# Evidence-Based Therapy Relationships

*Edited by*

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# Chapter 1
# Evidence-Based Therapy Relationships

John C. Norcross, Ph.D., & Michael J. Lambert, Ph.D.

Decades of careful scientific research have documented the effectiveness of psychotherapy. Both qualitative and quantitative reviews of thousands of scientific studies have shown that about 75–80% of patients who enter psychotherapy show benefit (Lambert & Ogles, 2004; Wampold, 2001). This finding generalizes across a wide range of disorders and different therapy formats, including individual, couple, family, and group therapies.

Research has more recently focused on what factors contribute to psychotherapy success. The emerging answer is that, like all complex human endeavors, many factors account for success (and failure): the patient, the treatment method, the psychotherapist, the context, and the relationship between the therapist and the patient. The optimal combination of these factors—a good match, a suitable fit—also promotes effective treatment.

The American Psychological Association's (APA) Division of Psychotherapy and Division of Clinical Psychology jointly sponsored a task force to identify and disseminate what works in the therapy relationship (Norcross, 2011). We commissioned a series of original meta-analyses to investigate the association between elements of the therapy relationship and treatment effectiveness. A meta-analysis is a study of studies, a sophisticated research method to aggregate the results of multiple studies on the same topic. The effectiveness of therapy in these studies is measured by clients' improved functioning, reduced suffering, physiological indicators, treatment retention, enhanced interactions with other people, work performance, and other indexes of recovery.

The results of these 20+ meta-analyses converge into a series of research-supported conclusions with important implications for psychotherapists and clients alike (Norcross, 2011).

- The therapy relationship makes substantial and consistent contributions to patient success in all types of psychotherapy studied (for example, psychodynamic, humanistic, cognitive, behavioral, systemic).
- The therapy relationship accounts for why clients improve (or fail to improve) as much as the particular treatment method.
- Practice and treatment guidelines should address therapist qualities and behaviors that promote the therapy relationship.
- Practitioners should routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, improve the relationship, modify technical strategies, and avoid premature termination (Lambert, 2010).
- Efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are incomplete and potentially misleading.
- The relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness. A comprehensive understanding of

effective (and ineffective) psychotherapy will consider all these determinants and their optimal combinations.

- ♦ Adapting or tailoring the relationship to several patient characteristics (in addition to diagnosis) enhances effectiveness (as summarized in chapter 13).

The meta-analyses of key elements of the therapy relationship are summarized here. The authors of each chapter define the particular relationship element in theoretically neutral language and provide a concrete example of the relationship behavior. They review the results of their meta-analysis between that relationship element and therapy success. The authors then bullet several therapeutic practices from the foregoing research, in terms of both the therapist's contribution and the client's perspective. A few references are offered for those interested in the details of the meta-analysis or more reading on the topic.

At first glance, the results of meta-analyses can appear intimidating and abstract, but a few explanations and the following table will help clarify what an "*r*" means in practical terms. A correlation coefficient—expressed as *r*—represents the association or relation between two variables; in this case, between a facet of therapy relationship (such as therapist empathy) and treatment success. A positive correlation means that more of one, such as empathy, is associated with the other, such as patient success. The higher the *r* value, the stronger the relation between the facet and therapeutic outcome—that is, the larger the *r*, the greater the facet can be used to predict the outcome of therapy.

How can one judge the importance of various values of *r*? Table 1 presents several concrete ways to interpret the effect size of *r* in healthcare research. The larger the magnitude of *r*, the higher the probability of patient success in psychotherapy. Given the large number of factors contributing to such success, and the inherent complexity of psychotherapy, we do not expect large, overpowering effects of any one of its facets. Instead, we expect to find a number of helpful facets. And that is exactly what we find in the following chapters—beneficial, medium-sized effects of several elements of the complex therapy relationship.

To follow with our example of empathy, the authors of chapter 6 conducted a meta-analysis of 57 studies that investigated the link between therapist empathy and patient success at the end of treatment. Their meta-analysis, involving a total of 3,599 clients, found a weighted mean *r* of .30. As shown in Table 1, this is a medium effect size. That translates into happier and healthier clients: Patients with empathic therapists tend to progress more in treatment and experience a higher probability of eventual improvement.

**Table 1. Interpretation of Effect Size (ES) Statistics**

| *d* | $r_p$ | Cohen's Benchmark | Type of Effect | Percentile of Treated Patients[a] | Success Rate of Treated Patients[b] | Number Needed to Treat[c] |
|---|---|---|---|---|---|---|
| 1.00 | .45 | | Beneficial | 84 | 72% | 2.2 |
| .90 | .41 | | Beneficial | 82 | 70% | 2.4 |
| .80 | .37 | Large | Beneficial | 79 | 69% | 2.7 |
| .70 | .33 | | Beneficial | 76 | 66% | 3.0 |
| .60 | .29 | | Beneficial | 73 | 64% | 3.5 |

| *d* | $r_p$ | Cohen's Benchmark | Type of Effect | Percentile of Treated Patients[a] | Success Rate of Treated Patients[b] | Number Needed to Treat[c] |
|---|---|---|---|---|---|---|
| .50 | .24 | Medium | Beneficial | 69 | 62% | 4.1 |
| .40 | .20 | | Beneficial | 66 | 60% | 5.1 |
| .30 | .15 | | Beneficial | 62 | 57% | 6.7 |
| .20 | .10 | Small | Beneficial | 58 | 55% | 10.0 |
| .10 | .05 | | No effect | 54 | 52% | 20.0 |
| .00 | 0 | | No effect | 50 | 50% | |
| -.10 | -.05 | | No effect | 46 | 48% | |
| -.20 | -.10 | | Detrimental | 42 | 45% | |
| -.30 | -.15 | | Detrimental | 38 | 43% | |

Sources: Cohen (1988); Norcross, Hogan, & Koocher (2008)

[a] Each ES can be conceptualized as reflecting a corresponding percentile value; in this case, the percentile standing of the average treated patient after psychotherapy relative to untreated patients.

[b] Each ES can also be translated into a success rate of treated patients relative to untreated patients; a *d* of .70, for example, would translate into approximately 66% of patients being treated successfully compared to 50% of untreated patients.

[c] Number needed to treat (NNT) refers to the number of patients who need to receive the experimental treatment vis-à-vis the comparison to achieve one success. An effect size of .70 approximates an NNT of 3: Three patients need to receive psychotherapy to achieve a success relative to untreated patients (Wampold, 2001).

The following chapters in this module are intentionally clustered together. Chapters 2–5 report on broader, more inclusive relationship elements. The therapy alliance and group cohesion are composed, in fact, of multiple elements. Chapters 6–9 feature more specific elements of the therapy relationship, and Chapters 10–12 review specific therapist behaviors that promote the relationship and favorable treatment results. We conclude with a chapter (13) that reviews the research findings on adapting or tailoring the relationship to the individual patient in an effort to achieve that good fit, that optimal match between a unique client and the treatment.

