

Relational Factors: it's the Relationship that Heals ... or is it?

This chapter discusses:

- The extent to which relational factors are linked to therapeutic outcomes.
- The extent to which *qualities* of the therapeutic relationship are linked to outcomes:
 - therapeutic alliance
 - goal consensus and collaboration.
- The extent to which therapists' *'generic' relational skills* are linked to outcomes:
 - empathy
 - positive regard
 - congruence.
- The extent to which therapists' *specific relational skills* are linked to outcomes:
 - management of countertransference
 - self-disclosure
 - feedback
 - repairing alliance ruptures
 - relational interpretations.

In Chapters 4 and 5 we looked at the relationship between client outcomes and factors that were 'internal' to the client and therapist. In this chapter, we turn our attention to the way in which client outcomes are related to relational factors: 'the feelings and

Within the psychotherapy research field, there has been considerable discussion and disagreement over the importance of relational factors for client outcomes. To a great extent, again, this is because of its implications for the 'Does orientation matter?' debate (Chapter 3). For a start, if relational factors turn out to be a key determinant of therapeutic success, then this is severely undermining for those who argue that different therapies are of differential effectiveness, because it suggests that it does not really matter what you 'do' with your clients, it is how you relate to them that counts. Also, however, if relational factors are the key determinants of therapeutic success, then this provides strong support for the relational forms of therapy (such as person-centred counselling and contemporary psychodynamic therapy), as compared with the more technique-oriented approaches, such as CBT.

As we saw at the end of Chapter 3, Lambert (Asay and Lambert, 1999), a leading figure in the counselling and psychotherapy research field, estimates that relational factors account for around 30 per cent of the variance in outcomes. This is twice the amount of variance that he attributes to therapists' techniques. A classic illustration of this relative efficacy comes from an analysis of the NIMH TDCRP data (Box 3.3; Krupnick et al., 1996). As we saw in Chapter 3, CBT and interpersonal therapy were found to be about equivalent, overall, in their effectiveness (Elkin et al., 1989); but what did correlate strongly with therapeutic improvements, in both CBT and interpersonal therapy, was the degree of 'therapeutic alliance' (see below) between therapist and client. Indeed, Krupnick and colleagues calculated that the therapeutic alliance, alone, contributed about 20 per cent of the variance in therapeutic outcomes.

Studies which ask clients to describe what they found most helpful in therapy also show that relational factors are considered among the most important aspects of the therapeutic process. Bohart and Tallman (1999: 51) write: 'From a client perspective, the most important aspects of therapy typically are the "nontechnological" factors: having a time and place to talk; having someone care, listen and understand; having someone provide encouragement and reassurance; and having someone offer an external perspective and advice.' Research also indicates that therapists can underestimate the importance of these relational dimensions, conceiving their aid as 'issuing strongly from their professional mastery' (Feifel and Eells, 1963: 317) when, to a large extent, it may come from helping to create an atmosphere of interest, warmth and tolerance.

What the research also suggests, as evident in the NIMH TDCRP findings, is that relational qualities are as important in non-relationally oriented therapies (e.g. CBT) as they are in relationally oriented ones. An extensive review of the impact of relational variables on outcome in CBT, for instance, summarised that there was 'conclusive empirical evidence' that relational factors, such as empathy and positive regard, *did* have a consistent impact across a variety of client groups (Keijsers et al., 2000). In fact, in a review of five retrospective studies in which clients were asked what had been the most helpful aspect of their CBT, it was consistently found that clients rated their relationship with their therapist as more helpful than the cognitive-behavioural techniques

employed. In one of these studies, for instance, Ryan and Gizynski (1971: 8) found no correlation between the implementation of behaviour modification techniques and outcomes; rather, what they found was that, for the clients, 'the most universally helpful elements of their experiences were the therapist's calm, sympathetic listening, support and approval, advice, and "faith"'.

