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RESEARCH ARTICLE

WILEY

A new therapy for each patient: Evidence-based relationships and responsiveness

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Abstract

In this study, we introduce the journal issue devoted to evidence-based responsiveness and frame it within the work of the third interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness. We summarize the meta-analytic results and clinical practices on the adaptations of psychotherapy to multiple transdiagnostic characteristics of the patient, including attachment style, culture (race/ethnicity), gender identity, coping style, therapy preferences, reactance level, religion and spirituality, sexual orientation, and stages of change. We then discuss the clinical and research process of determining what works, and what does not work, for whom. The limitations of the Task Force's work are outlined and frequently asked questions are addressed. The article closes with the Task Force's formal conclusions and 28 recommendations and with some reflections on fitting psychotherapy to the individual client.

KEYWORDS

meta-analyses, psychotherapy, psychotherapy outcome, responsiveness, therapeutic relationship, treatment adaptations

1 | INTRODUCTION

The need to adapt or fit psychotherapy to the individual patients has been universally recognized from the beginning of modern psychotherapy. As early as 1919, Freud introduced psychoanalytic psychotherapy as an alternative to classical analysis based on the recognition that the more rarified approach lacked universal applicability and that many patients did not possess the requisite psychological mindedness. The mandate for individualizing psychotherapy was embodied in Gordon Paul's (1967 , p. 111) iconic question: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under which set of circumstances?" Every psychotherapist recognizes that what works for one person may not work for another; we seek "different strokes for different folks" (Blatt & Felsen, 1993).

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To many, the means of such matching were to tailor the psychotherapy to the patient's disorder or presenting problem, that is, to find the best treatment for a particular disorder. The research suggests that Treatment A for Disorder Z may prove differentially useful for a handful of disorders, such as some form of exposure for trauma and parent management training for childhood externalizing disorders. Although some psychotherapies may make better marriages with some mental health disorders, the repeated Dodo Bird conclusion in general as well as for most disorders indicates that bona fide psychotherapies produce similar outcomes, once the researchers' allegiance effect is identified and controlled (Wampold & Imel, 2015).

Still, the overwhelming majority of randomized clinical trials (RCTs) in psychotherapy investigates the efficacy of specific treatments for particular disorders. Problematically, in those studies, patients with a single diagnosis are collapsed. It is a false and, to be blunt, misleading presupposition in RCTs that the patient sample is homogeneous (Beutler & Clarkin, 1990). Perhaps the patients are diagnostically homogeneous, but nondiagnostic variability is the rule. It is precisely the unique individual and the singular context that many psychotherapists attempt to "treat."

As every clinician knows, matching psychotherapy solely to a disorder proves incomplete and not always effective. Particularly absent from much of the controlled research and clinical training has been adapting psychotherapy to the person of the patient, beyond his/her disorder. As Sir William Osler (1906), father of modern medicine, wrote: "It is much more important to know what sort of a patient has a disease than what sort of disease a patient has." The accumulating research demonstrates that it is indeed frequently effective to tailor or match psychotherapy to the entire person.

Hundreds of potential client characteristics have been proposed as markers for using one type of treatment or style rather than another (Clarkin & Levy, 2004); however, it has been only in the past 20 years that the perennial quest for adapting psychotherapy to transdiagnostic patient characteristics on sound research has been fulfilled. As manifested in the meta-analyses and systematic reviews in this journal issue, multiple methods of relational responsiveness or treatment adaptations have proven effective. These rightfully carry the designation of evidence-based practices.

In this study, we introduce this journal issue on evidence-based transdiagnostic adaptations, which updates and expands a 2011 issue on the same topic. We begin by noting what is new in this issue and by reviewing the innumerable terms accorded to this process of matching therapy and client. We summarize the purposes and processes of the third interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness, which sponsored the two book volumes (Norcross & Lambert, 2019; Norcross & Wampold, 2019) from which these articles were drawn. We then discuss the clinical and research process of determining what works, and what does not work, for whom. The limitations of the Task Force's work are outlined, and frequently asked questions are addressed. We conclude with the Task Force's formal conclusions and 28 recommendations and with some closing reflections on effectively adapting psychotherapy to the individual patient.

2 | WHAT IS NEW?

This journal issue updates and expands the previous issue in 2011 (Volume 67(2); Norcross & Wampold, 2011) on adapting psychotherapy. The general aims remain the same as its predecessor—to determine effective methods of adapting or tailoring therapy to the individual client—but its sponsorship and contents differ somewhat. The third Task Force was cosponsored by the Society for the Advancement of Psychotherapy (APA Division 29) and the Society of Counseling Psychology (APA Division 17).

