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# Psychotherapy Relationships That Work III

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This article introduces the journal issue devoted to the most recent iteration of *evidence-based psychotherapy relationships* and frames it within the work of the Third Interdivisional American Psychological Association Task Force on Evidence-Based Relationships and Responsiveness. The authors summarize the overarching purposes and processes of the Task Force and trace the devaluation of the therapy relationship in contemporary treatment guidelines and evidence-based practices. The article outlines the meta-analytic results of the subsequent 16 articles in the issue, each devoted to the link between a particular relationship element and treatment outcome. The expert consensus deemed 9 of the relationship elements as demonstrably effective, 7 as probably effective, and 1 as promising but with insufficient research to judge. What works—and what does not—in the therapy relationship is emphasized throughout. The limitations of the task force work are also addressed. The article closes with the Task Force's formal conclusions and 28 recommendations. The authors conclude that decades of research evidence and clinical experience converge: The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment.

***Clinical Impact Statement***

***Question:*** What, specifically, is effective in the powerful psychotherapy relationship? ***Findings:*** Clinicians can use these meta-analytic conclusions and the practice recommendations of the Task Force on Evidence-Based Relationships and Responsiveness to provide what works in the relationship and simultaneously to avoid what does not work. ***Meaning:*** Based on original meta-analyses, experts deemed nine of the relationship elements as demonstrably effective, seven as probably effective, and one as promising. ***Next Steps:*** Future directions are to disseminate these findings to practice communities, to implement them in training programs, and to examine the interrelations of the effective elements of the relationship.

*Keywords:* psychotherapy, therapeutic relationship, psychotherapy outcome, meta-analysis, evidence-based practice



Ask patients what they find most helpful in their psychotherapy. Ask practitioners which component of psychotherapy ensures the highest probability of success. Ask researchers what the evidence favors in predicting effective psychological treatment. Ask psychotherapists what they are most eager to learn about (Tasca et al., 2015). Ask proponents of diverse psychotherapy systems on what point they can find commonality. The probable answer, for all these questions, is the *psychotherapy relationship*, the healing alliance between the client and the clinician.

In 1999, the American Psychological Association (APA) Division of Psychotherapy first commissioned a task force to identify, operationalize, and disseminate information on empirically supported therapy relationships. That task force summarized its findings and detailed its recommendations in a 2001 special issue of this journal, *Psychotherapy*, and in a 2002 book (Norcross, 2002). In 2009, the APA Division of Psychotherapy along with the Division of Clinical Psychology commissioned a second task force on evidence-based therapy relationships to update the research base and clinical practices on the psychotherapist–patient relationship. A second edition of the book (Norcross, 2011) and a second special issue of this journal, appearing in 2011, did just that.

Our aim for the third task force and the third iteration of this special journal issue, *Evidence-Based Psychotherapy Relationships III*, is to build upon and update the first two task forces in the research evidence for the impacts of relational elements, the number of those elements reviewed, and the rigor of the meta-analyses. In short, this issue summarizes the best available

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research and clinical practices on numerous facets of the therapy relationship.

In this article, we frame this special issue on evidence-based psychotherapy relationships within the work of the Third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness, which was cosponsored by the Society for the Advancement of Psychotherapy (APA Division 29) and the Society for Counseling Psychology (APA Division 17). We begin by summarizing the overarching purposes and processes of the Task Force and trace the devaluation of the therapy relationship in contemporary treatment guidelines and evidence-based practices. We provide a numerical summary of the meta-analytic results and the evidentiary strength of the subsequent 16 articles in the issue, each devoted to a particular relationship element. We then emphasize what works—and what does not—in the relationship. Prominent limitations of the task force work are highlighted. We present the formal conclusions and recommendations of the Third Interdivisional Task Force. Those statements, approved by the 10 members of the Steering Committee, refer to the work in both this special issue on therapy relationships and another volume on treatment adaptations or relational responsiveness (Norcross & Wampold, 2019).

## The Third Interdivisional Task Force

The dual purposes of the Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness were to identify effective elements of the therapy relationship and to determine effective methods of adapting or tailoring therapy to the individual patient on the basis of his or her transdiagnostic characteristics. In other words, the Task Force was interested in both what works in general and what works for particular patients.

For the purposes of our work, we again adopted Gelso and Carter's (1985, 1994) operational definition of the relationship: The *therapeutic relationship* is the feelings and attitudes that the therapist and the 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 (for an extended discussion, see Gelso & Hayes, 1998). Nonetheless, it serves as a concise, consensual, theoretically neutral, and sufficiently precise definition.

Treatment methods and the therapeutic relationship constantly shape and inform each other. Both clinical experience and research evidence point to a complex, reciprocal interaction between the interpersonal relationship and the instrumental methods. 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" describe *how* therapists and clients behave toward each other. By contrast, terms like "technique" or "intervention" 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. Trying 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 the 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.

The Task Force applies 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 therapeutic relationship—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, that do not degrade the simultaneous contributions of treatment methods, patients, or therapists to outcome.

An immediate challenge to the Task Force was to establish the inclusion and exclusion criteria for the elements of the therapy relationship. We readily agreed that the traditional features of the therapeutic relationship—the alliance in individual therapy, cohesion in group therapy, and the Rogerian facilitative conditions, for example—would constitute core elements. We further agreed that discrete, relatively nonrelational techniques were not part of our purview; therapy methods were considered for inclusion if their content, goal, and context were inextricably interwoven into the emergent therapy relationship. We settled on several "relational" methods (e.g., collecting real-time client feedback, repairing alliance ruptures, facilitating emotional expression, and managing countertransference) because these methods are deeply embedded in the interpersonal character of the relationship itself. As "methods," it also proves possible to randomly assign patients to one treatment condition with the method (for instance, feedback or rupture repairs) and other patients to a treatment without them. But which relational behaviors to include and which to exclude under the rubric of the *therapy relationship* bedeviled us, as it has the field.

We struggled on how finely to slice the therapy relationship. As a general rule, we opted to divide the meta-analytic reviews into smaller chunks so that the research conclusions were more specific and the practice and training implications more concrete.

We consulted psychotherapy experts, the research literature, and potential authors to discern whether there were sufficient numbers of studies on a particular relationship element to conduct a systematic review and meta-analysis. Three relational elements—therapist humor, self-doubt/humility, and deliberate practice—exhibited initial research support but not a sufficient number of empirical studies for a meta-analysis. Five new relationship behaviors surpassed our research threshold, and thus, we added the real relationship, self-disclosure, immediacy, emotional expression, and treatment credibility.

Once these decisions were finalized, we commissioned original meta-analyses on the relationship elements. Authors followed a comprehensive chapter structure and specific guidelines for their meta-analyses. The analyses quantitatively linked the relationship element to psychotherapy outcome. Outcome was primarily defined as distal posttreatment outcomes. Authors specified the outcome criterion when a particular study did not use a typical end-of-treatment measure; indeed, the type of outcome measure was frequently analyzed as a possible moderator of the overall

effect size. This emphasis on distal outcomes sharpened our focus on "what works" and countered the partial truth that some of the meta-analyses examining predominantly proximal outcome measures in earlier iterations of the task force merely illustrated that "the good stuff in session correlates with other good stuff in session." We have responded to that criticism in these articles while also explicating several consequential process linkages.

When the meta-analyses were finalized, the 10-person Steering Committee (identified in the Appendix) independently reviewed and rated the evidentiary strength of the relationship element according to the following criteria: number of empirical studies, consistency of empirical results, independence of supportive studies, magnitude of association between the relationship element and outcome, evidence for causal link between relationship element and outcome, and the ecological or external validity of research. Using these criteria, experts independently judged the strength of the research evidence as *demonstrably effective*, *probably effective*, *promising but insufficient research to judge*, *important but not yet investigated*, or *not effective*.

We then aggregated the individual ratings to render a consensus conclusion on each relationship element. These conclusions are presented later in this article, as are 28 recommendations approved by all members of the Steering Committee. Our deliberations relied on expert opinion referencing best practices, professional consensus using objective rating criteria, and, most importantly, meta-analytic reviews of the research evidence. But these were all human decisions—open to cavil, contention, and revision.

## This Issue

Following this introductory article are 16 articles on particular facets of the psychotherapy relationship and their relation to treatment outcome. Except for this introduction, each article uses identical major headings and consistent structure, as follows:

*Introduction* (untitled): Introduce the relationship element in a couple of reader-friendly paragraphs.

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

*Clinical Examples*: Provide a couple of concrete examples of the relationship behavior under consideration.

*Results of Previous Reviews*: Offer a quick synopsis of the findings of previous meta-analyses and systematic reviews on the topic.

*Meta-Analytic Review*: Compile all available empirical studies linking the relationship behavior to treatment outcome (distal, end-of-treatment outcome); report results of the literature search, preferably by means of a PRISMA flowchart if space allows; include only actual psychotherapy studies (not analogue studies); use a random-effects model; report the effect size as both weighted *r* and *d* (or *g*); provide a summary table for individual studies (if <50; if >50, provide a supplemental online appendix); perform and report a test of homogeneity (*Q* and *I*); include a fail-safe statistic to address the file-drawer problem; and provide a table or funnel plot for each study in the meta-analysis (if fewer than 50 studies).

*Mediators and Moderators*: Present the results of the potential mediators and moderators of the association between the relationship element and treatment outcome.

*Patient Contributions*: Address the patient's contribution to that relationship and the distinctive perspective he or she brings to the interaction.

*Limitations of the Research*: Point to the major limitations of the research conducted to date.

*Diversity Considerations*: Outline how diversity (e.g., gender, race/ethnicity, sexual orientation, and socioeconomic status) fares in the research studies and the meta-analytic results.

*Therapeutic Practices*: Highlight the practice implications from the foregoing research, primarily in terms of the therapist's contribution and secondarily in terms of the patient's perspective. Go beyond the numerical data to provide practical, bulleted clinical practices.

(Three sections of the book chapters—landmark studies, evidence for causality, and training implications—were jettisoned for these journal articles in the interest of space. Readers can access these sections and more methodological details in the book itself; Norcross & Lambert, 2019).

Insisting on quantitative meta-analyses for all articles (with one exception) enables direct estimates of the magnitude of association in the form of effect sizes. These are standardized difference between two group means, say psychotherapy and a control, divided by the (pooled) standard deviation. The resultant effect size is in standard deviation units. Both Cohen's *d* and Hedges's *g* estimate the population effect size.

The meta-analyses in this issue used the weighted *r* and its equivalent *d* or *g*. Most of the articles analyzed studies that were correlational in nature; for example, studies that correlated the patient's ratings of empathy during psychotherapy with their outcome at the end of treatment. The correlation coefficients (*r*) were then converted into *d* or *g*. We did so for consistency among the meta-analyses, enhancing their interpretability (square *r* for the amount of variance accounted for) and enabling direct comparisons of the meta-analytic results to one another as well as to *d* (the effect size typically used when comparing the relative effects of two treatments). In all of these analyses, the larger the magnitude of *r* or *d*, the higher the probability of patient success in psychotherapy based on the relationship variable under consideration.