In closing, we would emphasize two lasting lessons from the decades of scientific research into the effectiveness of psychotherapy. First, the relationship between the client and the clinician is a crucial, fundamental determinant of success. Both parties bring themselves into the human endeavor known as psychotherapy. Second, how we create and cultivate that powerful human relationship can be guided by the fruits of research, which is why we characterize this module as *evidence-based therapy relationships* and why we proudly present the following cutting-edge research summaries.

**References**


Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, & feedback in clinical practice.* Washington, DC: American Psychological Association.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Norcross, J. C., Hogan, T. P., & Koocher, G. P. (2008). *Clinician's guide to evidence-based practices: Mental health and the addictions.* New York: Oxford University Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

# Chapter 2
# Alliance in Individual Psychotherapy

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**Definition.** The alliance has been defined in a number of different ways, but the core consensus among these definitions is that the alliance is an emergent quality of partnership and mutual collaboration between therapist and client. Bordin (1994) suggested the alliance in the early stages of treatment is built principally on a positive *emotional bond* between therapist and client (such as trust, respect, and liking), their ability to *agree on the goals* of the treatment, and their establishment of a mutual *consensus on the tasks* (e.g., homework, Socratic dialogue, free association) that form the substance of the specific therapy.

**Clinical Example.** The development and fostering of the alliance is not separate from the methods the therapist implements to help clients; it is influenced by and is an essential, inseparable part of everything that happens in therapy. The following excerpt provides the flavor of the kinds of therapist-client interactions that likely contribute to the development of the alliance.

Therapist: *Maybe we better take a step back. I am a therapist, but I can't give you a pill or shock you to fix you. And looking for these unfinished patterns doesn't seem to make an awful lot of sense to you right now. But I hear you are willing to be a "good client."*

The therapist becomes aware of the client's ambivalent feelings about dealing with the past—and possibly about being in treatment—so he drops his original agenda and demonstrates his commitment to find a way of working collaboratively with the client. The therapist steps back from pursuing his agenda and prioritizes the negotiation of a collaborative relationship.

**Meta-Analytic Review.** We conducted a meta-analysis of the research to examine the relation between the alliance in individual therapy and treatment outcome. The review covered the period between 1973 and 2009 inclusive. The criteria for inclusion in this analysis were: the author(s) referred to the therapy process variable as *alliance* (including variants of the term); the research was based on clinical as opposed to analogue data; five or more patients participated in the study; the treatment was individual (as opposed to group or family therapy); clients were adults (as opposed to children); and the data reported were such that we could extract or estimate a value indicating the relation between alliance and outcome.

In total, we located 201 studies (158 published, 53 unpublished) that met the inclusion criteria. A number of these studies shared data, while other reports included results based on multiple independent samples. Following adjustments to take account of these issues, we identified 190 independent data sets that are the bases of this study. Our analysis represents over 14,000 patients.

The overall effect size (ES)—adjusted for sample size and intercorrelation among outcome measures—was $r$ = .275. The magnitude of this relation accounts for roughly 8% of the total

variance in therapy outcomes. The alliance, along with therapist effects, is one of the strongest validated factors influencing therapy success (Wampold, 2001). In addition, the aggregate ES is statistically very robust ($p > .001$), appears to be free of publication bias, and the effect sizes are similar across different types of treatments (Horvath, Del Re, Flückiger, & Symonds, 2011).

There are differences in the strength of the alliance-outcome relation depending on who (client, therapist, or observer) rates the alliance and the therapy outcome. In general, client judgment provides the best prediction. The correlation between alliance and outcome increases as treatment progresses over time, but alliance assessment early in therapy (third to fifth session) provides reliable prognosis not only for outcome but also for dropouts.

**Therapeutic Practices**

- The development of a good alliance is essential for the success of psychotherapy, regardless of the type of treatment.
- The ability of the therapist to bridge the client's needs, expectations, and abilities into a therapeutic plan is important in building the alliance.
- Because the therapist and client often judge the quality of the alliance differently, active monitoring of the alliance throughout therapy is recommended.
- Responding nondefensively to a client's hostility or negativity is critical to establishing and maintaining a strong alliance.
- Clients' evaluation of the quality of the alliance is the best predictor of outcome; however, the therapist's input has a strong influence on the client and is therefore critical.

**References**

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice*. New York: Wiley.

Horvath, A. O., Del Re, A., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Wampold, B. E. (2001). *The great psychotherapy debate*. Mahwah, NJ: Erlbaum.

# Chapter 3
# Alliance in Child and Adolescent Psychotherapy

Stephen R. Shirk, Ph.D., & Marc Karver, Ph.D

**Definition.** The alliance in youth treatment has been conceptualized as a collaborative bond between client and therapist. The therapeutic alliance with youth may be a unitary rather than a multidimensional construct (Faw, Hogue, Johnson, Diamond, & Liddle, 2005).

There are other important developmental differences between youth and adult alliance. A positive bond between youth and therapist may be based on relational features, such as the degree to which the therapist is stimulating, humorous, or rewarding, especially among younger clients. Cognitive development can limit younger clients' ability to evaluate connections between therapy tasks and goals, and the involvement of parents or other caregivers in youth therapy complicate the issue of goal consensus. Given that youth rarely refer or bring themselves for treatment, multiple alliances with youth clients as well as their caregivers characterize child and adolescent therapy.

**Clinical Example.** The following example illustrates a strong emotional bond between a young adolescent and her therapist.

*Therapist*: So, what's it like when you're feeling really down?

*Client*: I get like I don't want to talk to anyone. I'm like get away, leave me alone. My dad asks me how I'm doing and I just say nothing or walk away.

*Therapist*: You just want some space. You don't want to be pushed.

*Client*: Exactly.

*Therapist*: In here, I'm going to ask you a lot about how you are feeling. If you feel like I'm pushing you, is it possible you won't want to talk with me?

*Client*: I don't think that'll happen because you're not in my face. Talking gets my stress out. When I'm in a bad mood on the day of our meetings, I look forward to our talking… it helps keep me going because I know you get me.

**Meta-Analytic Review.** We conducted a meta-analysis of published studies and doctoral dissertations to estimate the association between alliance and outcome in youth therapy. Studies were restricted to those involving youth samples (age 18 or less). Based on a comprehensive search, 29 studies with 2,202 youth clients and 892 parents were identified. A subset of studies (16) that focused on individual youth therapy and evaluated alliance–outcome associations prospectively were examined separately to make a direct comparison with results from the adult meta-analysis.

The overall effect size was .19. A slightly larger effect size was obtained with the sample of individual, prospective studies (mean ES = .22). Both estimates are reliably different from zero ($p < .05$). The magnitude of this effect is comparable to effect sizes obtained in comparisons of active youth treatments; that is, to differences in specific techniques (Miller, Wampold, & Varhely, 2008). Current results are consistent with previous findings from earlier meta-analyses of alliance–outcome associations in youth therapy (Shirk & Karver, 2003).