We have expanded the breadth of coverage. The issue is composed of original meta-analyses and systematic reviews on adapting psychotherapy to a patient's transdiagnostic characteristics, or what we call "a new therapy for each patient." Updated meta-analyses examine the research evidence and clinical practices on fitting treatment methods and relational behaviors to a client's attachment style, racial/ethnic culture, therapy preferences, religious/spiritual commitment, reactance level, stage of change, and coping style. For good measure, the article on cultural identity also explores the relation of the therapist's cultural competence to treatment outcome. New review articles were commissioned on tailoring psychotherapy to the client's gender identity, sexual orientation, and functional impairment, although the latter did not

survive the pressing timeline of the project. (The other meta-analyses commissioned for this project were on elements of the therapeutic relationship; these are reported in Norcross & Lambert, 2019.)

The content of each article has also expanded by adding a section on diversity considerations. This addition helps readers appreciate the context of the research evidence and unpack its results, especially for treating diverse clients. This new journal issue, appearing 8 years after the prior incarnation, proves more practical by featuring more clinical examples and by ending each article with bulleted recommendations for clinical practice.

The net result is a compilation of nine, original cutting-edge reviews on what works in personalizing psychotherapy. Seven of the nine articles report original meta-analyses; the remaining two articles could not locate published controlled research studies to meta-analyze, so instead provided a narrative review of the literature.

3 | A ROSE BY ANY NAME

The process of creating the optimal match in psychotherapy has been accorded multiple names over the years. In alphabetical order, these terms include: aptitude by treatment interaction (a research design), attunement, customizing, differential therapeutics, fitting, individualizing, matchmaking, personalizing, prescriptionism, responsiveness, specificity factor, tailoring, therapy fit, treatment adaptation, and treatment selection. In the professional literature, *treatment adaptation* and *responsiveness* tend to prevail; we will employ both terms interchangeably here in the interest of theoretical neutrality (*adaptation* tends to be favored by cognitive-behavior therapists, whereas *responsiveness* is favored by relational, humanistic, and psychodynamic therapists). In clinical work, patients tend to prefer the terms *individualizing* and *personalizing* as they are self-explanatory and parallel language in personalized medicine (these conclusions hail from focus groups on psychotherapy clients).

By whatever name, the goal is to enhance treatment effectiveness by tailoring it to the unique individual and his/her particular situation. In other words, psychotherapists endeavor to create a new therapy for each patient. They do so by capitalizing on both the nomothetic and idiographic traditions: attuning psychotherapy to the *particulars* of the individual according to the *generalities* of the research findings. And when we speak of the individual, we naturally recognize that the person may be in individual therapy or in a larger treatment format, such as a couple or in a group.

This position can be effortlessly misunderstood as an authority-figure therapist prescribing a specific form of psychotherapy for a passive client. Far from it; the goal is for an empathic therapist to collaboratively create an optimal relationship with an active client on the basis of the client's personality, culture, and preferences. When a client resists participating in the therapeutic procedures of a treatment, for example, then the therapist considers whether she is using an approach that the client finds incompatible with her values, attitudes, culture, or beliefs (preferences), or the client is not ready to make those changes (stage of change) or is uncomfortable with a directive style (reactance). Clinicians strive to offer a therapy that fits or resonates to the patient's characteristics, proclivities, and worldviews—in addition to diagnosis.

4 | THE THIRD INTERDIVISIONAL TASK FORCE

The dual purposes of the third 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/her transdiagnostic characteristics. In other words, the Task Force was interested in both what works in general and what works for particular patients.

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 treatment adaptations and therapy relationships. Focusing on one area—in this volume, responsiveness—may unfortunately convey the impression that this is

the only important area of inquiry. Thus, we recognize here and elsewhere the simultaneous contribution of treatment methods to patient success.

At the same time, decades of careful research indicate that the patient, the therapy relationship, and these transdiagnostic adaptations exercise more influence on outcome than the particular treatment method. Put differently, *culture eats strategy*, as the famed management consultant Peter Drucker has said. The relational ambience of psychotherapy and responsiveness to patients prove typically more powerful than the particular therapeutic method or strategy. We endorse Jerome Frank's position, in his classic *Persuasion and Healing* (Frank & Frank, 1991, p. xv):

> *My position is not that technique is irrelevant to outcome. Rather, I maintain that … the success of all techniques depends on the patient's sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem.*

We consulted psychotherapy experts, the research literature, and potential authors to discern whether there were sufficient numbers of studies on a treatment adaptation or matching strategy to conduct a systematic review and meta-analysis. The analyses quantitatively analyzed the efficacy of adapting psychotherapy to that patient quality. Outcome was primarily defined as distal posttreatment outcomes, which sharpened our focus on "what works."