Table 1 presents several practical ways to interpret *r* and *d* in behavioral health care. 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. By contrast, a *d* of .30 is considered a small effect, .50 a medium effect, and .80 a large effect. Of course, these general rules or conventions cannot be dissociated from the context of decisions and comparative values. There is little inherent value to an effect size of 2.0 or 0.2; it depends on what benefits can be achieved at what cost (Smith, Glass, & Miller, 1980).

Table 1
*Practical Interpretation of d and r Values*

| *d* | *r* | Cohen's benchmark | Type of effect | Percentile of treated patients[a] | Success rate of treated patients (%)[b] |
|---|---|---|---|---|---|
| 1.00 | | | Beneficial | 84 | 72 |
| .90 | | | Beneficial | 82 | 70 |
| .80 | .50 | Large | Beneficial | 79 | 69 |
| .70 | | | Beneficial | 76 | 66 |
| .60 | | | Beneficial | 73 | 64 |
| .50 | .30 | Medium | Beneficial | 69 | 62 |
| .40 | | | Beneficial | 66 | 60 |
| .30 | | | Beneficial | 62 | 57 |
| .20 | .10 | Small | Beneficial | 58 | 55 |
| .10 | | | No effect | 54 | 52 |
| .00 | 0 | | No effect | 50 | 50 |
| −.10 | | | No effect | 46 | 48 |
| −.20 | .10 | | Detrimental | 42 | 45 |
| −.30 | | | Detrimental | 38 | 43 |

*Note.* Adapted from Cohen (1988); Norcross, Hogan, Koocher, and Maggio (2017); and Wampold and Imel (2015).
[a] Each effect size 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 effect size can also be translated into a success rate of treated patients relative to untreated patients; a *d* of .80, for example, would translate into approximately 70% of patients being treated successfully compared with 50% of untreated patients.

Given the large number of factors contributing to patient success, and the inherent complexity of psychotherapy, we do not expect large, overpowering effects of any one relationship behavior. 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.

For example, Elliott, Bohart, Watson, and Murphy (2018) conducted a meta-analysis of 82 studies that investigated the association between therapist empathy and patient success at the end of treatment. Their meta-analysis, involving a total of 6,138 patients, found a weighted mean *r* of .28. As shown in Table 1, this is a medium effect size. The corresponding *d* was .58. Relative to studies that compare one psychotherapy with another psychotherapy (where typical *d*s tend to be less than .20; Lambert, 2013; Wampold & Imel, 2015), a *d* of .58 is quite high. These numbers translate into happier and healthier clients; that is, clients with more empathic therapists tend to progress more in treatment and experience greater improvement.

## Therapy Relationship

Recent decades have witnessed the controversial compilation of practice guidelines and evidence-based treatments in mental health. In the United States and other countries, the introduction of such guidelines has provoked practice modifications, training refinements, and organizational conflicts. Insurance carriers and government policymakers increasingly turn to such guidelines to determine which psychotherapies to approve and fund. Indeed, along with the negative influence of managed care, there is probably no issue more central to clinicians than the evolution of evidence-based treatments in psychotherapy (Barlow, 2000; Norcross, Hogan, Koocher, & Maggio, 2017).

Efforts to promulgate evidence-based psychotherapies have been noble in intent and timely in distribution. They are praiseworthy efforts to distill scientific research into clinical applications and to guide practice and training. They wisely demonstrate that, in a climate of accountability, psychotherapy stands up to empirical scrutiny with the best of health-care interventions. And within psychology, these have proactively counterbalanced documents that accorded primacy to biomedical treatments for mental disorders and largely ignored the outcome data for psychological therapies. On many accounts, then, the extant efforts addressed the realpolitik of the socioeconomic situation (Messer, 2001; Nathan & Gorman, 2015).

At the same time, many practitioners and researchers alike have found these recent efforts to codify evidence-based treatments seriously incomplete. Although scientifically laudable in their intent, these efforts largely ignored the therapy relationship and the person of the therapist. Practically all treatment guidelines have followed the antiquated medical model of identifying only particular treatment methods for specific diagnoses: Treatment A for Disorder Z. If one reads the documents literally, disembodied providers apply manualized interventions to discrete *DSM* and ICD disorders. Not only is the language offensive on clinical grounds to some practitioners, but the research evidence is weak for validating treatment methods in isolation from specific therapists, the therapy relationship, and the individual patient.

Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing, and teaching. Henry (1998, p. 128) concluded that such a panel,

> would find the answer obvious, and *empirically validated*. As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of decades of empirical research.

What is missing in treatment guidelines, now across 5 decades of research, are the person of the therapist and the therapeutic relationship.

## Person of the Therapist

Most practice or treatment guideline compilations depict interchangeable providers performing treatment procedures. This stands in marked contrast to the clinician's and the client's experience of psychotherapy as an intensely interpersonal and deeply emotional experience. Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact of the matter is that it is simply not possible to mask the person and the contribution of the therapist (Castonguay & Hill, 2017; Orlinsky & Howard, 1977). The curative contribution of the person of the therapist is, arguably, as evidence based as manualized treatments or psychotherapy methods (Hubble, Wampold, Duncan, & Miller, 2011).

Multiple and converging sources of evidence indicate that the *person* of the psychotherapist is inextricably intertwined with the outcome of psychotherapy. A large, naturalistic study estimated the outcomes attributable to 581 psychotherapists treating 6,146 patients in a managed care setting. About 5% of the outcome variation was due to therapist effects and 0% was due to specific treatment methods (Wampold & Brown, 2005).

Quantitative reviews of therapist effects in psychotherapy outcome studies show consistent and robust therapist effects, probably accounting for 5%–8% of psychotherapy outcome effects (Barkham, Lutz, Lambert, & Saxon, 2017; Crits-Christoph et al., 1991). The Barkham study combined data from four countries, 362 therapists, 14,254 clients, and four outcome measures. They found that about 8% of the variance in outcome was due to the therapist, so-called *therapist effects*. Moreover, the size of the therapist effect was strongly related to initial client severity. The more disturbed a client was at the beginning of therapy, the more it mattered which therapist the client saw.

A controlled study examining therapist effects in the outcomes of cognitive–behavioral therapy is instructive (Huppert et al., 2001). In the Multicenter Collaborative Study for the Treatment of Panic Disorder, considerable care was taken to standardize the treatment, the therapist, and the patients to increase the experimental rigor of the study and to minimize therapist effects. The treatment was manualized and structured, the therapists were identically trained and monitored for adherence, and the patients were rigorously evaluated and relatively uniform. Nonetheless, the therapists significantly differed in the magnitude of change among caseloads. Effect sizes for therapist impact on outcome measures ranged from 0% to 18%. Despite impressive attempts to experimentally render individual practitioners as controlled variables, it is simply not possible to mask the person and the contribution of the therapist.

Even when treatments are effectively delivered with minimal therapist contact (King, Orr, Poulsen, Giacomantonio, & Haden, 2017), their relational context includes interpersonal skill, persuasion, warmth, and even, on occasion, charisma. Self-help resources typically contain their developers' self-disclosures, interpersonal support, and normalizing concerns. Thus, it is not surprising that the relation between treatment outcome and the therapeutic alliance in Internet-based psychotherapy is of the same strength as that for the alliance–outcome association in face-to-face psychotherapy (Flückiger, Del Re, Wampold, & Horvath, 2018). Therapist effects are strong, ubiquitous, and sadly ignored in most guidelines on what works.

## Therapeutic Relationship

A second omission in most treatment guidelines has been the decision to validate only the efficacy of treatment methods or technical interventions, as opposed to the therapy relationship or therapist interpersonal skills. This decision both reflects and reinforces the ongoing movement toward high-quality, comparative effectiveness research on brand-name psychotherapies. "This trend of putting all of the eggs in the 'technique' basket began in the late 1970s and is now reaching the peak of influence" (Bergin, 1997, p. 83).

Both clinical experience and research findings underscore that the therapy relationship accounts for as much, and probably more, of the outcome variance as particular treatment methods. Meta-analyses of psychotherapy outcome literature consistently reveal that specific treatment methods account for 0%–10% of the outcome variance (Lambert, 2013; Wampold & Imel, 2015), and much of that is attributable to the investigator's therapy allegiance (Cuijpers et al., 2012; Luborsky et al., 1999).

Even those practice guidelines enjoining practitioners to attend to the therapy relationship do not provide specific, evidence-based means of doing so. For example, the scholarly and comprehensive review on treatment choice from Great Britain (Department of Health, 2001) devotes a single paragraph to the therapeutic relationship. Its recommended principle is that "Effectiveness of all types of therapy depends on the patient and the therapist forming a good working relationship" (p. 35), but no evidence-based guidance is offered on which therapist behaviors contribute to or cultivate that relationship.

All of this is to say that treatment guidelines give short shrift—some would say lip service—to the person of the therapist and the emergent therapeutic relationship. The vast majority of current attempts are thus seriously incomplete and potentially misleading, both on clinical and empirical grounds.

## Limitations of the Work

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

The products of the third Task Force probably suffer first 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 collaboration, which is considered in the same article, and both of those are considered parts of the therapeutic alliance. 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 meta-analyses. Thus, to some the content may appear swollen; to others, the Task Force may have failed to make necessary distinctions.

Another lacuna in the Task Force work is that we may have neglected, relatively speaking, the productive contribution of the client to the therapy relationship. Virtually all of the relationship elements in this issue represent mutual processes of shared communicative attunement (Orlinsky, Ronnestad, & Willutzki, 2004). They exist in the human connection, in the transactional process, rather than solely as a therapist (or client) variable. We encouraged authors to attend to the chain of events among the therapist's contributions, the patient processes, and eventual treatment outcomes. Nevertheless, this limitation proves especially ironic in that the moderator analyses of several meta-analyses in this special issue indicated the patient's perspective of the relationship proves more predictive of their treatment outcome than the therapist's.

As with the previous two task forces, the overwhelming majority of research studies meta-analyzed were conducted in Western developed nations and published in English-language journals. The literature searches are definitely improving in accessing studies conducted internationally, but most authors did not translate articles published in other languages. An encouraging exception were

the authors of the alliance meta-analysis (this issue), who included studies published in English, Italian, German, and French languages.

Researcher allegiance may have also posed a problem in conducting and interpreting the meta-analyses. Of course, we invited authors with an interest and expertise in a relationship element, but in some cases, the authors might have experienced conflicts of interest due to their emotional, academic, or financial interests. The use of objective meta-analytic guidelines, peer review, and transparent data reporting may have attenuated the effects of their allegiance, but it remains a strong human propensity in any discipline.

Another prominent limitation across these research reviews is the difficulty of establishing causal connections between the relationship behavior and treatment outcome. The only meta-analyses that contain randomized clinical trials (RCTs) capable of demonstrating a causal effect are collecting client feedback and repairing appliance ruptures. With these two exceptions, all of the meta-analyses in this issue reported the association and prediction of the relationship element to psychotherapy outcome. These were overwhelmingly correlational designs. It is methodologically difficult to meet the three conditions needed 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 when the therapeutic relationship is a mediator, moderator, or mechanism of change in psychotherapy (Kazdin, 2007).

There is much confusion between relational factors related to outcome and those are characteristics or actions of effective therapists. Consider the example of empathy. There are dozens of studies and several meta-analyses now that indicate that empathy, as expressed or perceived in a session, is reliably related to psychotherapy outcome; that is called a total correlation. We do not know if that correlation is due to the patient (verbal and cooperative patients elicit empathy from their therapist and also get better) or the therapist (some therapists are generally more empathic than others, across patients, and these therapists achieve better outcomes).