Closer evaluation of the individual, prospective studies showed that the alliance is relatively robust across age groups (children, adolescents, and parents) and types of treatment. There was some suggestion that alliance–outcome relations are stronger in behavioral than nonbehavioral youth therapies, though given the limited sample sizes, the difference did not attain statistical significance.

**Therapeutic Practices**

- Alliances with both youth and their parents are predictive of treatment outcomes. Psychotherapists need to attend to the development of multiple alliances, not just to the alliance with the youth. A solid alliance with the parent may be particularly important for treatment continuation.
- Parents and youth often have divergent views about treatment goals. A good alliance with both youth and parent requires the therapist to attend to multiple perspectives and to develop a treatment plan that accommodates both youth and parent perspectives.
- The maintenance of a positive alliance over time predicts successful outcomes with youth. Therapists are advised to monitor alliance over the course of treatment. Alliance formation is not simply an early treatment task; it is a recurrent task.

**References**


Faw, L., Hogue, A., Johnson, S., Diamond, G. M., & Liddle, H. A. (2005). The Adolescent Therapeutic Alliance Scale (ATAS): Initial psychometrics and prediction of outcome in family-based substance abuse prevention counseling. *Psychotherapy Research, 15*(1–2), 141–154.

Miller, S., Wampold, B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18*(1), 5–14.

Shirk, S., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71,* 462–471.

Shirk, S. R., & Karver, M. (2011). Alliance in child and adolescent therapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

# Chapter 4
# Alliance in Couple and Family Therapy

Myrna L. Friedlander, Ph.D., Valentín Escudero, Ph.D.,
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**Definition.** Just as in individual therapy, the working alliance in couple and family therapy (CFT) involves the creation of a strong emotional bond as well as negotiation of goals and tasks with the therapist. However, family members often vary in the degree to which they like and agree with the therapist about treatment goals and tasks. Moreover, each person observes and is influenced by how others in the family feel about the therapy and by how the couple or family unit as a whole is responding to what is taking place in treatment (Friedlander, Escudero, & Heatherington, 2006).

Thus, a unique characteristic of CFT is that at any point in treatment there are multiple alliances that interact systemically (Pinsof, 1994). For example, the degree to which a mother likes the therapist and is engaged in the treatment may have a facilitating (or hindering) effect on her son's willingness to trust the therapist. The son's involvement also depends on the mother-son bond, his sense of safety, and whether he agrees with his mother about the problems, goals, or need for treatment. This within-system alliance, also called *shared sense of purpose within the family*, is critically important (Friedlander et al., 2006).

**Clinical Example.** A middle-aged couple brought their reluctant adolescent son and daughter to psychotherapy. The girl, who was exceptionally anxious, refused to speak in the session, as did the boy, who had vandalized a neighbor's car and was failing in school. While the parents barely glanced at each other, both adamantly insisted that their children were in desperate need of help. Thus ended the first session, which clearly evidenced a lack of safety all around and an exceedingly poor within-family alliance.

By strategically focusing on different alliances, the therapist moved a stalled treatment forward. He began by separating the parents and children to enhance safety and negotiate different goals within each subsystem. With the adolescents, the therapist emphasized trust, honesty, and confidentiality; he explained the importance of collaborating in therapy; he helped each teen define personally meaningful goals and, most importantly, he presented himself as their ally. With the parents, he emphasized the need for cooperative coparenting despite their stated "emotional divorce" from one another. Using his personal bond with each family member to encourage involvement, the therapist was able to redefine the family's collaboration with each other (i.e., within-family alliance) as "learning to respect everyone's individuality and still be caring toward one another."

**Meta-Analytic Review.** We conducted a meta-analysis of 24 studies (7 couples, 17 family studies; totaling 1,461 clients) in which CFT alliances were used to predict treatment retention, improvement midtreatment, and/or final outcomes. The overall effect size was $r = .26$, with a 95% confidence interval of .33 and .20. These results indicate that the association between alliance and outcome was statistically significant and accounted for a substantial proportion of variance in CFT retention and/or outcome (Friedlander, Escudero, Heatherington, & Diamond,

2011). According to conventional benchmarks, an *r* of .26 (*d* = .53) is a medium effect size in the behavioral sciences.

**Therapeutic Practices**

- Therapists need to be aware of what is going on within the family system while monitoring the personal bond and agreement on goals and tasks with each individual family member.
- Shared sense of purpose within the family, a particularly important dimension of the alliance, involves establishing overarching systemic goals (e.g., "It sounds like what the two of you want is a relationship in which you feel both connected and that you can sometimes do your own thing") rather than competing, first-order, individual goals (i.e., "I want him to stop watching sports on TV every Saturday," or "I want her to give me more space").
- An important aspect of CFT alliances is the degree to which family members feel safe and comfortable with each other in the therapeutic context. Creating a safe space is critical, particularly early on in therapy, but doing so requires caution. A therapist who allies too strongly with a resistant adolescent may unwittingly damage the alliance with the parents, particularly when the latter are expecting the teen to change but are not expecting to be personally challenged by the therapist.

**References**


Friedlander, M. L., Escudero, V., & Heatherington, L. (2006). *Therapeutic alliances with couples and families: An empirically-informed guide to practice.* Washington, DC: American Psychological Association.

Friedlander, M. L., Escudero, V., Heatherington, L., & Diamond, G. M . (2011). Alliance in couple and family therapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work.* (2nd ed.). New York: Oxford University Press.

Pinsof, W. B. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 173–195). New York: Wiley.

# Chapter 5
# Cohesion in Group Therapy

Gary M. Burlingame, Ph.D., Debra Theobald McClendon, Ph.D., & Jennifer Alonso, B.S.

**Definition.** Cohesion describes therapeutic relationships in group psychotherapy and has two dimensions: relationship *structure* and relationship *quality*. *Structure* refers to the direction of the relationship. In describing direction, vertical cohesion refers to a group member's perception of the group leader's competence, genuineness, and warmth. Horizontal cohesion describes a group member's relationship with other group members and with the group as a whole. The *quality* of the group relationships is defined by how members feel with their leader and with other members (positive bond), by the tasks and goals of the group (positive work), and also the empathic failure with the leader and conflict in the group (negative relationship; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005).

**Clinical Example**. This example comes from session 14 of a 15-session therapy group (Burlingame & Barlow, 1996) and illustrates the multidimensional aspects of cohesion (identified in italics).