Except for this opening article, authors followed a consistent structure for their articles and specific guidelines for their meta-analyses, as follows:

- *Introduction (untitled)*. Introduce the patient transdiagnostic characteristics in a few, reader-friendly paragraphs.
- *Definitions*. Define in theoretically neutral language the patient characteristic and identify any highly similar or equivalent constructs from diverse theoretical traditions.
- *Measures*. Review the popular measures used in the research and included in the ensuing meta-analysis.
- *Clinical examples*. Provide several concrete examples of the patient characteristic being reviewed. Portions of psychotherapy transcripts are encouraged here while protecting the privacy of patients.
- *Meta-analytic review*. Conduct an original meta-analysis of all available studies employing a random effect's model. Compile all available empirical studies on the psychotherapy adaptation of the client characteristic to distal, end-of-treatment outcome in the English language (and other languages, if possible). Include only actual psychotherapy studies; no analogue studies. Perform and report a test of heterogeneity. Report the effect size as d or g (or other standardized mean difference).
- *Moderators and mediators*. Present the results of the potential mediators and moderators in your meta-analysis. Examples include year of publication, rater perspective (assessed by therapist, patient, or external raters), therapist variables, patient factors (including cultural diversity), different measures of treatment outcome, time of assessment (when in the course of therapy), and type of psychotherapy/theoretical orientation.
- *Limitations of the research*. Point to the major limitations of the research conducted to date.
- *Diversity considerations*. Address how dimensions of diversity (e.g., gender, race/ethnicity, sexual orientation, socioeconomic status) fare in the research studies and the meta-analytic results.
- *Therapeutic practices*. Bullet the practice implications from the foregoing research, primarily in terms of the therapist's contribution and secondarily in terms of the patient's perspective.

In the interest of saving space and highlighting diversity considerations and therapeutic practices, authors have jettisoned in these journal articles four sections that appeared in their respective book chapters: Results of Previous Meta-Analyses, Landmark Studies, Evidence for Causality, and Training Implications. These sections and additional findings can be located in the lengthier chapters (Norcross & Wampold, 2019).

The meta-analyses and systematic reviews were peer reviewed by at least two editors and subsequently underwent at least one substantive revision. In particular, the review established that the meta-analyses adhered to the Meta-Analysis Reporting Standards and reported the requisite information.

When the meta-analyses were finalized, a 10-person expert panel (identified in the Appendix) reviewed and rated the evidentiary strength of the effectiveness of fitting psychotherapy to that patient dimension. They did so according to the following criteria: number of empirical studies; consistency of empirical results; independence of supportive studies; magnitude of the effect size; evidence for causal link; and the ecological or external validity of research. Using these criteria, experts independently judged the strength of the research evidence as follows: demonstrably effective, probably effective, promising but insufficient research to judge, important but not yet investigated, or not effective.

We then aggregated the individual expert ratings to reach a consensus conclusion on each adaptation method. The articles in this issue are presented in the approximate order of the strength of their research evidence, beginning with the three demonstrably effective responsiveness/adaptation methods, three judged probably effective, one as promising, and ending with important but not yet investigated (in controlled research). All of the Task Force conclusions are summarized later in this study, as are 28 recommendations approved by all members of the Steering Committee.

5 | WHAT WORKS FOR WHOM

As the field of psychotherapy has matured, the identical psychosocial treatment for all patients is now recognized as inappropriate and, in select cases, detrimental and perhaps unethical. We will not progress, and our patients will not benefit, by imposing a Procrustean bed onto unwitting consumers of psychological services. In his Foreword to the landmark *Differential Therapeutics in Psychiatry* (Frances, Clarkin, & Perry, 1984), Robert Michels (1984, xiii) summed it as follows:

> *The easiest way to practice psychiatry is to view all patients and problems as basically the same, and to apply one standard therapy or mix of therapies for their treatment. Although some may still employ this model, everything we have learned in recent decades tells us that it is wrong—wrong for our patients in that it deprives them of the most effective treatment, and wrong for everyone else in that it wastes scarce resources.*

The clinical reality is that no single psychotherapy is effective for all patients and situations, no matter how good it is for some. Clinical practice has come to demand a flexible, if not integrative, perspective. Of course, as Michels notes, one treatment for a particular disorder would simplify treatment selection—give every patient the same psychotherapy!—but it flies in the face of what we know about individual differences, patient preferences, and disparate cultures.

Concisely put, no theory is uniformly valid and no mechanism of therapeutic action is equally applicable to all individuals. As a consequence, the goal is to select different methods, stances, and relationships according to the patient and the context. The result is a more efficient and efficacious therapy—and one that fits both the client and the clinician. Psychotherapy matching is an old idea come to evidence-based fruition.

The clinical decision-making may be expressed in a series of *when…then* statements. *When* the client presents with this (feature) or expresses this (value or belief), *then* consider doing this. In that way, the clinician matches to the entire person, not simply diagnoses.

One of our favorite clinical tales of responsiveness comes from the late Arnold Lazarus (1993), who related an illuminating incident with Mrs. Healy, a middle-aged woman who indicated she sought an assertive, humorous, and challenging relationship with her therapist. When she first entered the office, she looked Lazarus up and down and asked, “Why do you have graves outside your office?” In perfect Rogerian style Lazarus responded, “I have graves outside my office?” “Look out the window, dummy!” she replied. He went to the office window and looked out. Two

new flower beds had been installed alongside the front walk on the grass. It was early spring and the shoots had yet to emerge from the soil. "Well, since you ask," Lazarus replied, "I have just buried one of my clinical failures in the one grave and the other is earmarked for you Mrs. Healy if you turn out to be an uncooperative client." The twinkle in her eye told Lazarus that the response was an appropriate one. Had he responded in a stodgy or serious way —"Oh, those are merely newly planted flower beds,"—he doubted whether the necessary rapport would have developed, because she strongly valued "people with a sense of humor." Indeed, each session would start with some friendly banter and jesting, followed by attention to the serious problems for which she sought psychotherapy.