Of all the relationship behaviors reviewed in this journal issue, only two (feedback and alliance ruptures) have addressed this disaggregation by means of RCTs and only one (alliance in individual therapy; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012) by other statistical means. And it turns out, the evidence is strong that it is the therapist who is important—therapists who generally form stronger alliances generally have better outcomes, but not vice versa (Del Re et al., 2012). It is largely the therapist's contribution, not the patient's contribution, that relates to therapy outcome (Baldwin, Wampold, & Imel, 2007; Wampold & Imel, 2015). Unfortunately, we do not know if this is true of empathy or most of the other relational elements.

At the same time as we acknowledge this limitation, let us remain mindful of several considerations about causation. First, in showing that these facets of a therapy relationship precede positive treatment outcome, we can certainly state that the relationship is, at a minimum, an important predictor and antecedent of that outcome. Second, dozens of lagged correlational, unconfounded regression, structural equation, and growth curve studies suggest that the therapy relationship probably casually contributes to outcome (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003; alliance article, this issue). 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 RCT has ever been conducted to conclusively determine the causal benefit of parents' 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 a nonempathic, authoritarian, and unsupportive therapist. We warn against an either/or conclusion on the ability of the therapy relationship to cause patient improvement.

A final interesting drawback to the present work involves 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 treatment of severe anxiety disorders (generalized anxiety disorder and obsessive–compulsive disorder) and substance abuse, the relationship may well exert less impact (Flückiger et al., 2012; Graves et al., 2017) than in other disorders, such as depression. The therapeutic alliance in the National Institute of Mental Health 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; Bedics, Atkins, Harned, & Linehan, 2015). As with research on specific psychotherapies, it may no longer suffice to ask, "Does the relationship work?" but "How does the relationship work for this disorder and this treatment method?"

## Conclusions of the Task Force on Evidence-Based Relationships and Responsiveness

The psychotherapy relationship makes substantial and consistent contributions to patient outcome independent of the specific type of psychological treatment.

The therapy relationship accounts for client improvement (or lack of improvement) as much as, and probably more than, the particular treatment method.

Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.

Efforts to promulgate best practices and evidence-based treatments without including the relationship and responsiveness are seriously incomplete and potentially misleading.

Adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of psychological treatment.

Adapting psychological treatment (or responsiveness) to transdiagnostic client characteristics contributes to successful outcomes at least as much as, and probably more than, adapting treatment to the client's diagnosis.

The therapy relationship acts in concert with treatment methods, patient characteristics, and other practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and how they work together to produce benefit.

Table 2 summarizes the Task Force conclusions regarding the evidentiary strength of (a) elements of the therapy relationship primarily provided by the psychotherapist and (b) methods of adapting psychotherapy to patient transdiagnostic characteristics.

The preceding conclusions do *not* constitute practice or treatment standards but represent current scientific knowledge to be understood and applied in the context of the clinical evidence available in each case.

## Recommendations of the Task Force on Evidence-Based Relationships and Responsiveness

### General Recommendations

1. We recommend that the results and conclusions of this third Task Force be widely disseminated to enhance awareness and use of what "works" in the psychotherapy relationship and treatment adaptations.

2. Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the Task Force's work.

3. We recommend that future task forces be established periodically to review these findings, include new elements of the relationship and responsiveness, incorporate the results of non-English language publications (where practical), and update these conclusions.

### Practice Recommendations

4. Practitioners are encouraged to make the creation and cultivation of the therapy relationship a primary aim of treatment. This is especially true for relationship elements found to be demonstrably and probably effective.

5. Practitioners are encouraged to assess relational behaviors (e.g., alliance, empathy, and cohesion) vis-à-vis cutoff scores on popular clinical measures in ways that lead to more positive outcomes.

6. Practitioners are encouraged to adapt or tailor psychotherapy to those specific client transdiagnostic characteristics in ways found to be demonstrably and probably effective.

7. Practitioners will experience increased treatment success by regularly assessing and responsively attuning psychotherapy to clients' cultural identities (broadly defined).

8. Practitioners are encouraged to routinely monitor patients' satisfaction with the therapy relationship, comfort with responsiveness efforts, and response to treatment. Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and investigate factors external to therapy that may be hindering its effects.

9. Practitioners are encouraged to concurrently use evidence-based relationships *and* evidence-based treatments adapted

Table 2
*Task Force Conclusions Regarding the Evidentiary Strength of Elements of the Therapy Relationship and Methods of Adapting Psychotherapy*

| Evidentiary strength | Elements of the relationship | Methods of adapting |
|---|---|---|
| Demonstrably effective | Alliance in individual psychotherapy<br>Alliance in child and adolescent psychotherapy<br>Alliances in couple and family therapy<br>Collaboration<br>Goal consensus<br>Cohesion in group therapy<br>Empathy<br>Positive regard and affirmation<br>Collecting and delivering client feedback | Culture (race/ethnicity)<br>Religion/spirituality<br>Patient preferences |
| Probably effective | Congruence/genuineness<br>Real relationship<br>Emotional expression<br>Cultivating positive expectations<br>Promoting treatment credibility<br>Managing countertransference<br>Repairing alliance ruptures | Reactance level<br>Stages of change<br>Coping style |
| Promising but insufficient research | Self-disclosure and immediacy | Attachment style |
| Important but not yet investigated | | Sexual orientation<br>Gender identity |

to the whole patient, as that is likely to generate the best outcomes in psychotherapy.

### Training Recommendations

10. Mental health training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship.

11. Mental health training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.

12. Psychotherapy educators and supervisors are encouraged to train students in assessing and honoring clients' cultural heritages, values, and beliefs in ways that enhance the therapeutic relationship and inform treatment adaptations.

13. Accreditation and certification bodies for mental health training programs are encouraged to develop criteria for assessing the adequacy of training in evidence-based therapy relationships and responsiveness.

### Research Recommendations

14. Researchers are encouraged to conduct research on the effectiveness of therapist relationship behaviors that do not presently have sufficient research evidence, such as self-disclosure, humility, flexibility, and deliberate practice.

15. Researchers are encouraged to investigate further the effectiveness of adaptation methods in psychotherapy, such as to clients' sexual orientation, gender identity, and attachment style, that do not presently have sufficient research evidence.

16. Researchers are encouraged to proactively conduct relationship and responsiveness outcome studies with culturally diverse and historically marginalized clients.

17. Researchers are encouraged to assess the relationship components using in-session observations in addition to postsession measures. The former track the client's moment-to-moment experience of a session and the latter summarize the patient's total experience of psychotherapy.

18. Researchers are encouraged to progress beyond correlational designs that associate the frequency and quality of relationship behaviors with client outcomes to methodologies capable of examining the complex causal associations among client qualities, clinician behaviors, and psychotherapy outcomes.

19. Researchers are encouraged to examine systematically the associations among the multitude of relationship elements and adaptation methods to establish a more coherent and empirically based typology that will improve clinical training and practice.

20. Researchers are encouraged to disentangle the patient contributions and the therapist contributions to relationship elements and ultimately outcome.

21. Researchers are encouraged to examine the specific moderators between relationship elements and treatment outcomes.

22. Researchers are encouraged to address the observational perspective (i.e., therapist, patient, or external rater) in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice.

23. Researchers are encouraged to increase translational research and dissemination on those relational behaviors and treatment adaptations that already have been judged effective.

24. Researchers are encouraged to examine the effectiveness of educational, training, and supervision methods used to teach relational skills and treatment adaptations/responsiveness.

### Policy Recommendations

25. APA's Society for the Advancement of Psychotherapy, the APA Society for Counseling Psychology, and all divisions are encouraged to educate their members on the benefits of evidence-based therapy relationships and responsiveness.

26. Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with higher levels of therapist-offered evidence-based therapy relationships, as they frequently now do about evidence-based treatments.

27. We recommend that the APA and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.

28. Finally, administrators of mental health services are encouraged to attend to and invest in the relational features and transdiagnostic adaptations of their services. Attempts to improve the quality of care should account for relationships and responsiveness, not only the implementation of evidence-based treatments for specific disorders.

## What Works

Table 3 summarizes the meta-analytic associations between the relationship elements and psychotherapy outcomes. As seen there,

Table 3
*Summary of Meta-Analytic Associations Between Relationship Components and Psychotherapy Outcomes*

| Relationship element | Number of studies (*k*) | Number of patients (*N*) | Effect size | | Consensus on evidentiary strength |
|---|---|---|---|---|---|
| | | | *r* | *d* or *g* | |
| Alliance in individual psychotherapy | 306 | 30,000+ | .28 | .57 | Demonstrably effective |
| Alliance in child and adolescent therapy | 43 | 3,447 | .20 | .40 | Demonstrably effective |
| Alliances in couple and family therapy | 40 | 4,113 | .30 | .62 | Demonstrably effective |
| Collaboration | 53 | 5,286 | .29 | .61 | Demonstrably effective |
| Goal consensus | 54 | 7,278 | .24 | .49 | Demonstrably effective |
| Cohesion in group therapy | 55 | 6,055 | .26 | .56 | Demonstrably effective |
| Empathy | 82 | 6,138 | .28 | .58 | Demonstrably effective |
| Positive regard and affirmation | 64 | 3,528 | | .28 | Demonstrably effective |
| Congruence/genuineness | 21 | 1,192 | .23 | .46 | Probably effective |
| The real relationship | 17 | 1,502 | .37 | .80 | Probably effective |
| Self-disclosure and immediacy | 21 | ~140 | NA | NA | Promising but insufficient research |
| Emotional expression | 42 | 925 | .40 | .85 | Probably effective |
| Cultivating positive expectation | 81 | 12,722 | .18 | .36 | Probably effective |
| Promoting treatment credibility | 24 | 1,504 | .12 | .24 | Probably effective |
| Managing countertransference | 9 | 392 therapists | .39 | .84 | Probably effective |
| Repairing alliance ruptures | 11 | 1,318 | .30 | .62 | Probably effective |
| Collecting and delivering client feedback | 24 | 10,921 | | .14–.49[a] | Demonstrably effective |

*Note.* NA = not applicable; the chapter used qualitative meta-analysis, which does not produce effect sizes.
[a] The effect sizes depended on the comparison group and the feedback method; feedback proved more effective with patients at risk for deterioration and less effective for all patients.



the expert consensus deemed nine of the relationship elements as demonstrably effective, seven as probably effective, and one as promising but insufficient research to judge. We were heartened to find the evidence base for all research elements had increased, and in some cases substantially, from the second edition (Norcross, 2011). We were also impressed by the disparate and perhaps elevated standards against which these relationship elements were evaluated.

Compare the evidentiary strength required for psychological treatments to be considered demonstrably efficacious in two influential compilations of evidence-based practices. The Division of Clinical Psychology's Subcommittee on Research-Supported Treatments (www.div12.org/PsychologicalTreatments/index.html) requires two between-groups design experiments demonstrating that a psychological treatment is either (a) statistically superior to pill or psychological placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate sample sizes. The studies must have been conducted with treatment manuals and conducted by at least two different investigators. The typical effect size of those studies was often smaller than the effects for the relationship elements reported in this series of articles. For listing in SAMHSA's National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov), which will be soon discontinued, only evidence of statistically significant behavioral outcomes demonstrated in at least one study, using an experimental or quasi-experimental design, that has been published in a peer-reviewed journal or comprehensive evaluation report is needed. By these standards, practically all of the relationship elements in this journal issue would be considered demonstrably effective, if not for the requirement of an RCT, which proves neither clinically nor ethically feasible for most of the relationship elements.