Leader to Steve: Steve, you OK? You seemed upset at the end of our last group meeting. *Leader-member, negative relationship probe*

Steve: I need to apologize to you because ... I said it was none of your damned business. [Group laughs] ...But uh, what I meant was I'm not handling it well, and therefore I can't share anything with you. *Member-leader, negative relationship*

Leader: You've done a lot of good work over the past few months but right now you feel like you've got nothing to give—that you're no longer handling it well. *Leader-member, positive work*

Steve: I also feel badly that Susan is not here today. I miss her. *Member-member, positive bond*

Steve: I've been thinking about her and her crisis a great deal, and I almost called you [leader] up to get her phone number… [As they are talking, Susan comes into the group, and the whole group cheers when she enters]. *Group-member, positive bond* toward Susan

… Steve to Susan: I apologize for being abrupt with you last week. That was tactless. I'm sorry. *Member-member, negative relationship*

Susan to Steve: It didn't bother me, but I accept your apology. It means a lot to me that you'd check in with me on that. *Member-member, positive bond*

**Meta-Analytic Review.** We conducted a meta-analysis of 40 studies, made up of 3,323 patients, on the association between cohesion and the success of group psychotherapy. The overall effect size was a statistically significant, moderate correlation ($r$ = .25). This indicates that, as cohesion levels increase in groups, client outcomes improve and psychological symptoms decrease. This

correlation was found for therapy groups across different settings (inpatient and outpatient) and diagnostic classifications.

**Therapeutic Practices**

- Cohesion is reliably associated with group outcome when outcome is defined as reduction in symptom distress or improvement in interpersonal functioning. All group leaders should foster cohesion in its multiple manifestations.
- Cohesion is certainly involved with patient improvement in groups using a cognitive-behavioral, psychodynamic, or interpersonal orientation.
- Group leaders emphasizing member interaction, irrespective of theoretical orientation, post higher cohesion-outcome links versus groups without this emphasis. Thus, it is important to encourage member interaction.
- Cohesion is strongest when a group lasts more than 12 sessions and is composed of 5 to 9 members. Group cohesion requires time to build.
- Younger group members experience the largest outcome changes when cohesion is present within their groups. Fostering cohesion will be particularly useful for those working in college counseling centers and with adolescent populations.

**References**

Burlingame, G. M., & Barlow, S. (1996). Outcome and process differences between professional and nonprofessional therapists in time-limited group psychotherapy. *International Journal of Group Psychotherapy, 46*, 455–478.

Burlingame, G., McClendon, D. T., Alonso, J. (2011). Group cohesion. In J. C. Norcross (Ed.), Psychotherapy relationships that work (2nd ed.). New York: Oxford University Press.

Johnson, J. E., Burlingame, G. M., Olsen, J. A., Davies, D. R., & Gleave, R. L. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of Counseling Psychology, 52*, 310–321.

# Chapter 6
# Empathy

Robert Elliott, Ph.D., Arthur C. Bohart, Ph.D.,
Jeanne C. Watson, Ph.D., & Leslie S. Greenberg, Ph.D.

**Definition.** Carl Rogers (1980, p. 85) defined empathy as: "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference....It means entering the private perceptual world of the other...being sensitive, moment by moment, to the changing felt meanings which flow in this other person....It means sensing meanings of which he or she is scarcely aware" (p. 142).

**Clinical Example.** "Mark" is a 30-year-old man who came to psychotherapy complaining of pervasive anxiety. Five minutes into the first session, the following took place:

*Client:* I'm really in a panic (anxious, looking plaintively at the therapist). I feel anxious all the time. Sometimes it seems so bad I really worry that I'm completely falling apart. Nothing like this has ever happened to me before.

*Therapist:* So a real sense of vulnerability—kind of like, you don't even know yourself anymore.

*Client:* Yes! That's it. I don't know myself anymore. I feel totally lost, like a big cloud that just takes me over, and I can't even find myself in it anymore. I don't even know what I want, what I trust….I'm lost.

*Therapist:* Totally lost, like, "Where did Mark go? I can't find myself anymore."

*Client:* No, I can't (sadly, and thoughtfully).

**Meta-Analytic Review.** We searched carefully for all English-language studies using a measure of therapist empathy to predict treatment outcome. We found 59 different samples of clients (from 57 studies), representing 3,599 clients and 224 separate effects.

Our meta-analysis resulted in an overall effect size of .30, a medium effect, between therapist empathy and client success. This effect size is about the same size as, or slightly larger than, previous analyses of the relationship between the alliance in individual therapy and treatment outcome.

However, there was statistically significant, nonrandom variability across the effects (Cochrane's $Q = 205.8$, $p < .001$), meaning that the empathy-outcome relation is not consistent and is affected by other factors. To investigate these sources of variability, we looked at a range of possible moderators. We found that empathy predicted treatment outcome consistently across different theoretical orientations (e.g., CBT, humanistic), treatment formats (individual, group), and levels of client problem severity. It was strongest for client- and observer-rated empathy. Empathy also appeared to predict outcome better for less experienced therapists.

## Therapeutic Practices

- It is important for psychotherapists to make efforts to understand their clients' experiences and to demonstrate this understanding through responses that address the client needs as the client perceives them.
- Empathic therapists do not parrot clients' words back or reflect only the content of those words; instead, they understand overall goals and moment-to-moment experiences.
- Empathic responses can take many forms, including straightforward responses that convey understanding of client experience, but also responses that validate the client's perspective, that try to bring the client's experience to life using evocative language, or that aim at what is implicit but not yet expressed in words.
- Therapists should neither assume that they are mind readers nor that their experience of understanding the client will be matched by clients feeling understood.
- Finally, because research has shown empathy to be inseparable from the other relational conditions, therapists should seek to offer empathy in a context of authentic caring for the client.

## References


Bohart, A. C., & Greenberg, L. S. (Eds.). (1997). *Empathy reconsidered: New directions in psychotherapy*. Washington, DC: American Psychological Association.

Elliott, R., Bohart, A.C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

# Chapter 7
# Goal Consensus and Collaboration

Georgiana Shick Tryon, Ph.D., & Greta Winograd, Ph.D.

**Definition.** At the beginning of treatment, psychotherapists and clients outline the conditions of their work together. Agreement about the nature of the problem for which the client is seeking help, goals for treatment, and the way that the two parties will work together to achieve these goals are the essence of *goal consensus*. To help clients fulfill mutually agreed-upon treatment goals, mental health service providers and consumers must function as a team. *Collaboration* represents the active process of their cooperation in this endeavor (Orlinsky, Ronnestad, & Willutzki, 2004).

**Clinical Example.** "Hope" is a 21-year-old college senior and honors student who has recently returned to college after a leave of absence due to hospitalization in a mental health crisis center. Elements of goal consensus and collaboration with her therapist are indicated in brackets.

*Therapist:* It sounds to me like some of the people you are close to have disappointed you. You'd like to reconnect with them but aren't sure how to do this. This makes it hard to relax around them and focus on your schoolwork. You also mentioned being quite isolated.

*Hope:* Yes, I am quite uncomfortable around other people now, almost all of the time. Since I don't know what to say or how to act, I've started to avoid people. [goal consensus: agreement on patient problem].