The adaptation or responsiveness can be based on patient–therapist similarity or complementarity. In general, the research favors therapists adopting a complementary style of interaction—a theory of opposites for interpersonal dimensions. Highly reactant or resistant patients usually benefit more from less directiveness, whereas low reactant patients benefit from more guidance and direction (Beutler et al., this issue). At other times, research favors similarity for more direct, conscious patient requests, such as cultural adaptations, therapy preferences, and religious/spiritual elements.

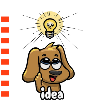
The number of permutations for every possible interaction or matching algorithm among patient, therapist, and relationship would prove endless without some empirical-driven guidance. The meta-analyses in this journal issue delimit the universe of possible client variables to a manageable number for clinical purposes. Research has isolated a handful of readily assessed client features that are reliably associated with differential responses to various styles of therapeutic relating. While consensus is no epistemic warrant and while research will never provide definitive answers to all matching questions (Mahoney & Norcross, 1993), we can enhance psychotherapy efficacy and efficiency by means of the nine adaptation/responsiveness methods highlighted in this issue.

6 | EFFECT SIZES

The subsequent articles feature original meta-analyses on the effectiveness of adapting or responsively matching psychotherapy to a particular patient characteristic. Insisting on quantitative meta-analyses (with the exceptions of gender identity and sexual orientation) enable direct estimates of the magnitude or strength of effectiveness in the form of effect sizes. These are standardized differences 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' *g* estimate the population effect size.

All of the meta-analyses in this volume used *d* or *g*. This increased the consistency among the meta-analyses, enhancing their interpretability, and enabled direct comparisons of the meta-analytic results to one another. In all of these analyses, the larger the magnitude of *d* or *g*, the higher the probability of patient success in psychotherapy.

Table 1 presents several practical ways to interpret the effect sizes *d* and *g* in behavioral health. By convention (Cohen, 1988), a *d* of 0.30 is considered a small effect, 0.50 a medium effect, and 0.80 a large effect. For the sake of comparison, across thousands of studies, average *d* for psychotherapy versus no psychotherapy is 0.80–0.85 and the average for one bona fide treatment method versus another (controlled for researcher allegiance) is 0.00–0.20 (Wampold & Imel, 2015).



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).

For example, Beutler et al. (this issue) conducted a meta-analysis of 13 RCTs that investigated the effectiveness of matching therapist directiveness to the client's reactance level. Their meta-analysis, involving a total of 1,208 patients, found a weighted mean *d* of 0.78. As shown in Table 1, this is a medium to large effect size. In concrete terms, this effect size indicates that matching versus not increases success rates by 18–20%. Such numbers translate into happier and healthier clients; responsively adapting or tailoring leads to more progress and fewer dropouts in psychotherapy.

TABLE 1 Practical interpretation of *d* and *g* values

d or *g*	Cohen's benchmark	Type of effect	Percentile of treated patients[a]	Success rate of treated patients, %[b]
1.00		Beneficial	84	72
0.90		Beneficial	82	70
0.80	Large	Beneficial	79	69
0.70		Beneficial	76	66
0.60		Beneficial	73	64
0.50	Medium	Beneficial	69	62
0.40		Beneficial	66	60
0.30		Beneficial	62	57
0.20	Small	Beneficial	58	55
0.10		No effect	54	52
0.00		No effect	50	50
−0.10		No effect	46	48
−0.20		Detrimental	42	45
−0.30		Detrimental	38	43

Note. Adapted from Cohen (1988), Norcross et al. (2017), and Wampold and Imel (2015).
[a]Each ES can be conceptualized as reflecting a corresponding percentile value; in this case, the percentile standing of the average treated patient after psychotherapy relative to untreated patients.
[b]Each ES can also be translated into a success rate of treated patients relative to untreated patients; a *d* of 0.80, for example, would translate into approximately 70% of patients being treated successfully compared with 50% of untreated patients.

7 | LIMITATIONS OF THE WORK

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

First, the work probably suffers from content overlap. A patient's therapy preferences probably reflect in part his or her cultural values, although these are considered in separate articles. A client's level of trait reactance correlates in the 0.30 range with the precontemplation stage of change for a particular problem, but these two patient dimensions are also treated in different articles. The field requires a gigantic factor analysis of sorts to identify construct overlap and to determine superordinate adaptation methods.

Researcher allegiance may have also posed a problem in conducting and interpreting the meta-analyses. We invited authors with an interest and expertise in a particular client characteristic and adaptation method, 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 probably attenuated effects of their allegiance, but it remains a strong human propensity in any discipline.