In several ways, the effectiveness criteria for relationship elements are more rigorous. Whereas the criteria for designating treatments as evidence-based rely on only one or two studies, the evidence for relationship elements presented here is based on comprehensive meta-analyses of many studies (in excess of 40 studies in the majority of meta-analyses), spanning various treatments, a wide variety of treatment settings, patient populations, treatment formats, and research groups. The studies used to establish evidence-based treatments are, however, RCTs. RCTs are often plagued by confounds, such as researcher allegiance, cannot be blinded, and often contain bogus comparisons (Luborsky et al., 1999; Mohr et al., 2009; Wampold, Baldwin, Holtforth, & Imel, 2017; Wampold et al., 2010). The point here is not to denigrate the criteria used to establish evidence-based treatments, but to underscore the robust scientific standards by which these relationship elements have been operationalized and evaluated. The evolving standards to judge evidence-based treatment methods are now moving away from the presence of an absolute number of studies to the presence of meta-analytic evidence (Tolin, McKay, Forman, Klonsky, & Thombs, 2015), a standard demonstrated repeatedly in this journal issue.

Consider as well the strength or magnitude of the therapy relationship. Across thousands of individual outcome studies and hundreds of meta-analytic reviews, the typical effect size difference (*d*) between psychotherapy and no psychotherapy averages .80–.85 (Lambert, 2010; Wampold & Imel, 2015), a large effect size. The effect size (*d*) for any *single* relationship behavior in Table 3 ranges between .24 and .80. The alliance in individual psychotherapy, for example, demonstrates an aggregate *r* of .28 and a *d* of .57 with treatment outcome, making the quality of the alliance one of the strongest and most robust predictors of successful psychotherapy. These relationship behaviors are robustly effective components and predictors of patient success. We need to proclaim publicly what decades of research have discovered and what hundreds of thousands of practitioners have witnessed: The relationship can heal.

It would probably prove advantageous to both practice and science to sum the individual effect sizes in Table 3 to arrive at a total of relationship contribution to treatment outcome, but reality is not so accommodating. Neither the research studies nor the relationship elements contained in the meta-analyses are independent; thus, the amount of variance accounted for by each element or construct cannot be added to estimate the overall contribution. For example, the correlations among the person-centered conditions (empathy, warmth/support, and congruence/genuineness) and the therapeutic alliance are typically in the .50s (Nienhuis et al., 2018; Watson & Geller, 2005). Many of the studies within the adult alliance meta-analysis also appear in the meta-analyses on collaboration and goal consensus, perhaps because a therapeutic alliance measure, subscale, or item was used to operationalize collaboration. Unfortunately, the degree of overlap between all the measures (and therefore relationship elements) is not available but bound to be substantial (Norcross & Lambert, 2014). Whether each relationship element is accounting for the same outcome variance or whether some of the elements are additive remains to be determined.

We present the relationship elements in this journal issue as separate, stand-alone practices, but every seasoned psychotherapist knows this is certainly never the case in clinical work. The alliance in individual therapy and cohesion in group therapy never act in isolation from other relationship behaviors, such as empathy or support. Nor does it seem humanly possible to cultivate a strong relationship with a patient without ascertaining her feedback on the therapeutic process and understanding the therapist's countertransference. All the relationship elements interconnect as we try to tailor therapy to the unique, complex individual. While these relationship elements "work," they work together and interdependently.

In any case, the meta-analytic results in this book probably underestimate the true effect due to the responsiveness problem (Kramer & Stiles, 2015; Stiles, Honos-Webb, & Surko, 1998). It is a problem for researchers but a boon to practitioners, who flexibly adjust the amount and timing of relational behaviors in psychotherapy to fit the unique individual and singular context. Effective psychotherapists responsively provide varying levels of relationship elements in different cases and, within the same case, at different moments. This responsiveness tends to confound attempts to find naturalistically observed linear relations of outcome with therapist behaviors (e.g., cohesion and positive regard). As a consequence, the statistical relation between therapy relationship and outcome cannot always be trusted and tends to be lower than it actually is. By being clinically attuned and flexible, psychotherapists ironically make it more difficult in research studies to discern what works.

The profusion of research-supported relationship elements proves, at once, encouraging and disconcerting. Encouraging because we have identified and measured potent predictors and contributions of the therapist that can be taught and implemented. Disconcerting because of the large number of potent relational behaviors that are highly intercorrelated and are without much organization or rationale.

Several researchers have clamored for a more coherent organization of relationship behaviors that could guide practice and training. One proposal would arrange the relational elements in a conceptual hierarchy of helping relationships (Horvath, Symonds, Flückiger, Del Re, & Lee, 2016). Superordinate, high-level *Descriptive Constructs* describe the way of therapy. Featured here are the alliance, cohesion, and empathy as global ways of being in therapy. Below that are *Strategies* for managing the relationship, such as positive regard, self-disclosure, managing emotional expression, promoting credibility, collecting formal feedback, and resolving ruptures. Then there are *Therapist Qualities*—more about the person than a strategy or skill. Exemplars are flexibility, congruence, and reactivity in responding to countertransference. The Strategies and the Therapist Qualities overlap of course, for example, in the personal quality of reactivity in responding to countertransference and in the Strategy of managing countertransference. Finally, on the bottom of the hierarchy, come *Client Contributions*. These describe the client's attachment style, preferences, expectations, coping styles, culture, reactance level, and diagnosis (all these may serve as reliable markers to adapt therapy and are featured in Volume 2 of *Psychotherapy Relationships That Work*; Norcross & Wampold, 2019). Horvath and colleagues' (2016) four-level structure of the helping relationship provides greater organization and perhaps clarity.

That organization will assuredly benefit from multivariate meta-analyses conducted on several relationship constructs simultaneously. However, too few studies exist to allow meta-analytic reviews of multiple relationship elements (e.g., measures of the therapeutic alliance, therapist empathy, and client expectations for improvement). Future multivariate meta-analyses could elevate the expectations for future scholarship, as most of these relationship variables share substantial variance and could inform conceptual schemes on their interrelations.

As the evidence base of therapist relationship behaviors develops, we will know more about their effectiveness for particular circumstances and conditions. A case in point is the meta-analysis on collecting and delivering client feedback (Lambert, 2018). The evidence is quite clear that adding formal feedback helps clinicians effectively treat patients at risk for deterioration ($d = .49$), whereas it is not needed in cases that are progressing well (see Table 3). How well, then, does relationship feedback work in psychotherapy? It depends; it depends on the purpose and the circumstances.

The strength of the therapy relationship also depends in some instances on the client's principal disorder. The meta-analyses occasionally find some relationship elements less efficacious with some disorders, usually substance abuse, severe anxiety, and eating disorders. Most moderator analyses usually find the relationship equally effective across disorders, but that conclusion may be due to the relatively small number of studies for any single disorder and the resulting low statistical power to find actual differences. And, of course, it gets more complicated as patients typically present with multiple, comorbid disorders.

Our point is that each context and patient needs something different. "We are differently organized," as Lord Byron wrote. Empathy is demonstrably effective in psychotherapy, but suspicious patients respond negatively to classic displays of empathy, requiring therapist responsiveness and idiosyncratic expressions of empathy. The need to adapt or personalize therapy to the individual patient is covered in detail in the other half of the Task Force's work on evidence-based responsiveness (Norcross & Wampold, 2019).

## What Does Not Work

Translational research is both prescriptive and proscriptive; it tells us what proves effective and what does not. We can optimize therapy relationships by simultaneously using what works and studiously avoiding what does not work. Here, we briefly highlight those therapist relational behaviors that are ineffective, perhaps even hurtful, in psychotherapy.

One means of identifying ineffective qualities of the therapeutic relationship is to reverse the effective behaviors identified in these meta-analyses. Thus, what does not work are poor alliances in adult, adolescent, child, couple, and family psychotherapy, as well as low levels of cohesion in group therapy. Paucity of collaboration, consensus, empathy, and positive regard predict treatment drop out and failure. The ineffective practitioner will not seek or be receptive to formal methods of providing client feedback on progress and relationship, will ignore alliance ruptures, and will not be aware of his or her countertransference. Incongruent therapists, discreditable treatments, and emotional-less sessions detract from patient success.

Another means of identifying ineffective qualities of the relationship is to scour the research literature (Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2010) and conduct polls of experts (Koocher, McMann, Stout, & Norcross, 2015; Norcross, Koocher, & Garofalo, 2006). In a previous review of that literature in 2011 (Norcross & Wampold, 2011), we recommended that practitioners avoid several behaviors: Confrontations, negative processes, assumptions, therapist–centricity, and rigidity. To that list we add *cultural arrogance*. Psychotherapy is inescapably bound to the cultures in which it is practiced by clinicians and experienced by clients. Arrogant impositions of therapists' cultural beliefs in terms of gender, race/ethnicity, sexual orientation, and other intersecting dimensions of identity are culturally insensitive and demonstrably less effective (Soto, Smith, Griner, Rodriguez, & Bernal, 2019). By contrast, therapists expressing cultural humility and tracking clients' satisfaction with cultural responsiveness markedly improve client engagement, retention, and eventual treatment outcome.

## Concluding Reflections

The future of psychotherapy portends the integration of the instrumental and the interpersonal, of the technical and the relational in the tradition of evidence-based practice (Norcross, Freedheim, & VandenBos, 2011). *Evidence-based psychotherapy 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" (APA Presidential Task Force on Evidence-Based Practice, 2006) as the relational behaviors in this special issue. We are reminded daily that research can guide how to create, cultivate, and customize that powerful human relationship.

Of course, that research knowledge serves little practical purpose if psychotherapists do not know it and if they do not enact the specific behaviors to enhance these relationship elements. The meta-analyses are complete now, but not the tasks of dissemination and implementation. Members of the Task Force Steering Committee plan to share these results widely in journal articles, public presentations, training workshops, and professional websites. A Society for the Advancement of Psychotherapy initiative, *Teaching and Learning Evidence-Based Relationships: Interviews with the Experts* (societyforpsychotherapy.org/teaching-learning-evidence-based-relationships), is underway to assist students and educators in these evidence-based therapy relationships.

The three interdivisional APA task forces originated to augment patient benefit. We continue to explore what works in the therapy relationship (and what works when we adapt that relationship to transdiagnostic patient characteristics). That remains our goal: improving patient outcomes, however measured and manifested in a given case. A dispassionate analysis of the avalanche of meta-analyses in this journal issue reveals that multiple relationship behaviors positively associate with, temporally predict, and perhaps causally contribute to client outcomes. This is reassuring news in a technology-driven and drug-filled world (Greenberg, 2016).

To repeat one of the Task Force's conclusions: The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment. Decades of research evidence and clinical experience converge: The relationship works! These effect sizes concretely translate into healthier and happier people.