Such research suggests that the relative efficacy of relational factors – against technique factors, in particular – may be considerable; and although allegiance effects may play some part here, even advocates of cognitive-behavioural and empirically supported therapies tend to accept that relational factors do influence the outcomes of therapy (Chambless and Ollendick, 2001; Emmelkamp, 2004) (although, contrary to a common misconception, very few CBT therapists have ever claimed otherwise – see, for instance, Chapter 3 on 'The therapeutic relationship' in Beck et al., 1979). However, what some researchers in these, and related, fields *have* questioned is the extent to which relational factors determine the efficacy and effectiveness of therapy. In their extensive review, for instance, Beutler and colleagues (2004) estimate that relational factors contribute between 7 per cent and 17 per cent of the variance in outcomes, while Chambless and Ollendick give the figure of 9 per cent. Writing in 2004, Beutler et al. (2004: 282) state that 'The collection of meta-analytic findings over the past 10 years indicates that relationship quality accounts for a far more modest proportion of the variance in outcome than the 30 per cent suggested by Lambert.' More recent studies have also challenged the assertion that clients in cognitive and behavioural therapies rate relational factors as *the* most important elements of therapy. In a qualitative analysis of CBT clients' 'end of therapy' evaluations, for instance, Clarke and colleagues (2004) found that clients cited both relational and technique factors as helpful, with no clear evidence that the former were more important than the latter. Also, as emphasised in Box 4.1, *correlation cannot be taken to imply causation*: good therapeutic relationships do seem to correspond with positive therapeutic outcomes, but this cannot be taken to mean that the former causes the latter. Some studies of cognitive therapy with depressed clients, for instance, have suggested that it is the symptom change that is responsible for bringing about the improvements in the alliance, rather than *vice versa* (DeRubeis and Feeley, 1990; Feeley et al., 1999).

What also provides a very strong challenge to the assumption that the relationship is *the* key agent in therapeutic change is the fact that entirely, or predominantly, 'non-relational' therapies – such as self-help manuals and web-based therapeutic programmes – can be highly efficacious, with effect sizes that are often close to those in face-to-face therapies (Barak et al., in press; Gould and Clum, 1993). Given that many of these studies are conducted with relatively specific behavioural problems (such as smoking cessation, Gould and Clum, 1993) and that some interpersonal contact *does* seem to boost the efficacy of these self-help therapies (e.g. van Boeijen et al., 2005), it cannot be concluded from this that the therapeutic relationship is entirely redundant. Nevertheless, contrary to Rogers' (1959) hypotheses regarding the necessary and sufficient conditions for constructive personality change, it would seem quite possible for clients to experience positive therapeutic development without any kind of 'real' interpersonal encounter.

In discussing this link between relational factors and outcomes, it is also important to bear in mind that many of these factors – such as the degree of goal agreement – may

be as much to do with how the client relates to his or her therapist as with how the therapist relates to his or her client. Indeed, in support of this hypothesis, there is *actually more evidence* that the client's contribution to the therapeutic relationship is linked to outcomes than there is for the therapist's contribution (Bachelor, 1991; Orlinsky et al., 2004). For instance, Orlinsky and colleagues report that, while 56 per cent of studies show a positive relationship between therapists' affirmation of their clients and outcomes, 69 per cent show a positive relationship between *clients' affirmation of their therapists* and outcomes. Furthermore, clients' (and observers') ratings of the therapeutic alliance, as with all relational variables, tend to be more predictive of outcomes than therapists' ratings (Horvath and Bedi, 2002). At the same time, a very recent study has suggested that it is the therapist's capacity to relate to his or her clients, and not *vice versa*, that is the principal determinant of outcomes (Baldwin et al., 2007). In this study, they found that outcomes were dependent on a therapist's general ability to form positive alliances, and that, beyond this, it did not matter how well or poorly individual clients got on with individual therapists.

A final point: one of the biggest challenges in researching the therapeutic relationship is attempting to identify discrete, distinguishable relational factors. '[T]he therapy relationship is like a diamond, a diamond composed of multiple, interconnected facets ... a complex, reciprocal and multidimensional entity' (Norcross, 2002a: 8). How do you distinguish, for instance, between 'congruence', 'feedback' and 'self-disclosure'? Certainly, the research indicates that many of the relational factors are highly correlated (e.g. Salvio et al., 1992), with some studies indicating that, from the clients' perspective, there is really just one main relational variable: an experiencing of the therapist as *caring/involved* (e.g. Williams and Chambless, 1990). These high levels of inter-correlation were acknowledged by the Steering Committee of the American Psychological Association's Division of Psychotherapy (Division 29) Task Force on Empirically Supported Therapy Relationships, which conducted the largest ever review of empirical evidence in this area (Norcross, 2002b). Nevertheless, the Task Force distinguished between eleven general elements of the therapeutic relationship, as well as ten 'moderating' and 'mediating' variables; and these will serve as the basis for the present chapter.

Mediating variable

A factor that accounts for the relationship between two variables: for instance, greater levels of empathy might lead to better outcomes because of the feelings of being valued it engenders.