Another prominent limitation of the work as a whole is the relatively small number of research-supported methods to responsively match psychotherapy to the individual. There are but nine represented in this issue, and two of those did not possess any controlled studies to meta-analyze. Seven probably overlapping methods is a modest number, although they all possess robust meta-analytic research support.

As with the previous task forces, the overwhelming majority of research studies 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 author teams did not translate articles published in other languages. The meta-analytic results are, therefore, English centric.

8 | CONCLUSIONS OF THE THIRD INTERDIVISIONAL TASK FORCE

- 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.
- The following list 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.

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

- 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.

10 | RECOMMENDATIONS OF THE THIRD INTERDIVISIONAL TASK FORCE

10.1 | 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.

10.2 | 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, cohesion) vis-a-vis cut-off 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 to the whole patient as that is likely to generate the best outcomes in psychotherapy.

10.3 | 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.

10.4 | 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.

10.5 | Policy recommendations

25. APA's Society for the Advancement of Psychotherapy, the APA Society for Counseling Psychology, and all divisions are encouraged to educate its 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 American Psychological Association 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 just the implementation of evidence-based treatments for specific disorders.

TABLE 2 Summary of meta-analytic results on the efficacy of treatment adaptations/relational responsiveness to patient transdiagnostic characteristics

Patient characteristic	No. of studies (*k*)	No. of patients (*N*)	Effect size *d* or *g*	Consensus on evidentiary strength
Attachment style	32	3,158	0.35[a]	Promising but insufficient research to judge
Coping style	18	1,947	0.60	Probably effective
Culture (race/ethnicity)	99	13,813	0.50	Demonstrably effective
Gender identity	NA	NA	NA	Important but not yet sufficiently investigated
Therapy preferences	51	16,269	0.28	Demonstrably effective
Reactance level	13	1,208	0.78	Probably effective
Religion and spirituality	97	7,181	0.13–0.43	Demonstrably effective
Sexual orientation	NA	NA	NA	Important but not yet sufficiently investigated
Stages of change	76	21,424	0.41[b]	Probably effective

Note. NA: not applicable; the authors did not locate studies to meta-analyze and instead performed a content analysis of select studies.
[a]Represents correlation between pretreatment security attachment and psychotherapy outcome; more secure attachment/less insecurity predicted better treatment outcomes.
[b] Represents correlation between pretreatment stages of change and psychotherapy outcome; patients further along the stages experience better treatment outcomes.

11 | WHAT WORKS

Table 2 summarizes the meta-analytic findings on the effectiveness of the eight adaptation/responsiveness methods. The meta-analyses used the weighted *d* or *g*, standardized mean differences between two treatments or conditions; in this case, the difference between the conventional or unadapted therapy and the adapted or matched therapy. In all of these analyses, the larger the value of *d*, the higher the effectiveness of the specific adaptation or tailoring.

As seen above in the Task Force conclusions and in Table 2, the expert consensus deemed three of the methods as demonstrably effective, three as probably effective, one as promising, and two as important but not yet sufficiently investigated. Practitioners will find that fitting the therapy to clients' racial/ethnic culture, religious/spiritual identity, and treatment preferences will demonstrably improve treatment outcomes, and doing so to clients' coping style, reactance level, and stages of change will probably do so as well. Correlational research relating patient attachment security to psychotherapy outcome is promising, but there are not yet any prospective matching studies. There are indications from qualitative studies and a handful of uncontrolled quantitative studies that attending to patients' gender identity and sexual orientation may prove efficacious, but the absence of controlled studies does not permit us to reach definitive conclusions.

Many of these treatment adaptations boast evidence of direct causal impact. The meta-analyses on the demonstrably and probably effective adaptation/responsiveness methods were conducted primarily on randomized or quasi-randomized controlled trials (in contrast to the largely correlational research designs in the therapy relationship and other process variables). Thus, these represent causal conclusions. Tailoring psychotherapy in these ways is not only correlated with improved outcomes, but they also actually cause the improved outcomes.

The meta-analytic effect sizes in Table 1 range from 0.13 to 0.78 (indicating a range small to large effects) and average about 0.50 (indicating a medium effect). Compare those numbers with the 0.0–0.20 average effect sizes for the differential efficacy of one bona fide psychotherapy over another for a particular mental disorder (Wampold &

Imel, 2015). That is why the Task Force confidently concluded, "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 meta-analytic findings on adapting psychotherapy to patient race/ethnicity, preferences, and religion/spirituality are particularly impressive. For cultural identity, the researchers analyzed 99 studies involving 13,813 patients. The mean effect size of 0.50 in favor of clients receiving culturally adapted treatments demonstrates that "cultural fit" works. Likewise, religious/spiritual-adapted psychotherapy resulted in greater improvement in clients' psychological ($g = 0.33$) and spiritual ($g = 0.43$) functioning compared with nonadapted psychotherapies. In more rigorous additive studies, accommodated psychotherapies were equally effective to standard approaches in reducing psychological distress ($g = 0.13$), but resulted in greater spiritual well-being ($g = 0.34$).