*Therapist:* I was thinking that over the next few sessions, we could work together to come up with ideas about how to talk about your hospitalization and recovery with your friends and family [collaboration: mutual involvement of patient and therapist in a helping relationship].

*Hope:* I like the sound of that. And I'd also like you to help me experiment with gradually coming out of my shell as I work on getting healthy again [goal consensus: discussion and specification of goals; collaboration: patient role involvement].

**Meta-Analytic Review.** We conducted two meta-analyses to address the question of how patient-therapist goal consensus and collaboration relate to psychotherapy outcome. The analyzed studies were published in English in refereed journals from 2000 through 2009. Each study included in the meta-analyses investigated the effectiveness of treatment among adult clients in individual psychotherapy.

The goal consensus-outcome meta-analysis—based on 15 studies with a total sample size of 1,302—yielded an overall effect size of .34 (*SD* = .19). This substantial result reflects the meaningful positive outcomes that are associated with improved agreement between therapists and clients about the aims of treatment and how to accomplish such aims.

The collaboration-outcome meta-analysis—based on 19 studies with a total sample of 2,260 patients—yielded an overall effect size of .33 (*SD* = .17). As with goal consensus, this result

suggests that patient well-being is considerably enhanced with a better collaborative relationship. Both meta-analytic results are particularly relevant to the provision of effective mental health services, given that each analysis was based on studies measuring important outcomes, such as client retention in treatment, symptom reduction, and adaptive functioning.

**Therapeutic Practices**

- Therapists and clients should begin problem-solving only when they agree on treatment goals and the ways they will go about reaching them together.
- Psychotherapists should rarely push their own agenda. Listen to what patients say and formulate interventions with their input and understanding.
- Good treatment entails clients' contributions throughout psychotherapy by respectfully requesting their feedback, insights, reflections, and elaborations.
- Clients need to recognize the importance they play in achieving goal consensus and collaboration with mental health professionals.

**References**

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. In J. C. Norcross (Ed*.), Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

# Chapter 8
# Positive Regard and Affirmation

Barry A. Farber, Ph.D., & Erin M. Doolin, M.Ed.

**Definition.** Carl Rogers (1951), the founder of client-centered therapy, did not believe that a therapist's neutrality, dispassionate stance, or intellectual understanding could facilitate a client's growth, no matter how astute the interpretations. Instead, he believed that treating clients in a consistently warm, supportive, highly regarding manner would enable them to grow psychologically and to reduce their suffering. Rogers' notion of positive regard is embodied in two questions he posed: "Do we tend to treat individuals as persons of worth, or do we subtly devaluate them by our attitudes and behavior? Is our philosophy one in which respect for the individual is uppermost?" (1951, p. 20). This caring attitude has most often been termed *positive regard*, but early studies and theoretical writings preferred the phrase *nonpossessive warmth*.

In his famous filmed work with Gloria (Shostrom, 1965), Rogers struggled to find a single phrase to illuminate this concept. It is, he said, "Real spontaneous praising; you can call that quality acceptance, you can call it caring, you can call it a non-possessive love. Any of those terms tend to describe it."

**Clinical Example.** *You're reading me entirely wrong. I don't have any of those feelings. I've been pleased with our work. You've shown a lot of courage, you work hard, you've never missed a session, you've never been late, you've taken chances by sharing so many intimate things with me. In every way here, you do your job. But I do notice that whenever you venture a guess about how I feel about you, it often does not jibe with my inner experience, and the error is always in the same direction: You read me as caring for you much less than I do* (Yalom, 2002, p. 24).

In this example, Yalom, an existential therapist, not only offers assumedly accurate feedback to his patient on her interpersonal tendencies, but in doing so, explicitly conveys the fact that he cares for this patient far more than she imagines to be the case.

**Meta-Analytic Review.** To investigate the association between the therapists' positive regard and treatment outcome, we performed a meta-analysis of 18 studies that met our criteria for inclusion (e.g., the treatment was individual psychotherapy, clients were either adolescents or adults). The overall effect size among these studies was $r = .27$, indicating that positive regard has a moderate association with therapeutic outcomes. Only 2 of the 18 studies had negative effect sizes. Thus, like many other relational factors, positive regard appears to be a significant but not exhaustive part of the process-outcome equation.

The only significant moderator found was the percentage of patients from racial/ethnic minority groups. The results indicated that as the percentage of racial/ethnic minorities increases in a study, the overall effect size also increases.

## Therapeutic Practices

- Psychotherapists' provision of positive regard is strongly indicated in practice. At a minimum, it "sets the stage" for other beneficial treatment methods.
- Positive regard may be especially useful in situations wherein a nonminority psychotherapist is working with a racial/ethnic minority client.
- Therapists should ensure that their positive feelings toward their clients are communicated to them. For many, if not most clients, the conviction that "my therapist really cares about me" likely serves a critical function, especially in times of stress.
- Therapists can monitor their expressed level of positive regard and adjust it as a function of the needs of particular patients and specific clinical situations. Clients vary greatly in the extent to which they need, elicit, and/or benefit from a therapist's positive regard; indeed, clients should strive to make explicit their need for their therapist's support and affirmation.

## References


Farber, B. A., & Doolin, E. M. (2011). Positive regard. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York: Oxford University Press.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Shostrom, E. L. (Producer). (1965). *Three approaches to psychotherapy.* (Part 1). [Film]. Orange, CA: Psychological Films.

Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients.* New York: HarperCollins.

# Chapter 9
# Congruence/Genuineness

Gregory G. Kolden, Ph.D., Marjorie H. Klein, Ph.D.,
Chia-Chiang Wang, M.Ed., & Sara B. Austin, B.S.

**Definition.** Congruence or genuineness refers to a relational quality of the psychotherapy relationship. There are two facets of congruence. The first reflects a mindful genuineness on the part of the therapist, underscoring present personal awareness as well as authenticity. The second facet of congruence refers to the therapist's capacity to conscientiously communicate his or her experience with the client to the client. Congruence is thus both a personal characteristic (intrapersonal) of the therapist, as well as an experiential quality of the therapy relationship (interpersonal).

**Clinical Example.** Consider how congruence appears in everyday interactions. Insurance agent Jones is quite formal and proper, appearing to play a prescribed role, rarely saying what he/she truly feels. Mr./Ms. Jones interacts in an *incongruent* manner. Coffee barista Brian, however, warmly greets you by your first name, attentively asks after your family, and openly shares his opinion about a movie he recently took in. Brian engages you, makes contact, and sincerely expresses himself in the brief time it takes to pour and pay for a cup of coffee. Brian interacts in a *congruent* fashion.

In psychotherapy, this means that the therapist is openly "being the feelings and attitudes which at the moment are flowing within him" (Rogers, Gendlin, Kiesler, & Truax, 1967, p. 100) and not hiding behind a professional role or holding back feelings that are obvious in the encounter. Congruence thus involves mindful self-awareness and self-acceptance on the part of the therapist, as well as a willingness to engage and tactfully share perceptions.

