reverse causation) render such studies less convincing then RCTs. It is methodologically difficult to meet the three conditions to make a causal claim: nonspuriousness, covariation between the process variable and the outcome measure, and temporal precedence of the process variable (Feeley, DeRubeis, & Gelfand, 1999). We still need to determine whether and when the therapeutic relationship is a mediator, moderator, or mechanism of change in psychotherapy (Kazdin, 2007).

At the same time as we acknowledge this central limitation, let's remain mindful of several considerations. First, the establishment of temporal ordering is essential for causal inference, but it is not sufficient. In showing that these facets of a therapy relationship precede positive treatment outcome, we can certainly state that the therapy relationship is, at a minimum, an important predictor and antecedent of that outcome. Second, within these reality constraints, dozens of lagged correlational, unconfounded regression, structural equation, and growth curve studies suggest that the therapy relationship probably causally contributes to outcome (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). For example, using growth-curve analyses and controlling for prior improvement and eight prognostically relevant client characteristics, Klein and colleagues (2003) found that the early alliance significantly predicted later improvement in 367 chronically depressed clients. Although we need to continue to parse out the causal linkages, the therapy relationship has probably been shown to exercise some causal association to outcome. Third, some of the most precious behaviors in life are incapable on ethical grounds of random assignment and experimental manipulation. Take parental love as an exemplar. Not a single randomized clinical trial has ever been conducted to conclusively determine the causal benefit of a parent's love on their children's functioning, yet virtually all humans aspire to it and practice it. Nor can we envision an institutional review board ever approving a grant proposal to randomize patients in a psychotherapy study to an empathic, collaborative, and supportive therapist versus an nonempathic, authoritarian, and unsupportive therapist.

A final interesting drawback to the present work—and psychotherapy research as a whole—is the paucity of attention paid to the disorder-specific and treatment-specific nature of the therapy relationship. It is premature to aggregate the research on how the patient's primary disorder or the type of treatment impacts the therapy relationship, but there are early links. For example, in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study, higher levels of the working alliance were associated with increased retention in supportive-expressive therapy, but in cognitive therapy, higher levels of alliance were associated with decreased retention (Barber et al., 2001). In the treatment of anxiety disorders (GAD and OCD), the specific treatments seem to exhibit more effect size than the therapy relationship, but in depression, the relationship appears more powerful. The therapeutic alliance in the NIMH Treatment of Depression Collaborative Research Program, in both psychotherapy and pharmacotherapy, emerged as the leading force in reducing a patient's depression (Krupnick et al., 1996). The therapeutic relationship probably exhibits more impact in some disorders and in some therapies than others (Beckner, Vella, Howard, & Mohr, 2007). As with research on specific treatments, it may no longer suffice to ask "Does the relationship work?" but "How does the relationship work for this disorder and this treatment?"

Concluding Reflections

The future of psychotherapy portends the integration of science and service, of the instrumental and the interpersonal, of the technical and the relational in the tradition of evidence-based practice (Norcross, VandenBos, & Freedheim, 2011). *Evidence-based therapy relationships* align with this future and embody a crucial part of evidence-based practice, when properly conceptualized. We can imagine few practices in all of psychotherapy that can confidently boast that they integrate as well "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" as these relational behaviors. We are reminded daily that research can guide how we create and cultivate that powerful human relationship. The following cutting-edge research summaries help us do just that.

Moreover, we fervently hope these research summaries serve another master: to heal the damage incurred by the culture wars in psychotherapy. If we are even a little bit successful as a task force,

then the pervasive gap between the science and practice communities will be narrowed and the insidious dichotomy between the therapy relationship and the treatment method will be lessened. Phrased more positively, psychotherapists from all camps will increasingly collaborate and our patients will benefit from the most efficacious treatments *and* relationships available.

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