Effect size numbers capture and convey limited information. The small to medium effect size (0.28) of accommodating psychotherapy to patient preferences proves a case in point. In 28 studies, clients not receiving preferences were almost twice as likely to drop out ($OR = 1.79$) that constitutes an important impact clinically.

The number of evidence-based treatment adaptations/responsiveness methods is smaller than the number of evidence-based treatment methods because the research evidence for matching has been more elusive, probably for several reasons. First, prospective matching studies on transdiagnostic patient characteristics are much rarer and far more difficult to fund; we estimate that approximately 90% of federal research grants for psychotherapy goes to comparing and disseminating manualized treatments for specific mental disorders. Second, since the matching hypothesis is rarely the principal objective of the RCT, researchers resort to retrospective or post hoc analyses and indirect measures to investigate the potential (client) aptitude by treatment interaction. That is a weak research design and typically underpowered statistical analyses. Third, experienced practitioners frequently adapt to their patients as a part of ongoing treatment. Even the most manual-bound psychotherapist in a fixed-duration RCT will evidence responsiveness by responding differently to, say, a patient in precontemplation than in the action stage or a highly oppositional patient than to a cooperative one (Hatcher, 2015). Aptitudes by treatment interaction studies try to capture quicksilver in the clinical setting.

The meta-analyses in this journal issue pertain to adapting psychotherapy, but adapting other psychosocial treatments in these ways may well prove efficacious. Consider the stages of change. Our expert panel opined that stage-matching face-to-face psychotherapy was probably effective, but other meta-analyses of RCTs show that stage matching in behavioral medicine and self-help interventions was demonstrably effective (see Krebs et al., this issue). Our conclusions pertain to psychotherapy, but we encourage researchers and practitioners to test the generalizability and boundaries of these adaptations to other treatments, such as self-help, internet mediated, and psychopharmacological.

We present the treatment adaptations/responsiveness methods as separate, stand-alone practices, but every seasoned psychotherapist knows this is certainly never the case in clinical work. The variance in outcomes for psychotherapy patients is not easily partitionable into independent contributions of treatments, relationships, therapists, and patients (Krause & Lutz, 2009). These adaptations never act in isolation from the psychotherapy relationship, such as empathy, collaboration, or support. All treatment adaptations probably interconnect—if only in spirit and intent—and prove symbiotic. In short, although the adaptation methods featured in this journal issue "work," they work together and interdependently. The design and analysis of psychotherapy outcome studies need to be improved if we are to learn who successfully treats whom and how (Baldwin & Imel, 2013).

In our clinical presentations and workshops, we are frequently asked about the additive benefits of simultaneously matching psychotherapy to several of these effective adaptation methods. "What happens if you match to culture and stages of change together?" Alas, we do not know for certain; only a couple of studies by Beutler (2011) have investigated the effects of concurrent matching on two client qualities. Those results indicated added benefit, but no definitive answers are available yet.

Nor has the discipline determined which particular adaptation/responsiveness methods work best for any particular patient. To some extent, it depends upon the magnitude or strength of the effect size of the adaptation.

To some extent, it surely depends upon the salience that the client accords to that particular dimension or personal identity (e.g., race/ethnicity, gender, religion, sexual orientation). And to some extent, it depends upon the clinical context and treatment goals. In all instances, success will largely depend on therapist flexibility and monitoring the client's experience of the intended responsiveness.

We expect that, in the future, psychotherapists will construct reliable assessments of their patients' likely responses to these adaptations. These assessments will follow the lead of personalized or precision medicine with treatment decisions tailored to the individual patient based on their predicted response and cost-risk considerations. Two exemplars of this approach are cultural adaptations and motive-oriented therapeutic relationship (or plan compatibility; Caspar, Grossmann, Unmüssig, & Schramm, 2005; Silberschatz, 2017). Research and practice in cultural adaptations have progressed to the point that, for both children and adults, clinicians can identity which adaptation elements generally prove most efficacious. In the second exemplar, therapists identify each patient's particular conflicts, motives (plan), and problems and then try to effectively address those via responsiveness (or plan compatibility). Multiple studies show that degree of therapist responsiveness correlates substantially with and predicts a variety of patient outcomes across psychotherapies.

As the evidence base on adaptations/responsiveness matures, we will know more about their effectiveness for particular circumstances and conditions. In quant speak, we will know more about their moderators and mediators. In cultural adaptations, research studies used multiple elements, such as language, metaphors, and concepts. The moderator analyses discerned that the single most effective adaptation was to use the client's native or preferred language (Soto et al., this issue). Further, the more the cultural adaptations used in treatment, the larger the effect size. How well, then, does cultural adaptation work in psychotherapy? It depends; it depends upon the adaptation and the circumstances.