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# PSYCHOTHERAPY RELATIONSHIPS THAT WORK

## *Volume 1: Evidence-Based Therapist Contributions*

THIRD EDITION

Edited By
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## ACCOUNTING FOR PSYCHOTHERAPY OUTCOME

What, then, accounts for psychotherapy success (and failure)? This question represents an understandable desire for clarity and guidance, but we raise the question here as a way of putting the research evidence on the psychotherapy relationship into an overall context. Our collective ability to answer in meaningful ways is limited by the huge variation in methodological designs, theoretical orientations, treatment settings, research measures, and patient presentations. Of the dozens of variables that contribute to patient outcome, only a few can be included in any given study. How can we divide the indivisible complexity of psychotherapy outcome?

Nonetheless, psychotherapy research has made tremendous strides in clarifying the question and addressing the uncertainty. Thus, we tentatively offer two models that account for psychotherapy outcome, averaging across thousands of outcome studies and hundreds of meta-analyses and acknowledging that this matter has been vigorously debated for over six decades. We implore readers to consider the following percentages as crude empirical estimates, not as exact numbers.

The first model estimates the percentage of psychotherapy outcome variance as a function of therapeutic factors. The comparative importance of each of these factors is summarized in Figure 1.1. The percentages are based on decades of research but not formally derived from meta-analytic methods. The patient's extratherapeutic change—self-change, spontaneous remission, social support, fortuitous events—accounts for

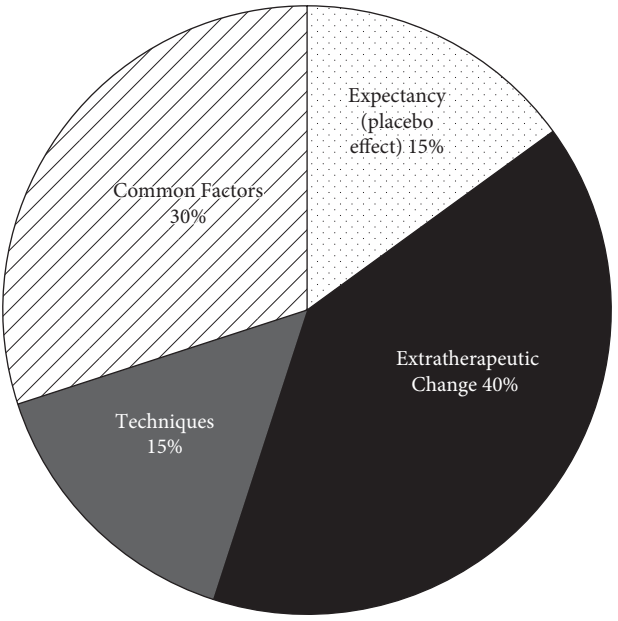


FIGURE 1.1 Percent of improvement in psychotherapy patients as a function of therapeutic factors.

roughly 40% of success. Humans have a tendency to move toward health and to take advantage of opportunities to stabilize themselves.

Common factors, variables found in most therapies regardless of theoretical orientation, probably account for another 30%. The therapy relationship represents the sine qua non of common factors, along with client and therapist factors. Technique factors, explaining approximately 15% of the variance, are those treatment methods fairly specific to prescribed therapy, such as biofeedback, transference interpretations, desensitization, prolonged exposure, or two-chair work. Finally, playing an important role is expectancy, or the placebo effect—the client's knowledge that he or she is being treated and his or her conviction in the treatment rationale and methods. These four broad factors account for the explained outcome variance.

The second model considers all outcome variance in psychotherapy outcome and begins with the unexplained variance, which necessarily decreases the amount of variance attributable to the other factors. As summarized in Figure 1.2, psychotherapy research—and research in any complicated human activity—cannot explain all of the variation in success. To be sure, some of this is attributable to measurement error and fallible methods, but some is also attributable to the complexity of human behavior. Thereafter, we estimate that the patient (including motivation for treatment and severity of disorder) accounts for approximately 30% of the total variance, the therapy relationship for 15%, and the specific treatment method for 10%, and the therapist for 7% (when not confounded with treatment effects). In this model, we assume that

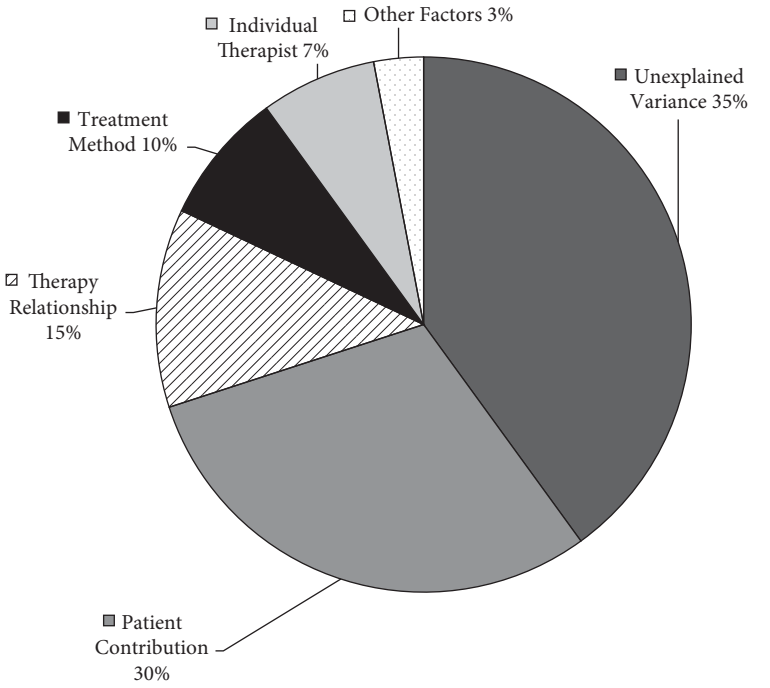


FIGURE 1.2 Percent of psychotherapy outcome attributable to therapeutic factors.

common factors are spread across the therapeutic factors—some pertain to the patient, some to the therapy method, some to the treatment method, and some to the therapist him/herself.

How can psychotherapy outcome be improved? Follow the evidence; follow what contributes to psychotherapy outcome. Begin by leveraging the patient's resources and self-healing capacities; emphasize the therapy relationship and so-called common factors; employ research-supported treatment methods; select interpersonally skilled and clinically motivated practitioners; and match all of them to the patient's characteristics, personality, and world views. This, not simply matching a treatment method to a particular disorder, will maximize success.

The differences between our two models help explain the rampant confusion in the field regarding the relative percentages accounted for by relationships and techniques. The first model presents only the explained variance and separates common factors and specific factors, whereas the second model presents the total variance and assigns common factors to each of the constituent elements. Hence, it is essential to inquire whether the percentages attributable to particular therapeutic factors are based on total or explained variance and how common factors are conceptualized in a particular model.

Despite the differing percentages, the results of both models converge mightily on several take-home points. One: patients contribute the lion's share of psychotherapy success (and failure). Consider the probable outcome of psychotherapy with an adjustment disorder in a healthy person in the action stage versus a chronically mentally ill person presenting in precontemplation/denial. Two: the therapeutic relationship generally accounts for at least as much psychotherapy success as the treatment method. Three: particular treatment methods do matter in some cases, especially more complex or severe cases (Lambert, 2013). Four: adapting or customizing therapy (as illustrated in Volume 2) to the patient enhances the effectiveness of psychotherapy probably by innervating multiple pathways—the patient, the relationship, the method, and expectancy. Five: psychotherapists need to consider multiple factors and their optimal combinations, not only one or two of their favorites.

Consider the results of an unusual meta-analysis of treatments for depression, which illustrate these general patterns. Cuijpers and colleagues (2012) focused on the effects of so-called nondirective supportive therapy (NDST) compared to wait-list control groups, other psychotherapies, and pharmacotherapies. Many psychotherapies have been found effective with depression, but the differences between them are small and unstable. "After more than three decades, most quantitative reviews suggest that the different therapies for depression are equally, or almost equally effective" (p. 281). Cuijpers et al. note that numerous clinical trials have included NDST comparison groups in order to control for common factors that are present across therapies (i.e., the failure to find differences between treatments is because common factors account for improvements, not the specific treatment techniques that are being tested). In these comparisons, NDST contains elements of relationship such as the therapeutic alliance, belief in the treatment, a clear rationale as to why the client has developed the problems, and the like. NDSTs are typically "an unstructured therapy without specific

psychological techniques other than those belonging to the basic interpersonal skills of the therapist, such as reflection, empathic listening, encouragement, and helping people to explore and express their experiences and emotions" (p. 281).

The results of 31 psychotherapy trials were examined in the meta-analysis and resulted in an estimate of three elements of change: (1) those due to extratherapeutic factors such as spontaneous remission, client, and community factors (33%); (2) those due to common factors such as therapist, relationship, and expectancy (50%); and (3) those due to specific therapeutic techniques (i.e., the comparison between NDST and other treatments; 17%). The authors suggest caution in relying on these estimates but conclude: "Despite these limitations, this study has made it clear that NDST has considerable effect on mild to moderate depression, that most of the effects of therapy for adult depression is accounted for by non-specific factors, and that the contribution of specific techniques in these patients is limited at best and may in fact be absent for many" (p. 290). Exactly our take-home points.

## LIMITATIONS OF THE WORK

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

The products of the task force probably suffer first 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 collaboration, which is considered in the same chapter, and both of those are frequently considered parts of the therapeutic alliance. 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 meta-analyses. Thus, to some, the content may appear swollen; to others, the task force may have failed to make necessary distinctions.

Another lacuna in the task force work is that we may have neglected, relatively speaking, the productive contribution of the client to the therapy relationship. Virtually all of the relationship elements in this book represent mutual processes of shared communicative attunement (Orlinsky et al., 2004). They exist in the human connection, in the transactional process, rather than solely as a therapist (or client) variable.

We decided not to commission a separate chapter on the client's contributions; instead, we asked the authors of each chapter to address them. We encouraged authors to attend to the chain of events among the therapist's contributions, the patient processes, and eventual treatment outcomes. This, we hoped, would maintain the focus on what is effective in patient change. (The chapters in Volume 2 examine patient contributions directly in terms of patient characteristics.) Nonetheless, by omitting separate chapters, we may be understandably accused of an omission akin to the error of leaving the relationship out at the expense of method. These volumes may be "therapist-centric" in minimizing the client's relational contribution and self-healing processes.

# 2

# ALLIANCE IN ADULT PSYCHOTHERAPY

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Since our previous review of this literature in 2011, the alliance has continued to be a major focus of the psychotherapy research community. The key words *alliance, helping alliance, working alliance*, and *therapeutic alliance* in PsycINFO resulted in over 2,000 hits in 2000 and generated an additional 5,000 hits in 2010. Our comparable search in early 2017 yielded over 5,000 further items, indicating a several-fold growth in the literature since 2000.

The prominence of the alliance for practitioners and researchers is, in part, based on its important historical roots as well as recent methodological and conceptual innovations. The emphasis on clinical trials in previous decades has failed to clearly elucidate what makes psychotherapy work (e.g., Deacon, 2013; Kazdin, 2009) and has not identified specific treatments that prove more effective than others (Wampold & Imel, 2015). The alliance continues to be one of the most important, if not the most important, factor in psychotherapy success. The impact of the therapist–patient relationship finds broad resonance across psychotherapy orientations.