Moderating variable

Factors that affect the relationship between two variables: for instance, levels of empathy might lead to better outcomes in males but not females – hence, gender would be a moderating variable.



For the purposes of this chapter, one other useful distinction is between *qualities* of the therapeutic interaction (such as the degree of goal agreement between therapist and client) and the extent to which therapists exhibit certain relational *skills* (such as the amount of positive regard that they extend to their clients) (Castonguay et al., 2006). (Some readers may object to the use of the term 'skills' to include less 'doing'-orientated 'ways of being'; but the term is used here in the broadest sense, as an 'ability' or 'proficiency' at something.) 'Skills' can be further broken down into more *generic* interpersonal competencies (such as being empathic and positively regarding), and those that are more *specifically* orientation-based (such as making relational interpretations). (Again, some readers may object to competences generally associated with person-centred therapy being termed 'generic', but there are few therapeutic orientations that would not subscribe to the importance of these modes of relating.) Hence, in the following sections, we will look at the evidence that links therapeutic outcomes to three types of relational factors: qualities of the therapeutic interaction, interpersonal skills and clinical relational skills. We will also use the framework adopted by the Division 29 Task Force to distinguish between those relational factors which, on the strength of the research evidence, can be considered 'demonstrably effective', and those that can be considered 'promising and probably effective' (Norcross, 2002a).

Quality of the Therapeutic Interaction

Therapeutic Alliance

What is it?

Within the world of counselling and psychotherapy training and practice, the concept of the 'therapeutic alliance' (also called the 'working alliance', 'therapeutic bond', 'helping alliance' or simply the 'alliance') tends to be less familiar than other relational factors, such as 'empathy'. In the world of counselling and psychotherapy research, however, it reigns supreme, with over 4,000 papers and dissertations written on it in the last thirty years and more than 24 different scales developed to measure it (Horvath and Bedi, 2002; Martin et al., 2000). The 'therapeutic alliance' emerged from the field of psychoanalytic and psychodynamic psychotherapy, where it was conceptualised as the conscious, adult-to-adult working bond between therapist and client, as opposed to the unconscious, transference and countertransference dynamic. Today, however, it is generally considered a pan-orientation concept (i.e. shared by many different therapeutic approaches), with humanistic, cognitive-behavioural and many other researchers interested in its links to clinical outcomes (see, for instance, Watson and Geller, 2005).

The therapeutic alliance has been defined in many ways, but perhaps the simplest definition is that it is the 'quality and the strength of the collaborative relationship between

client and therapist' (Horvath and Bedi, 2002: 41). Bordin (1979) conceptualised this collaborative relationship as having three main components:

- 1 The therapist's and client's agreement on the *goals* of therapy: i.e. the targeted outcomes of their work.
- 2 Therapist and client consensus on the *tasks* of therapy: i.e. the in-therapy behaviours and processes that form the substance of their work.
- 3 The existence of a positive affective *bond* between therapist and client: i.e. the positive personal attachments between therapist and client, including levels of mutual trust, acceptance and confidence.

The therapeutic alliance

The quality and the strength of the collaborative relationship between therapist and client.

This three-way conceptualisation has been widely accepted in the psychotherapy research field, and is the basis for the most commonly used alliance measure (Martin et al., 2000), the 'Working Alliance Inventory' (Horvath and Greenberg, 1989). However, it should be noted that considerable overlap exists between the three sub-scales of the measure (goal agreement, task agreement and bond), as well as with other relational variables, such as empathy (Horvath and Greenberg, 1989).

How Does it Relate to Outcomes?

A recent meta-analysis of the data suggests that the correlation between alliance and outcomes is in the range of 0.21 to 0.25 (Horvath and Bedi, 2002; Martin et al., 2000). This is equivalent to a Cohen's *d* of about 0.45 (i.e. a moderate effect), and suggests that about 5 per cent of the variance in overall therapeutic outcomes can be related to the quality of the therapeutic alliance. On the basis of the strength of this evidence – both in terms of the magnitude of the relationship and the amount and consistency of the data – the Division 29 Task Force concluded that the therapeutic alliance was one of four 'demonstrably effective' elements of the therapeutic relationship (Steering Committee, 2002) (another demonstrably effective factor being 'cohesion' in group psychotherapy (Burlingame et al., 2002), a variable closely related to alliance but within a group context). Qualitative studies of the factors that clients perceive as helpful in therapy also indicate the value of a collaborative relationship 'that deemphasises the power imbalance and in which both therapist and client are working together' (Glass and Arnkoff, 2000: 1469). In addition, the more positive the therapeutic alliance, the less likely clients are to drop out of therapy (e.g. Piper et al., 1999).