The meta-analyses establish that responsiveness works. Take a mindful moment to consider the direct practice implications: adapting therapy to the entire person improves success and decreases dropouts; the power of responsiveness exceeds that associated with Tx Method A for Disorder Z; this represents not clinical lore but established fact. Indeed, in our professional lifetimes, that is the sea change that we have witnessed in our beloved art and science of psychotherapy. The question of practitioners is no longer "What is my theoretical orientation?" but rather "What relationship, adaptation, and approach will prove most effective with this particular client?"

12 | WHAT DOES NOT WORK

Translational research proves both prescriptive and proscriptive; it tells us what works and what does not. Of course, we could reverse the effective adaptations identified in these meta-analyses. In this section, we highlight a few broader therapist actions that prove generally ineffective, perhaps even hurtful, in psychotherapy.

- *Procrustean bed.* We should avoid the crimes of Procrustes, the mythological Greek giant who would cut the long limbs of clients or stretch short limbs to fit his one-size iron bed. The efficacy and applicability of psychotherapy will be enhanced by tailoring it to the unique needs of the client, not by imposing a Procrustean bed onto unwitting consumers of psychological services. Psychotherapists ought to be adapting to clients, not the converse.
- *Singularity*. In the quest to adapt psychotherapy, some psychotherapists become enamored with a single matching protocol and apply that match to virtually every patient who crosses their path. They are convinced that a single adaptation, be it the patient's reactance, diagnosis, culture, or stage of change, is the exclusive means of tailoring treatment to a successful outcome. We must also guard against imposing the Procrustean bed when we adapt psychotherapy; one size, even in adaptation or responsiveness, never works for all clients.
- *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

. Los metanálisis establecen que el ajuste funciona. Tómese un momento para considerar las implicaciones que ello tiene para la práctica: adaptar la terapia a cada persona mejora el éxito y reduce los abandonos; su valor poder excede al de adaptar tratamientos a diagnósticos; esto no constituye una tradición clínica, sino un hecho. Hasta el punto que constituye , el cambio más radical que hemos presenciado a lo largo de nuestra vida profesional en nuestro amado arte y ciencia de la psicoterapia. La pregunta de los profesionales ya no es: "¿Cuál es mi orientación teórica?", sino más bien ": ¿Qué relación, adaptación y enfoque resultarán más eficaces con este cliente en particular?".

effective (Soto et al., this issue). By contrast, therapists' expressing cultural humility and tracking clients' satisfaction with cultural responsiveness markedly improve client engagement, retention, and eventual treatment outcome.

- *Flexibility without fidelity*. The desire to be attuned and responsive with patients frequently gives rise to a clinical dilemma (Norcross, Hogan, Koocher, & Maggio, 2017). Therapist flexibility to the patient's preferences, values, and cultures promises that psychotherapy "fits" but not necessarily that it possesses research support. Therapist fidelity to a research-supported treatment promises that psychotherapy typically "works" but not necessarily with that particular client in that particular context. Errors in either direction can portend clinical failure, but we especially caution against ignoring the research evidence on the effectiveness of psychological treatments. Focusing solely on accommodating without addressing the client's problems or distress will not prove optimally effective (Yulish et al., 2017). Although the research supports adaptation in many cases, the research also recommends fidelity to treatments found effective in controlled research. We need to balance flexibility with fidelity (Chu & Leino, 2017).

13 | FREQUENTLY ASKED QUESTIONS

The third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness has generated considerable enthusiasm, but it has also engendered misunderstandings and reservations. Here, we address frequently asked questions about the Task Force's goals and results.

- *Are you saying that matching treatment methods to the particular disorder is ineffective?*

Not quite. We are saying that matching psychotherapy to the entire person, principally to the transdiagnostic characteristics identified in this journal volume, typically proves more effective than matching psychotherapy to the disorder. Culture eats strategy, so to speak. Practitioners are not forced to select between one way or the other; use all that work. Engage and customize to the full range of the human condition, refusing to be restricted by a single clinical method or patient characteristic.

- *My favorite patient characteristic—say, symptom severity—is not reviewed here. Is that not an effective way to match? Are there others that work?*

You bet! We have neither completed the search nor exhausted the matching possibilities. Along with symptom severity and its associated functional impairment, we suspect that the client's cognitive complexity, psychological mindedness, and ability to disclose painful material probably "work" as markers of therapy adaptation. Unfortunately, sufficient controlled research has not yet been published (at least in English) to include them. The absence of research evidence does not mean the absence of clinical effectiveness.

- *Can psychotherapists really adapt their relational style to fit the proclivities and personalities of their patients?*

It may be difficult to change interaction styles from client to client and session to session, assuming one is both aware and in control of one's styles of relating. At the same time, years of training experience and some research evidence support the assertion that psychotherapists can authentically differ from their preferred or habitual style of relating. Effective therapists are capable of more malleability, more flexible repertoires, and "mood transcendence" (Castonguay and Hill 2017; Tracey et al., 2014). The research on the therapist's experience suggests that experience begets heightened attention to the client (less self-preoccupation), an innovative perspective, and in general, more endorsement of an "integrative" orientation predicated on client need (Auerbach

& Johnson, 1977; Norcross & Goldfried, 2019). Indeed, several research studies have demonstrated that therapists can consistently use different treatments in a discriminative fashion. Experienced therapists help clients respond sooner and provide a smoother course to recovery (Lambert, 2010).