The continued growth of the alliance literature is probably attributable to the dual facts that (a) research consistently finds a moderate but robust relation between the alliance and outcome across a broad array of treatments (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000) and (b) the alliance can be assessed in a practical and direct manner. Items such as "I believe my therapist is genuinely concerned for my welfare," "We agree on what is important for me to work on," and "My therapist and I respect each other" can be utilized in many clinical contexts.

In this chapter, we begin with an overview of the origins and definitions of the alliance, its measures, and clinical examples. We provide a meta-analysis of the

alliance–outcome literature (1978–2017). The results confirm the robustness of the positive relation between the alliance between therapist and client and psychotherapy outcomes across assessor perspectives, alliance measures, treatment approaches, and countries. We conclude with evidence for causality, limitations of the research, patient contributions, diversity considerations, training implications, and then therapeutic practices.

## DEFINITIONS

The term *alliance* (sometimes preceded by *therapeutic, working,* or *helping*) refers to the collaborative aspects of the therapist–client relationship. However, there are nontrivial differences among authors in the precise meaning of the term. As with many other psychological constructs, such as *intelligence*, alliance concepts cover qualities of a broad psychological phenomenon that includes many perspectives and facets. As highlighted in the prior versions of the present chapter (Horvath et al., 2011), one way to grasp the complexity of this concept is by briefly reviewing its history.

### Historical Background

The alliance focuses on fundamental considerations of the therapist–client relationship from an interactive perspective: How are decisions about treatment methods made? Who decides therapy goals? What is the quality of the human relationship between therapist and the client?

The concept of the alliance (though not the term itself) originated with Freud (1913). His premise was that all relationships were transference based (Freud, 1912/1958). Early in his writings he struggled with the question of what keeps the analysand in treatment in the face of the unconscious fear and rejection of exploring repressed material. His first formulation suggested that he thought that there was an "analyst" within the client supporting the healing journey (Freud, 1912/1956). Later he speculated about the reality-based collaboration between therapist and client, a conjoint effort to conquer the client's pain. He referred to this process as the unobjectionable or positive transference (Freud, 1927).

Both the importance of the client's attachment to the therapist and his or her ambiguity about this attachment (viz., reality based and conscious versus transferential and unconscious) has echoed throughout the evolution of the alliance. For example, Freud (1925) wrote, "Even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed. . . . The personal emotional relation between doctor and client was after all stronger than the whole cathartic process" (p. 35).

The term *ego alliance* was coined by Sterba (1934), who conceptualized it as part of the client's ego-observing process that alternated with the experiencing (transferential) process. Zetzel (1956) used the term *therapeutic alliance* to refer to the client's ability to use the healthy part of her or his ego to link up or join with the analyst to accomplish the therapeutic tasks. Greenson (1965, 1967) made a distinction between the *working*

*alliance* (i.e., the client's ability to align with the tasks of analysis) and the *therapeutic alliance* (i.e., the capacity of therapist and client to form a personal bond with the therapist; Horvath & Luborsky, 1993).

During the 1970s, efforts were made to detach the alliance from its psychodynamic roots and language to encompass the relational component of all types of helping endeavors. Luborsky (1976) proposed an extension of Zetzel's conceptualization when he suggested that the alliance between therapist and client developed in two phases. The first phase, "Type I alliance," involved the client's belief in the therapist as a potent source of help provided through a warm, supporting, and caring relationship. This level of alliance results in a secure holding relationship within which the work of the therapy can begin. The second phase, "Type II alliance," involved the client's investment and faith in the therapeutic process itself, a commitment to some of the concepts undergirding the therapy (e.g., nature of the problem, value of the exploratory process), as well as a willing investment of herself or himself to share ownership for the therapy process. Although Luborsky's (1976) conceptualization about the therapy process were grounded in psychodynamic theory, his description of the alliance as a therapeutic process was easily applicable to all forms of treatments.

Bordin (1975, 1976, 1989, 1994) proposed a pantheoretical version of the alliance that he called the *working alliance*. His concept of the alliance was based on Greenson's (1965) ideas as a starting point but departed from the psychodynamic premises. Furthermore, the idea of a pan-theoretical model was impacted by Rosenzweig's (1936) identification of common factors across particular orientations. For Bordin, the core of the alliance was a collaborative stance in therapy built on three components: agreement on the therapeutic goals, consensus on the tasks that make up therapy, and a bond between the client and the therapist. He predicted that different therapies would place different demands on the relationship; thus, the "profile" of the ideal working alliance would differ across orientations (e.g., Strunk et al., 2010; Ulvenes et al., 2012; Zickgraf et al., 2016).

A significant consequence of the way the alliance was "reinvented" was that from the beginning the two major voices (Luborsky and Bordin) did not address the boundaries of the alliance and its relations to other parts of the therapeutic relationship. This theoretical ambiguity created a void, which was filled by a number of alliance assessments that were developed more or less in parallel between 1978 and 1986 to empirically explore the role and function of the alliance (Horvath, 2018; Horvath & Luborsky, 1993).

Perhaps the most distinguishing feature of the modern pantheoretical reconceptualization of the alliance is its emphasis on collaboration and consensus (Hatcher & Barends, 2006). In contrast to previous formulations that primarily emphasized the therapist's contributions to the relationship, the therapists' interpersonal effectiveness, or the unconscious distortions of the therapist and client, this new pantheoretical alliance emphasized the active collaboration between the participants. Thus, it highlighted the collaborative parts of therapists as well as clients.

Starting in psychotherapy, the term *alliance* has become increasingly popular in a variety of helping professions, including nursing, social work, medicine (Horvath et al., 2014), and health media (Bickmore et al., 2005). The alliance's emphasis on

collaboration is in fortuitous synchrony with the emergent emphasis on the value of collaboration within health services (e.g., Bickmore et al., 2005; Kashe et al., 2017) and medical treatments (e.g., Elwyn, Frosch, Thomson, Joseph-William, Lloyd, et al., 2012).

## Recent Alliance Definitions

An increasing number of empirical investigations highlight different aspects of the alliance. In common, however, they assume that the alliance is positively associated with outcome, which is the major focus of the present meta-analytic synthesis.

### Psychometric Focus

Some research on the alliance asserts that the alliance is composed of independent elements (facets or components) and attempts to determine to what extent one component may be prioritized in comparison to the other components (e.g., Falkenström et al., 2015; Webb et al., 2011). Other research highlights the alliance as a synergistic assembly of components where the whole is more than the sum of its parts (e.g., goal agreement, task consensus, and bond together produce the therapeutic benefit; e.g., Horvath & Greenberg, 1989).

### Longitudinal Unfolding

In contrast to distinct alliance components, some researchers have investigated the alliance as a generalized factor across sessions (e.g., Crits-Christoph, Gibbons et al., 2011; Flückiger et al., 2019). Meanwhile, others have investigated its over-time changes on a session by session basis (e.g., Falkenström et al., 2013; Rubel, Rosenbaum, & Lutz, 2017; Zilcha-Mano et al., 2016).

### Participant Perspective

The alliance exists in a transaction (at least a dyadic construct), so different participants understandably experience it differently. The collaborative quality of the alliance highlights all therapy participants, including not only the client and therapist but also partners, group members, and observers. That typically results in simultaneous, interdependent evaluations of the alliance from several participants over time, each representing a particular (e.g., Atzil-Slonim et al., 2015; Kivlighan et al., 2016).

### Nested Data Structures

The alliance assessments often are based on multiple nested levels; that is, sessions are frequently nested within patients, patients are nested within therapists, and therapists are nested within clinics. By estimating the proportion of the variance at each level (e.g., Baldwin, Wampold, & Imel, 2007; Dinger et al., 2007) and examining which level

contributes most to the overall variability (by not only clients and therapists but also clinics; e.g., Crits-Christoph, Hamilton, et al., 2011), the alliance–outcome association can be unpacked to better understand how it works to increase the benefits of treatment.

For the purposes of this chapter, then, we included all alliance measures so named by the investigator that were used to report an alliance–outcome relation in adult individual psychotherapy. There was no particular definitional restriction to a certain understanding or tradition of the alliance.

## MEASURES

What we refer to as the alliance in this meta-analysis is an aggregate based on more than 30 alliance measures, each providing a distinctive operational definition of the concept. The differences among these measures pertain to how the alliance is defined, the source of the data (patient report, therapist report, observer), as well as the time span over which the alliance is sampled.

Consistent with the previous meta-analyses, four measures—California Psychotherapy Alliance Scale (CALPAS; Marmar et al., 1986), Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986), Vanderbilt Psychotherapy Process Scale (VPPS; Suh et al., 1986), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989)—accounted for approximately two thirds of the data. In the current search, 73 (69%) of the 105 articles used an inventory that was based on WAI items. Over time, there is a pronounced tendency to use shorter versions of the measures. Each of these four core instruments has been in use for over 30 years and have demonstrated acceptable levels of internal consistency, in the range of .81 to .87 (Cronbach's alpha). Rated (observer) measures tend to report similar inter-rater reliability coefficients.

The shared variance, even among these well-established measures, has been shown to be less than 50% (Horvath, 2009). An investigation of the shared factor structure of the WAI, CALPAS, and HAQ found that "confident collaborative relationship" was the central common theme among them (Hatcher et al., 1996). Items such "My therapist and I respect each other" (WAI patient), "I feel I am working together with the therapist in a joint effort" (HAQ-II patient), "Did you feel that you were working together with your therapist, that the two of you were joined in a struggle to overcome your problems?" (CALPAS patient), and "How productive was this hour?" (VPPS patient) illustrate the shared understanding of the global, heuristic quality of collaboration across measures.

Nonetheless, adding to the diversity of measures is the fact that over time the four questionnaire traditions have evolved. A number of different forms (e.g., short versions, observer versions, translations) of the core measures now thrive. For example, the original HAQ has undergone a major revision (HAQ II; Luborsky et al., 1996) and the two versions of the instrument have in common less than 30% of content; consequently, we coded HAQ and HAQ II as separate measures in our meta-analysis.

In addition, some of alliance research relied on measures related to but not specifically designed to measure the alliance (e.g., Barrett-Lennard, 1978), while in other instances alliance items were combined with other process instruments (e.g., Flückiger et al., 2011; Mander et al., 2013). In some studies, a person might report on a number of different process concepts; for instance, the therapist evaluates empathy and alliance within one scale. The point is that each of the previously mentioned procedures introduces additional variability to the alliance measurement.

The nature of the alliance itself is likely to change over the course of treatment (Tschacher et al., 1998). Therefore, the meaning of a single item across psychotherapy for each person might differ (Beltz et al., 2016). For example, the item "I feel that my therapist appreciates me" may have a qualitatively different meaning at the beginning of a treatment than at a later session when the therapist and client address highly emotional topics. Even though the diversity of the alliance measures likely contributes to the variability of the alliance–outcome relation, it also demonstrates the broadly accepted relevance of diverse ways to assess the collaborative qualities of the dyadic relationship of therapist and client.

## CLINICAL EXAMPLES

The alliance represents an emergent quality of mutual collaboration and partnership between therapist and client. As such, it is not the outcome of a particular intervention; its development can take different forms and may be achieved almost instantly or nurtured over a longer period of time (Bordin, 1994) within a responsive, collaborative relationship (Stiles, 2009).