**Meta-Analytic Review.** We conducted a meta-analysis on the relation between therapist congruence and treatment outcome. In order to be included in the analysis, a study had to report quantitative information adequate to calculate an effect size (ES). This resulted in 16 studies on 863 clients. The overall effect size for congruence with outcome was .24 (95% CI = .12 to .36). This is considered a small to medium-sized effect, accounting for about 6% of the variance in outcome, and providing evidence for congruence as a noteworthy facet of the therapy relationship.

## Therapeutic Practices

- Psychotherapists must embrace the idea of striving for congruence with their clients. This involves acceptance of and receptivity to the client as well as a willingness to use this information in conversation.
- Congruence must be mindfully *developed* by therapists. As with all complex skills, this will require discipline, practice, and effort. This includes active and engaged listening on the part of the therapist.
- An effective therapist *models* congruence. This may involve self-disclosure as well as sharing of thoughts and feelings, opinions, pointed questions, and feedback regarding client

behavior. Congruent responses are honest; they are not disrespectful, overly intellectualized, or insincere.

- Therapists can identify their *congruence style* and discern the differing needs, preferences, and expectations that clients have for congruence. Effective therapists will modify and tailor their congruence style according to client characteristics (e.g., culture, age, education).
- A congruent therapist *communicates* acceptance and the possibility of engaging in a genuine relationship, something not easily expected from others in clients' lives.

**References**


Kolden, G. G., Klein, M. H., Wang, C., & Austin, S. B. (2011). Congruence/Genuineness. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Rogers, C. R., Gendlin, E. T., Kiesler, D. J., & Truax, C. B. (Eds.). (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics*. Madison, WI: University of Wisconsin Press.

# Chapter 10
# Collecting Client Feedback

Michael J. Lambert, Ph.D., & Kenichi Shimokawa, Ph.D.

**Definition.** Systematic monitoring of client mental health vital signs through the use of standardized scales and expected treatment response can improve psychotherapy effectiveness when this information is provided to clinicians in a timely manner. Feedback of this nature is especially useful in helping clinicians identify the possible failure of ongoing treatment and collaborating with the client in restoring positive outcomes.

**Clinical Example.** A graph of a client's self-reported progress is provided to her psychotherapist in relation to the progress of similar clients and the functioning of a normative sample of patients receiving psychotherapy for similar problems. Alerts are provided to the therapist indicating risk for treatment failure and outright negative outcome. The therapist can then discuss with the client reasons for this negative response and adjust treatment accordingly.

**Meta-Analytic Review**. We conducted a meta-analysis to estimate the impact of feedback methods on treatment outcomes. Two well-developed feedback systems (OQ Measures, Lambert, 2010, and the Partners for Change Outcome Measurement System, Duncan & Miller, 2008) that have been subject to experimental study were identified. Our meta-analysis contained nine studies that examined the effectiveness of one of these two similar but distinct feedback methods.

Results of the meta-analysis showed overall effect sizes between .23 and .33 (Hedge's *g* of .70). Furthermore, rates of patient deterioration in psychotherapy were cut in half, and rates of positive responding were several times those of clients who received treatment without formal feedback. The most dramatic effects were achieved for the clients at risk for negative outcomes early in psychotherapy and for psychotherapists providing information about the client's perception of the therapeutic relationship, motivation for treatment, social support system, and negative life events.

## Therapeutic Practices

- Employ real-time client feedback to compensate for therapist's limited ability to accurately detect client worsening in psychotherapy.
- If practitioners are aware early on that their clients are at risk of treatment failure, they can organize problem-solving and improve the treatment outcome for many.
- Practitioners can realize that they are not particularly sensitive and alert to treatment failure. Both they and their patients can agree early in treatment to frequently share their mutual impressions about progress of the treatment and satisfaction with the therapy relationship.
- Beware of those situations in which clients feel it may be in their interest to understate (or overstate) their problems and produce inaccurate ratings on feedback systems. The feedback systems are predicated on accurate self-reporting of disturbance and corresponding changes.
- Supplement treatment with clinical support tools. As suggested by the general literature on feedback and the evidence presented in our meta-analysis, problem-solving and decision-

enhancement tools prove helpful to clinicians and, most importantly, clients whose treatment response is in doubt.

- The research is uncertain yet of the necessity of sharing progress feedback directly with clients. In the PCOMS system, progress and relationship information is gathered within session and discussed routinely. Since both are a part of the session, either may account for the therapeutic effects. In contrast, the OQ system has examined therapist feedback and direct client feedback separately with inconclusive results about additive effectiveness of direct client feedback.
- Consider using electronic versions of feedback systems that expedite and ease practical difficulties. Fortunately, the brevity of the PCOMs and the software of OQ Measures can provide instantaneous feedback to clinicians.

**References**


Duncan, B. L., & Miller, S. D. (2008). *The Outcome and Session Rating Scales: The revised administration and scoring manual, including the Child Outcome Rating Scale.* Chicago: Institute for the Study of Therapeutic Change.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice.* Washington, DC: American Psychological Association.

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting & Clinical Psychology, 78,* 298–311.

# Chapter 11
# Repairing Alliance Ruptures

Jeremy D. Safran, Ph.D., J. Christopher Muran, Ph.D., & Catherine Eubanks-Carter, Ph.D.

**Definition.** Ruptures in the therapeutic alliance are episodes of tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2000). Exploring and repairing alliance ruptures when they occur can be an important element contributing to positive treatment outcome.

**Clinical Example.** A patient feels misunderstood by his or her therapist and responds angrily or by withdrawing. At this point, the therapist explores the patient's experience, empathizes with his or her feelings, clarifies any misunderstandings, and acknowledges ways in which his/her intervention may have contributed to the rupture. This leads to an improvement in the quality of the alliance and may also help to deepen the therapist's and patient's understanding of themes that may be relevant to the patient's problems.

**Meta-Analytic Review.** We conducted two meta-analyses (Safran, Muran, & Eubacks-Carter, 2011). The first set of analyses examined the relation between the presence of rupture-repair episodes over the course of therapy and treatment outcome; it included three studies and a total of 148 patients. The overall effect size was .24, 95% CI (.09–.39), $p = .002$. This represents a statistically significant and small to medium-size effect that indicates the presence of rupture-repair episodes was positively related to good outcome.

The second set of analyses examined the impact of rupture resolution training or supervision on patient outcome; it included 8 studies and a total of 188 patients. Pre-post contrast effect sizes were calculated for all eight studies, and between group effect sizes were calculated on the subset of studies that had control or comparison groups. The overall pre-post *r* for the rupture resolution training studies was .65, 95% CI (.46–.78.), $p < .001$. This statistically significant finding is considered a large effect size. It must be kept in mind, however, that without a comparison to a control group, we cannot determine whether this improvement was greater than what patients would experience with treatment from psychotherapists who were not trained in rupture resolution. A meta-analysis of the between-group effect sizes for the 7 studies (a total of 155 patients) with control conditions yielded an overall effect of .15, 95% CI (.04–.26), $p = .01$. These results indicate that rupture resolution training/supervision leads to small but statistically significant patient improvements relative to treatment by therapists who did not receive such training.