Thus, our clinical experience and a modest amount of research attest that practitioners can shift back and forth among different relationship styles for a given case. At the same time, we caution therapists that the blending of stances and strategies should never deteriorate into play-acting or capricious posturing.

- *But what about behavioral drift—the ubiquitous tendency to revert to old behavioral patterns? Don't we return over time to our practice baseline or pet methods?*

A definite possibility. We endorse responsiveness adherence checks, ongoing case reformulation, frequent client feedback, and deliberate practice to maintain flexibility with each patient. Moreover, clients and clinicians reciprocally shape each other during the course of psychotherapy, and responsiveness evolves over their time together. Each patient, each session, requires something different or new (Stiles, Honos-Webb, & Surko, 1998).

- *What should we do if we are unable or unwilling to adapt our therapy to the patient in the manner that research indicates is likely to enhance psychotherapy outcome?*

Four possibilities spring to mind. First, address the matter forthrightly with the patient as part of the evolving therapeutic contract and the creation of respective tasks, in much the same way one would with patients requesting a form of therapy or a type of medication that research has indicated would fit particularly well in their case but which is not in your repertoire. Second, treatment decisions are the result of multiple and recursive considerations on the part of the patient, the therapist, and the context. A single evidence-based guideline should be seriously considered, but only as one of many determinants of treatment itself. Third, an alternative to the one-therapist-fits-most-patients perspective is practice limits. Without a willingness and ability to engage in a range of interpersonal stances, the therapist may limit his or her practice to clients who fit that practice. Mental health professionals need not offer all services to all patients. Fourth, consider a judicious referral to a colleague who can offer the relationship stance (or treatment method or medication) indicated in a particular case.

- *Your relational responsiveness seems at odds with what managed care and administrators ask of me in my practice. How do you reconcile these?*

We do not reconcile these views, but we hope to influence managed care and behavioral health administrators with these compelling meta-analytic findings. Among payers and policy makers, the dominant image of modern psychotherapy is as a mental health treatment. This "treatment" or "medical" model inclines people to define process in terms of method, therapists as providers applying techniques, treatment in terms of number of contact hours, patients as embodiments of mental disorders, and outcome solely as symptom reduction (Orlinsky, 1989).

The Steering Committee believes the managed care model to be restricted and inaccurate. The psychotherapy enterprise is far more complex and interactive than the linear "Treatment operates on disorders to produce effects." We prefer a broader, integrative view that aligns with the tripartite evidence-based practice model that privileges best available research, clinician expertise, and patient characteristics, cultures, and values. That model incorporates the relational and educational features of psychotherapy, one that recognizes both the interpersonal and instrumental components of psychotherapy, one that appreciates the bidirectional process of therapy, and one in which the therapist and patient cocreate an optimal process and outcome.

- *Are the Task Force's conclusions and recommendations intended as practice standards?*

No. These are research-based conclusions that can lead, inform, and guide practitioners toward responsiveness or treatment adaptations. They are not legal, ethical, or professional mandates.

- *Well, don't these represent the official positions of APA Division 29 (Psychotherapy), Division 17 (Counseling Psychology), or the American Psychological Association?*

No. No. No.

- *So, are you saying that the therapy relationship (in addition to the treatment method) is crucial to outcome, that it can be improved by certain therapist actions, and that it can be effectively tailored to the individual patient?*

Precisely. And this journal issue shows specifically how to do so on the basis of the research evidence.

14 | IN CLOSING

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

In a technology-fueled and drug-filled world (Greenberg, 2016), there is a growing and pervasive tendency to standardize, industrialize, mechanize, and biologize what we do with our clients. Psychotherapists would do well to heed the ancient wisdom in the Hippocratic Oath (modern version): "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug," and "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being…." Reaffirming the human element and attending to the patient's totality in psychotherapy stem from both a moral commitment and robust evidence.

That research evidence amounts to little if it is not enacted in practice and taught in graduate programs. We implore our colleagues to progress beyond the well-intended slogans of "different strokes for different folks," "meet the clients where they are," and "a new therapy for each patient." It is time to implement what works in adaptations/responsiveness and simultaneously to avoid what does not. Build in transdiagnostic responsiveness into graduate programs and provide training and uptake in those adaptation methods that are demonstrably and probably effective.

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. Evidence-based responsiveness aligns with this future and embodies 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" (American Psychological Association Task Force on Evidence-Based Practice, 2006) as the relational responsiveness and treatment adaptations presented here. We are reminded daily that research can guide how to create, cultivate, and customize that powerful human relationship.

APPENDIX

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