The following dialogue illustrates a realistic conversation about negotiating the clients' collaborative engagement in goal agreement and task consensus, as well as trustful confidentiality at the check-in phase at session three. The client (C) and therapist (T) are discussing a thought diary:

C: I think you are the expert, and therefore I trust you that you can show me the best way to get over my indecisiveness.
T: I really appreciate your openness and trust. At the same time, I believe we need a common understanding about your situation and how we should proceed in your therapy.
C: Well, aren't you going to tell me what I should do?
T: Because [during the last session] we scheduled to take a more precise look at your behaviors and thoughts based on your diary?
C: Well, documentation of situations and thoughts. . . . And all that, sorry to say it, damned silly stuff. [Laugh]
T: Were your thoughts and emotions silly or the structured diary itself?
C: Well, . . . look, I mean a little bit both. . . . You are the therapist and I keep fucking up. So I guess I better start with the documentation. . . . I wish there was a pill or electric shock therapy to . . . it would be easier.

T: I understand that taking a pill or shock might make things easier. At the same time, I am not sure if taking a pill would be a good reason to not take a precise look at your recent situation . . . which basically can be exhausting.
C: I see. Therapy is hard work hard, and, of course, this is not always lot of fun.
T: Well, I understand this "damned silly stuff" is hard work . . . but at the same time, there is also straight-laced humor here . . . right now.
C: Mhmmm . . . It's crazy you know, before I got married I was a pretty wild dog . . . long hair, motorcycles, pretty crazy. Lot of fun!
T: Something like a wild dog that is not fully welcome anymore?
C: Well, I got, let's say "domesticated." . . . You know, married, good job, slick house, kids. . . . Maybe I lost the good parts of my wild side.
T: . . . And the wild side might have something interesting to say . . .
C: I might be a little afraid of my old wild dog. . . . But [with different voice], Doc, basically, my old man was trash, my whole family is trash!
T: You fear that your trashy parts are too negative to let them give a voice?
C: Well, I really fear taking an honest look at this "wild dog" during therapy. At the same time . . . of course . . . I somewhat fear the consequences.
T: I am optimistic that opening the box does not mean destroying all the good things. But, of course, it seems to be important that both of us are careful and honest to bring all the potential consequences to the table.
T: [Pause 10 sec] So, actually, as potential consequence . . . is your wife reading your diaries right now?
C: Well, I thought it would be good to discuss it with her . . . but, I am not sure, if I really should.
T: Ok, I see. Maybe there are different steps here?

In this excerpt, the therapist starts to go forward with his treatment plan, but when he becomes aware of the client's ambivalence, he demonstrates his commitment to explore collaboratively alternatives without losing the therapeutic focus. Clients frequently have a mixture of hopes and worries about therapy. The therapist's challenge in building the alliance is to recognize, legitimize, and work through these conflicts and engage the client in a joint exploration of obstacles.

Some clients, especially in the beginning of treatment, may be somewhat hostile, rejecting, or fearful of treatment or the therapist. The therapist's ability to respond with acceptance and an openness to discuss these challenges is important in establishing the alliance. The following excerpt provides a brief example of such a process at the end of session five (Horvath et al., 2011):

C: [The topic discussed last week] . . . was interesting. . . . But sometimes I can't remember what I talked about from one week to the next.
T: . . . We talked about how difficult it is to imagine how things would be different if . . .
C: [overlap] I sometimes wonder . . . what do therapists do after the session? I mean, . . . do you walk around the block to forget all this craziness? Do you go home and dream about it?

T: Hmm, I . . .

C: [overlap] I mean, it is not like having a discussion with a friend; though goodness knows, I sometimes forget about those too. I think to myself, does he [T] need to hear all of this? How often do I tell you that stuff? I read that Freud sometimes napped behind the couch. . . . Not, mind you, that I think you are falling asleep during our session! But sometimes you look tired. [Laughs] Oh, never mind; this was a useful session. [Looks at the clock] Are we done? [Stands up]

T: So, are you wondering, "What is it in it for him [T]"?

C: I knew you'd say that!

T: Well . . . the therapy relationship is different than other relationships. It is a strange thing to pour one's heart out to someone and then wonder: Did it mean anything to him? What am I to him?

C: Yeah, I guess . . . that's therapy, for you! [stand up again as to go]

T: Not sure if you want to talk about this or go. . . . We still have 10 minutes until the end of our session.

C: Well it is late . . .

T: Interesting that this came up today. And . . . then it's kind of left hanging between us.

C: You mean hit and run? When I don't get something that I want I don't wait for an answer?

T: There was something you wanted . . . from me . . . ?

C: Doesn't take a rocket scientist to figure out. . . . When you were asking "Does it [therapy] work for you" [reference to last week's discussion]," I thought here it comes . . .

T: You mean that I'll quit on you?

C: I know you would not do that. I know you wouldn't. But, I mean, we are talking about this all this time, and I think . . . I talk about it to others too [relates an incident of talking about his marriage to a colleague]. Now I know she [the colleague] feels sorry for me, but of course this doesn't help either. But that's different. Kind of . . . it's not sympathy I need, but sometimes [voice goes shallow, eyes moist]

T: You want from me . . . how I feel personally about . . .

C: [Change of expression; sarcastic] Good fucking time to bring it up!

T: Does this; like this . . . remind . . .

C: You mean do I do this hit and run with [wife]. Yeah. I've been thinking about that. Kind of stupid but interesting; I felt we were really . . . I was telling you something in a way I have not been able to talk about before. Last week, I mean . . . pulled back and felt mixed up when we started. . . . I don't like risking myself as much as I do? Hmm, I guess I went to the right school: "The hit and run academy of motherly love" . . . I am so tired of it. [Pause] . . . I think I am making the connection. . . . [Pause] We got someplace today.

## LANDMARK STUDIES

The following landmark research articles have had a lasting impact on the alliance literature.

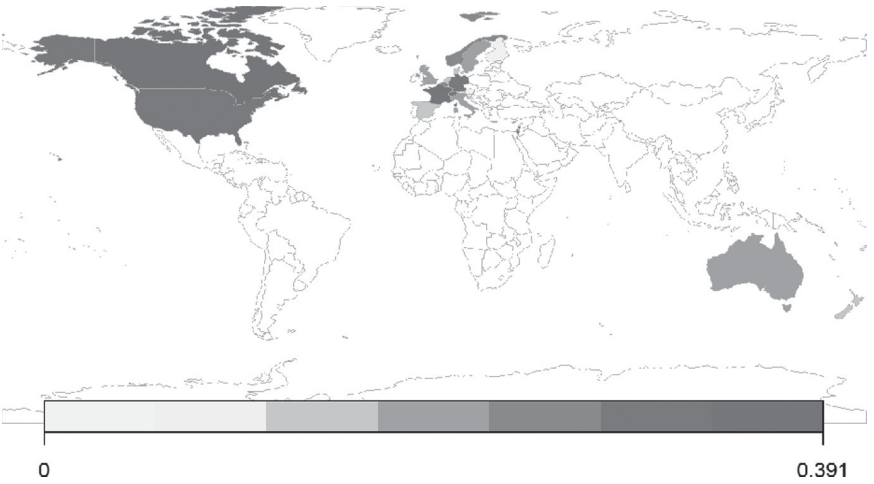


FIGURE 2.9 The international context of studies reporting an alliance–outcome correlation (white: no studies; grey tones: aggregated alliance–outcome correlation).

an effect that is not present in its absence, we infer that the variable has caused the effect. Clearly, removing the alliance from therapy while everything else is held constant is practically impossible and ethically unacceptable. Moreover, research evidence suggests that in psychotherapy multiple, mutuality interactive variables contribute to the changes associated with positive outcome (e.g., Horvath et al., 2011; Norcross & Wampold, 2018). Rather than a single "cause" producing a finite effect, progress, or positive change, therapy process is more accurately understood as the result of interaction of a variety of factors each acting the context of the other (Kramer et al., 2014; Wampold & Imel, 2015). While conceptually we can think of interventions or variables as finite entities (e.g., homework, practice, empathy, interpretation etc.) each having the potential of bring about salutary effect, in clinical practice, all interventions happen in a particular context that includes -among other things- the relational connection between the helper and client (a at least dyadic quality), the timing of the intervention, the place in which therapy unfolds, etc. Each conceptually distinct element in therapy can potentiate or reduce the impact of the others. For example, the impact of offering the client a particular intervention depends not only on the quality of the intervention but weather it was offered responsively "at the right time" and delivered in a form most appropriate for that particular client (e.g., Crits-Cristoph et al., 1988; Grosse-holtforth & Flückiger, 2012; Norcross & Wampold, 2018; Stiles & Horvath, 2017). In this inclusive view of the therapy process, the distinction between causal ingredients and relationship/context becomes less clear and the variety of features of the unfolding processes and dynamic systems of therapy are conceptualized to interact to impact the outcomes synergistically. The degree of effectiveness of an intervention is contingent on the interpersonal dimension, the timing

and the capacities, resources and needs of both therapist and client (Horvath, 2018; Stiles et al., 2015).

What research *can* tell us about contribution of the quality of the alliance to positive outcome is twofold: First, meta analytic methods (such as the one we report) can give a reliable estimate of the proportion of variance in outcome that is contingent on the quality of the alliance in general. As noted above, alliance accounts for about 8% of the outcome variance and, while this may not seem like a large proportion, it should be noted that it is not smaller in comparison variances discussed for other well-investigated psychotherapy factors such as treatment methods or therapist effects. And, second, we can answer the question weather the alliance is a surrogate variable standing in for a more basic underlying entity. In this regard, studies have investigated a wide range of possibilities such as: whether the link between alliance and outcomes was a consequence of early gains in therapy, specific to sources of report, kind of treatments, type of outcome measures, phases of therapy, measuring methods, and kind of psychological problems (Crits-Christoph et al., 2006; Flückiger et al., 2012). In each of these investigations (as well as in the current and prior meta-analyses) the results indicate that the alliance indeed makes a real and unique contribution to the therapy process, though the specific ways that the alliance contributes to therapy process likely varies among different kinds of treatments as Bordin (1994) predicted.

Nonetheless, does the alliance actually cause successful treatment outcomes? That question has been investigated and discussed using a variety of advanced empirical models with particular statistical assumptions. For example, several approaches focused on the within-patient, session-by-session prediction during treatment (e.g., Barber et al., 2014; Falkenström et al., 2013; Hoffart et al., 2013; Rubel et al., 2017; Strunk et al., 2010; Tasca & Lampard, 2012; Weiss et al., 2014; Xu & Tracey, 2015; Zilcha-Mano & Errazuriz, 2017). Many of such studies report a significant small to moderate within-patient association between alliance and subsequent outcome variables (e.g., Zilcha-Mano, 2017), even though systematic meta-analyses on these studies are not available at present. One of the more straightforward meta-analytic approaches to answer the causal question lies in the within-study comparison of zero-order alliance–outcome correlations with partial correlations that adjust for intake characteristics and related early symptom change. The partial correlation coefficient is a coefficient used to describe the linear association between X and Y (i.e., alliance and outcome) after excluding the effect of one or more independent factors Z (e.g., intake characteristics, alternative process variables). In the present meta-analysis data, 66 studies reported both coefficients (zero-order alliance–outcome correlations as well as partial correlations). Our results indicated there were no statistically significant differences between zero-order and partial correlations ($Q_{(1)} = 1.651$; $p = .199$), indicating that the potential covariates measured did not reduce the magnitude of the alliance and outcome relations (for zero-order correlations $r_{adjusted} = .25$, for partial-correlations $r_{adjusted} = .22$).