**Therapeutic Practices**

- The presence of alliance rupture-repair episodes over the course of treatment is positively related to psychotherapy success.
- It is important for therapists to be attuned to ruptures in the relationship and to take the initiative in exploring what is transpiring during ruptures and repairing them.
- It can be helpful for patients to express negative feelings about the treatment to the therapist should they emerge or to assert their perspective on what is going on when it differs from the therapist's.

- When ruptures occur, it is important for therapists to respond in an empathic and nondefensive fashion, and to accept responsibility for their contribution to the interaction, as opposed to blaming the patient for misunderstanding or distorting.

**References**


Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guilford Press.

Safran, J. D, Muran, J. C., & Eubacks-Carter, C. (2011). Repairing alliance ruptures. In J. C. Norcross (Eds.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work.* New York: Oxford University.

# Chapter 12
# Managing Countertransference

Jeffrey A. Hayes, Ph.D., Charles J. Gelso, Ph.D., & Ann M. Hummel, M.S.

**Definition.** Countertransference (CT) is a psychotherapist's internal and external reactions to a client that are influenced by the therapist's personal vulnerabilities and unresolved conflicts (Gelso & Hayes, 2007). Several therapist characteristics—such as self-insight, empathy, and anxiety management—have been found to help therapists manage problematic CT reactions. Therapists who successfully manage their CT can use their reactions to gain a better understanding of their work with clients.

**Clinical Example.** A psychotherapist was in her fourth practicum of a doctoral program, and by every indication appeared to have extraordinary potential as a psychotherapist. In the early part of her treatment with a 20-year-old male patient, she experienced continued strong irritation, and she reacted to the patient in a controlled, muted, and metallic manner. For his part, the patient was an angry, obsessive young man suffering from personality difficulties. He negated the therapist's attempts to help him understand how his conflicts might be contributing to his ongoing problems with women, and he denied that the treatment could have any impact. The therapist's emotional reactions were "natural," given the patient's negativity and hostility. Yet, the therapist's unresolved anxieties about not being good enough, about fearing that she could not take care of others sufficiently, and about fears of her supervisor's evaluation of her were clearly implicated in her irritation and her muted reaction to the patient. As she came to understand these countertransference dynamics, her irritation with the patient lessened, and she empathically grasped the terrifying emotions that were underlying much of the patient's negativity.

**Meta-Analytic Review.** We located 27 studies involving a total of 1,152 patients that investigated CT, CT management, and client outcome (Hayes, Gelso, & Hummel, 2011).

Ten studies examined the relation between CT and outcome (Hayes, Gelso, & Hummel, 2011). The overall association of CT with outcome in these studies was significant and small, $r = -.16$, $p < .05$. That is, CT was found to relate negatively, although modestly, to client outcome.

We also conducted a meta-analysis of seven studies on the relation between CT management and treatment outcome (Hayes, Gelso, & Hummel, 2011). The overall association of CT management to treatment outcome was significant and large, $r = .56$, $p < .05$. CT management definitely appears to be positively related to outcome.

In summary, psychotherapists' unresolved inner conflicts seem to be related to the likelihood of antitherapeutic effects of CT, which in turn are associated with poorer client outcomes. CT management can probably facilitate positive treatment outcomes.

## Therapeutic Practices

- Psychotherapists acting out of their CT can be harmful, and it appears wise for therapists to work at preventing such acting out.
- Because CT management seems to promote successful treatment and positive patient functioning, therapists are urged to manage internal CT reactions in ways that prevent them from manifesting them behaviorally in session.
- Therapists are encouraged to resolve their personal conflicts through personal therapy, clinical supervision, or both.
- Patients probably benefit from psychotherapists who help them learn about the interpersonal reactions that they evoke in others.

## References


Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the inner world of the psychotherapist: Perils and possibilities*. Mahwah, NJ: Erlbaum.

Hayes, J., Gelso, C., & Hummel, A. (2011). Managing countertransference. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Hayes, J. A., Riker, J. B., & Ingram, K. M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research, 7*, 145–154.

# Chapter 13
# Adapting the Relationship to the Individual Patient

John C. Norcross, Ph.D., & Bruce E. Wampold, Ph.D.

One of the most consequential trends in mental health concerns the movement toward evidence-based practice (EBP). The purpose of EBP is to promote effective mental health services. As applied to individual clinicians, EBP should increase the efficacy and efficiency of services provided to individual patients (or patient groups). As applied to society as a whole, EBP should enhance public health (Norcross, Hogan, & Koocher, 2008).

The Institute of Medicine (2001, p. 147) defined *evidence-based medicine* as "the integration of best research evidence with clinical expertise and patient values." An American Psychological Association task force (2006, p. 273), beginning with this foundation and expanding it to mental health, defined *evidence-based practice* as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

EBP thus rests on three pillars: best available research, clinical expertise (of the practitioner), and patient characteristics. In fact, EBP resides in the intersection or overlap of these three evidentiary sources. The patient, the therapist, and the research all need to be in alignment or "on the same page."

Psychotherapy has long concerned itself with tailoring the treatment to best match the needs of the individual patient according to the research. Every psychotherapist recognizes that what works for one person may not work for another; we embrace the maxim, "Different strokes for different folks." This matching process has been accorded different names: adaptation, responsiveness, attunement, tailoring, matchmaking, customizing, prescriptive, and individualizing. However, the goal is identical: to increase treatment effectiveness by tailoring it to the unique individual and his/her singular situation.

The historical means of tailoring or adapting treatment to the individual patient has been to match the patient's disorder to a particular treatment method. A patient presenting with, say, a specific anxiety disorder might be matched with cognitive-behavioral therapy, the most researched form of psychotherapy for anxiety. Another patient suffering from bipolar disorder (manic-depressive illness) might receive mood stabilizing medications, the most researched treatment for that condition.

This matching is certainly useful for select disorders; some psychotherapies make better marriages with some mental health disorders (Barlow, 2007; Nathan & Gorman, 2002). But only matching disorder to treatment in this way is incomplete and not always effective (Wampold, 2001). As Sir William Osler, father of modern medicine, is reported to have said: "It is sometimes much more important to know what sort of a patient has a disease than what sort of disease a patient has." The research demonstrates that it is indeed frequently effective to match psychotherapy to the entire person—not only to his/her disorder (Norcross, 2011). And that match or adaptation should consider both the treatment method and the therapeutic relationship.

In this way, the best available research, clinical expertise, and the patient's characteristics are seamlessly integrated in EBP.