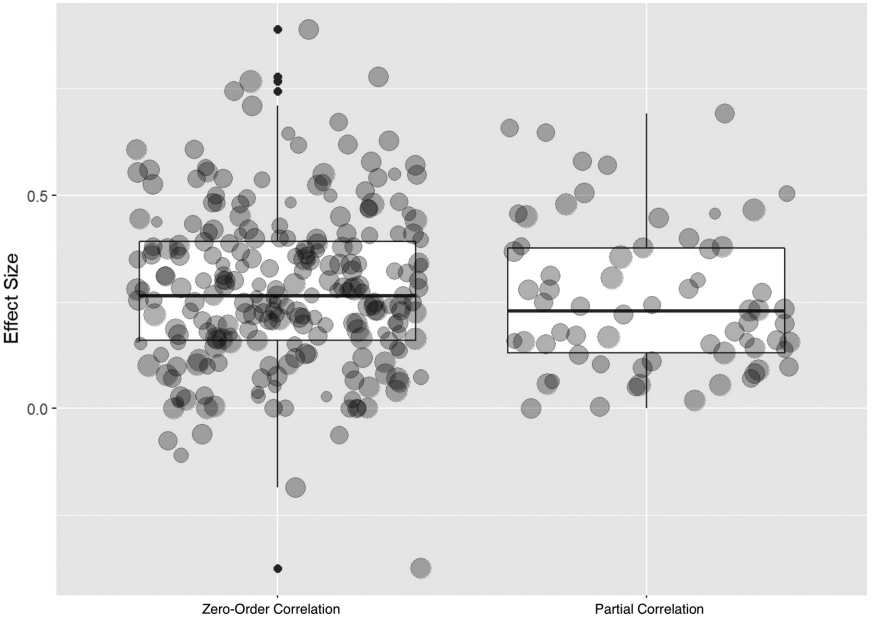


FIGURE 2.10 Comparison of reported zero-order and partial correlations.

These results support the hypothesis that the association between alliance and outcome is not mainly an epiphenomena linked to intake characteristics and related early therapy gains. Figure 2.10 displays the box plot comparing the two categories.

## PATIENT CONTRIBUTIONS

The alliance represents a proactive collaboration of clients and therapists across sessions and in moment-to-moment interactions. The alliance is an emergent dyadic quality highlighting the co-contribution and coordination between both patient and therapist. Clearly, from an ethical point of view, all psychotherapy participants have to consent for the overall therapy goals and tasks in a highly confidential setting. Patient proactive engagement is desirable and necessary in the majority of people seeking a psychotherapist. As such, there is no psychotherapy process and outcome without patient contributions (Pope & Vasquez, 2016).

With respect to the alliance, the reviewed research indicates that the therapist makes the largest contribution to the development of the alliance, but certainly the patient contributes to the dyadic relationship. For example, patient trust (Birkhäuser et al., 2017), processing activities (Bohart & Wade, 2013), capacity for attachment and bond (Levy et al., 2018), and social support (Coyne et al., 2018; Levin et al., 2012, Probst et al., 2015) may impact the cooperative quality of the alliance as micro outcome.

Clients' high problem severity may present challenges to the development of the alliance. Personality disorders have been advanced as one notable population with

difficult alliances (e.g., Forster et al., 2014). However, personality disordered samples indicate a comparable alliance–outcome association to other diagnostic groups. Our findings show high variability of the alliance–outcome ES in BPD. This variability might go along with unstable emotional states, which might impact the perception of the alliance in single sessions (Bedics et al., 2015; Spinhoven et al., 2007; Ulvenes et al., 2012).

In the current study, we replicated the earlier meta-analytic findings that SUD (Flückiger, Del Re, et al., 2013) and eating disorder (Graves et al., 2017) populations have slightly lower alliance–outcome ESs in adult samples. However, those previous meta-analyses also indicated that the alliance is embedded in a variety of moderating factors such as ethnic minorities in SUD samples and clients' age in eating disorders, highlighting the related psychosocial context within these samples.

## LIMITATIONS OF THE RESEARCH

This chapter is based on a quantitative synthesis of the research results. While our team made a sustained effort to seek all the available research on alliance–outcome relation, no meta-analysis is truly exhaustive, and as Figure 2.9 impressively shows, this one is no exception. Given the robust finding of the positive association between alliance and outcome, major changes in the association are not likely in the future, even though there was a slight decrease of the alliance–outcome relation in more recent studies.

A significant challenge for research on the alliance lies in the quantification of potentially different qualities (sometimes called the apples and oranges problem; Schmidt & Hunter, 2014). Given the considerable diversity in what researchers and psychotherapists call the "alliance," we might have collected and summarized different kinds of idiographic and nomothetic understandings. This is a complicated concern, especially in light of the fact that the ESs are quite diverse, albeit positively correlated. A practical response to this challenge is that this chapter provides a "birds-eye view" of the quantitative question: What have researches found about the alliance–outcome relation in individual psychotherapy?

There are also some technical constrains to these analyses. We chose to use independent data. To achieve this, we performed a three-level multivariate meta-analysis. These analyses account for different outcome assessments applied in the primary studies. As a result, the adjusted alliance–outcome correlation was slightly lower in magnitude in comparison to analyses that do not adjust for these potential confounds. In the long run, the use of independent data is statistically justified and provides further evidence that the alliance–outcome ES is far from being zero-correlated even when applying rigorous and conservative statistical models.

In the future, research designs are needed that can test the causal impact of the alliance in psychotherapy outcome. More research is needed in culturally specific samples inside and outside Western countries. More research is also needed that examines the boundary conditions of the alliance measures and their interaction to interpersonal

and general process indicators, such as empathy, the real relationship, and corrective experiences.

## DIVERSITY CONSIDERATIONS

The relationship between a therapist and a client is embedded in cultural norms, memories, and expectations about the psychotherapist/helper role. Our meta-analysis contained hundreds of studies from North American and European countries but not many from other (maybe less industrialized or "Western") countries. As well, except for substance abuse treatment studies, the percentage of ethnic minority clients appeared low indeed. And hardly any studies reported characteristics of their samples beyond age, gender, and race in terms of sexual orientation, gender identity, and other intersecting dimensions of patient diversity. The same (and even more pronounced) can be said for psychotherapists, where the description of the therapists often only includes the number of therapists.

Except in SUD studies, ethnic minorities are underrepresented and may prove an artifact of the research samples (Barber et al., 1999). Furthermore, SUD samples often used dropout dichotomy (yes/no) as outcome, which may have further diminished the overall outcome association. This is an important finding because it demonstrates that a straightforward focus to categorization systems, such as diagnoses categories or ethnic minority status, without a carful integration of the patients overall psychosocial situation may result in single-edged interpretations. Even though the present meta-analysis is a summary, the present analysis could not disentangle these various psychosocial factors.

## TRAINING IMPLICATIONS

Given the consistent correlation between in-therapy alliance and treatment outcome, it seems eminently sensible that mental health professionals could benefit from training to learn how to establish and maintain a strong alliance with their clients. Unfortunately, this is easier said than done.

At present, alliance training in graduate training programs is often nonexistent or, if in existence, the training is not systematic. Reports of clinical and counseling psychology programs in the United States and Canada indicate that systematic training in alliance is desirable and important but relatively rare (Constantino, Morrison, Coyne, & Howard, 2017; Morrison, 2014). The alliance is part of some training and supervision guidelines (American Psychological Association, 2015; Beinart & Clohessy, 2017) and embedded in some therapeutic frameworks (for an overview, see Muran & Barber, 2010). Examples of training programs that prominently focus on the alliance include the relational psychodynamic (Safran & Muran, 2000), humanistic (such as motivational interviewing; Miller & Rollnick, 2012), and cognitive-behavioral (e.g., Kazantzis et al., 2017; Tarrier & Johnson, 2017) approaches.

Three published pilot studies have examined alliance training and investigated its effects on alliance formation (Crits-Christoph et al., 2006; Hilsenroth et al., 2002; Safran et al., 2014). Despite their quasi-experimental design and small samples, these efforts show promise that training can improve a therapist's development of a strong alliance with their clients. Moreover, as the number of studies in this meta-analysis and the integration of the alliance assessments in routine practice clearly attest, the alliance is part of the professional life of many psychotherapy trainees, therapists, and supervisors.

From the meta-analytic results and our collective training experiences, we offer the following training considerations.

- Training can include both long-term (therapy goals, task, bond) as well as short-term perspectives (session goals, task, bond) skills. Alliance training needs coordination at a higher level of abstraction (e.g., coordination of therapy goals and tasks) as well as at an action level (e.g., collaborative communication skills).
- Trainees and their supervisors should be aware that there is no alliance without a psychotherapeutic approach. That is, agreement about the tasks and goal of therapy requires an overall concept of treatment.
- The alliance is part of the individual case formulation. Therapists need to be responsive to patients' individual problems as well as their preferences, abilities and motivational readiness.
- Students can be taught to hold a positive attitude toward receiving participants' honest evaluations of the alliance and of treatment progress.
- Students can be taught to assess the alliance in ways that each participant contributes. Disagreement between therapist assessment and the client assessment is not something negative but instead may be a marker that a discussion of the relationship might prove helpful or necessary (e.g., Atzil-Slonim et al., 2015; Hartmann et al., 2015; Kivlighan et al., 2016).
- Goal and task agreement does not mean that the therapist automatically accepts the patient's goals and tasks, or vice versa. A strong alliance is often a result of negotiation. The shared decisions on treatment goals and tasks should attend ethical considerations.

## THERAPEUTIC PRACTICES

The accumulated volume of research on the alliance is impressive. It is certainly among the richest bodies of empirical research on psychotherapy process outcome. Alliance research indicates that collaborative practice has a positive impact on outcome.

- Build and maintain the alliance throughout the course of psychotherapy. That entails creating a warm emotional bond or collaborative attachment with the patient.

- Develop early on in treatment agreement on therapy goals and on respective tasks of patient and practitioner. Those reliably predict therapeutic success.
- Respond to clients' motivational readiness/stage of change and their capabilities during the first sessions of therapy.
- Create wording or therapist slang with a customized quality of inclusiveness and negotiation (e.g., Stiles & Horvath, 2017).
- Collaborate in words and in nonverbal language. Humans detect and perceive nonverbal behaviors—maybe not in every moment but in many moments.
- Address ruptures in the alliance directly and immediately (e.g., Eubanks et al., 2018).
- The alliance of each evaluator (therapist, patient) may be impacted by different social reference groups that may result in divergent alliance ratings. These divergences should be interpreted carefully since they do not have to indicate disagreement.
- Assess regularly from the client's perspective the strength or quality of the alliance. Assessing the alliance in routine practice may help to detect unsatisfactory progress and identify premature terminations. Existing clinical support tools can then help restore the alliance and move patients to improved outcomes (e.g., Lambert et al., 2018; Pinsof et al., 2015; Rise et al., 2012).

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## Appendix

### Steering Committee Members of the Third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness

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