In this chapter, we provide a summary of the research on effectively adapting the treatment and the relationship to the individual patient in psychotherapy. Here are six effective means of tailoring psychotherapy to the entire person beyond diagnosis alone. For each, we identify the patient characteristic (e.g., reactance, preferences, culture) and review the research that indicates matching to it enhances the success of psychotherapy. We then feature how this adaptation can be actualized in session by the psychotherapist and the patient. Details of the research and recommendations for practice can be found in the book, *Psychotherapy Relationships that Work* (Norcross, 2011), from which this chapter is drawn with the permission of Oxford University Press.

**Reactance Level**

This patient characteristic refers to being easily provoked and responding oppositionally to external demands. Think of this personality trait along a defiance–compliance continuum: Some people tend to respond defiantly to authority figures and power, while others tend to respond in more compliant, easygoing ways. A meta-analysis of 12 select studies (1,102 patients) revealed a medium effect size *(d* = .76) for matching therapist directiveness to patient reactance (Beutler, Harwood, Michelson, Song, & Holman, 2011). Specifically, high-reactance patients benefit more from self-control methods and less structured treatments. Low-reactance clients, on the other hand, benefit more from therapist directiveness, explicit guidance, and more structured treatments. Thus, psychotherapists and consumers can together decide the optimal level of directiveness and structure that will work for them.

**Stages of Change**

Patients enter psychotherapy with varying readiness to change or what researchers have called stages of change. Some minimize or deny their problems (precontemplation stage), some acknowledge their problems but are not yet ready to modify them (contemplation stage), while others are ready and eager to alter their problems immediately (action stage). A patient's stage of change reliably predicts the success of psychotherapy; in a meta-analysis of 39 studies involving 8,238 patients, those clients starting treatment in the precontemplation stage did not fare nearly as well as those starting in contemplation or action (*d* = .46; Norcross, Krebs, & Prochaska, 2011). Another meta-analysis of 47 different studies showed large effect sizes (*d* = .70–.80) for matching treatment methods to the different stages of change (Rosen, 2000). Specifically, consciousness-raising and emotion-generating methods are most effective in helping people move from contemplation, while skills training and more behavioral methods are most effective for those in the action stage. Disparate systems of psychotherapy can be effective when tailored specifically to the patient's stage of change.

**Preferences**

Psychotherapy can also be profitably matched in many cases to the patient's preferences in terms of the desired therapy method (e.g., psychodynamic, cognitive-behavioral, solution-focused),

treatment format (individual, family, group), relationship style (e.g., active vs. more a listener), therapist characteristic (e.g., age, gender, religion), and treatment length (brief, medium, or long). A meta-analysis of 35 studies compared the treatment success of clients matched to their preferences versus clients who were not matched. The clients receiving their preferences did significantly better ($d$ = .31) and were a third less likely to drop out of psychotherapy prematurely (Swift, Callahan, & Vollmer, 2011). It is the wise psychotherapist and the assertive consumer who explicitly discuss accommodating the client's strong preferences whenever practically possible.

**Culture**

EBP integrates the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, 2006). Thus, an escalating amount of research has investigated the effectiveness of tailoring or adapting psychotherapy to the patient's culture. A meta-analysis of 65 studies, entailing 8,620 clients, evaluated the impact of these culturally adapted therapies vs. traditional (nonadapted) therapies. The results showed a definite advantage ($d$ = .46) in favor of clients receiving culturally adapted treatments (Smith, Rodriguez, & Bernal, 2011). Professionals and consumers can adapt psychotherapy to culture in various ways, such as incorporating cultural content/values into treatment, using the client's preferred language, and matching clients with therapists of similar ethnicity/race.

**Coping Style**

Another patient personality trait concerns coping style: how we characteristically respond to new or problematic situations in our lives. Some people tend to habitually withdraw or blame themselves (internalizers), some tend to regularly lash out or act out (externalizers), and of course, others are in the middle and use a balanced coping style. A meta-analysis of 12 rigorous studies (1,291 patients) found medium effect sizes ($d$ = .55) for matching the therapist's method to the patient coping style (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011). In practice, the research suggests that interpersonal and insight-oriented treatments tend to be more effective among internalizing patients. By contrast, the symptom-focused and skill-building treatments tend as a rule to be more effective among externalizing patients. Together, patients and their therapist can decide among several treatment methods that fit their personalities and preferences.

**Religion/Spirituality**

Some patients enter psychotherapy with a definite interest in incorporating their religious beliefs or spiritual values into the work. Many research studies have investigated whether these religious-accommodative therapies work as well as, or better than, their secular counterparts. A meta-analysis of 46 studies, involving 3,290 clients, found that patients receiving such therapies experienced equivalent if not superior progress. When examining the most rigorous studies, in which the religious-accommodative therapies and alternative therapies shared the same theoretical orientation and treatment duration, there were no significant differences in the mental health outcomes between the treatments. However, patients receiving the religious or spiritual-

accommodative therapies progressed significantly better ($d$ = .33) in their spiritual outcomes than patients receiving secular therapies (Worthington, Hook, Davis, & McDaniel, 2011).

The effectiveness of psychotherapy can be demonstrably improved by tailoring psychotherapy to one or more of these six patient characteristics: reactance level, stage of change, preferences, culture, coping style, and religion/spirituality. Two more dimensions—patient expectations (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011) and patient attachment style (Levy, Ellison, Scott, & Bernecker, 2011)—are definitely related to treatment outcome. More hopeful and more securely attached patients benefit more from psychotherapy, but we do not yet have as much or as compelling research on how to adapt psychotherapy specifically to them.

Decades of research now scientifically support what psychotherapists have long known: Different clients require different treatments and relationships. But the research has now identified specific patient characteristics and optimal matches by which to tailor or adapt treatment. In the tradition of EBP, psychotherapists can create a new, responsive psychotherapy for each distinctive patient and singular situation—in addition to his/her disorder.

**References**


American Psychological Association Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285.

Barlow, D. H. (Ed.). (2007). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.). New York: Guilford.

Beutler, L. E., Harwood, M. T., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Reactance/resistance level. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

Levy, K. N., Ellison, W. D., Scott, L. N., & Bernecker, S. L. (2011) Attachment style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Nathan, P. E., & Gorman, J. M. (Eds.). (2002). *A guide to treatments that work* (2nd ed.). NY: Oxford University Press.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Norcross, J. C., Hogan, T. P., & Koocher, G. P. (2008). *Clinician's guide to evidence-based practices: Mental health and the addictions.* New York: Oxford University Press.

Norcross, J. C, Krebs, P., & Prochaska, J. O. (2011). Stages of change. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Rosen, C. S. (2000). Is the sequencing of change processes by stage consistent across health problems? A meta-analysis. *Health Psychology, 19*(6), 593-604.

Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Swift, J. K., Callahan, J. L., & Vollmer, B. M., (2011). Preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Worthington, E. L. Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.