Moderators and Mediators

As indicated in the introduction to this chapter, this relationship between alliance and outcomes seems to be independent of the type of therapy being practised (Horvath and Bedi, 2002), with large correlations (equivalent to a Cohen's d of about 1.12 and more) for some of the less relationally oriented therapies, such as CBT (Castonguay et al., 1996; Safran and Wallner, 1991). In other words, agreement on the goals and methods of therapy and having a good sense of working together would seem to be of no less importance in the cognitive and behavioural therapies than in the more relational ones; and the evidence also indicates that therapists working in such orientations have just as strong an alliance as in more relationally oriented therapies (e.g. Marmar et al., 1989). There is some evidence, however, that measures of the alliance in the early stages of therapy (i.e. the third to the fifth sessions) are especially strong predictors of positive therapeutic outcomes (Bachelor and Hovarth, 1999; Horvath and Bedi, 2002); and this suggests that therapists should be particularly mindful of establishing a strong collaborative relationship in the first few sessions of therapy. Indeed, based on the empirical data, Hovarth and Bedi (2002: 60) state that therapists should make the development of the alliance 'the highest priority in the early phases of therapy'. There is also some evidence to suggest that a 'high-low-high' pattern of alliance development (i.e. where the alliance starts off well, dips, and then improves again towards the end of therapy) is particularly predictive of positive outcomes (Kivlighan and Shaughnessy, 2000); indicating that a therapeutic relationship in which alliance 'ruptures' are experienced, and repaired, may be of particular value to clients (see below).

IMPLICATIONS FOR PRACTICE

In the first few sessions of therapy, one of the main priorities should be to establish a strong therapeutic alliance with the client: a positive affective bond, a sense of working together towards the same goals, and some agreement about how therapy should proceed. Until such an alliance has been fostered, therapists should be cautious about using more challenging interventions.



Goal Consensus and Collaboration

What Are They?

Goal consensus can be defined as 'therapist-client agreement on therapy goals and expectations' (see Box 6.1) while collaborative involvement can be defined as 'mutual involvement of patient and therapist in a helping relationship' (Tryon and Winograd, 2002: 109). Both are very closely related to the concept of therapeutic alliance, particularly as defined in Bordin's tripartite formulation (see above), but their relationship to outcomes is also analysed independently by the APA Division 29 Task Force.

Box 6.1 The process of therapy: clients' goals

What do clients want from therapy? Research indicates that clients often have a range of diverse goals, with an average of 3.25 per client (Holtforth and Grawe, 2002). A study of Swiss psychotherapy outpatients found that the following types of goals were most common (in descending order):

- *Interpersonal goals* (74.5 per cent of all clients had one or more of these goals): for instance, increased assertiveness and developing greater intimacy.
- *Coping with specific problems/symptoms* (60.3 per cent): for instance, overcoming depressive symptoms or coping with trauma (note: fewer than one in ten clients gave symptom-relief goals alone, though these goals were more prevalent in a sample of psychiatric inpatients, Holtforth et al., 2004).
- *Personal growth* (45.9 per cent): for instance, enhanced attitude towards self.
- *Wellbeing/functioning* (13.4 per cent): for instance, becoming more relaxed.
- *Existential issues* (11.1 per cent): for instance, reflecting on self and future.

These goals correspond relatively well to what counsellors and psychotherapists believe is most important for clients to realise in therapy (in descending order):

- To have a strong sense of self-worth and identity.
 - To improve the quality of their relationships.
 - To understand their feelings, motives and/or behaviours.
 - To integrate excluded or segregated aspects of experience.
 - To experience a decrease in their symptoms.
- (Orlinsky and Rønnestad, 2005: 227)

How Do They Relate to Outcome?

As one component of the therapeutic alliance, we have already seen that agreement on the goals of therapy tends to be related to outcomes. However, Tryon and Winograd (2002) found that, reviewed in isolation, evidence for a relationship between goal agreement and therapeutic outcomes was 'mixed'. On the one hand, some studies have shown that these two variables are related (Dormaar et al., 1989); and low levels of client-therapist goal consensus have also been related to difficulties in therapy. Also, in an in-depth qualitative study of clients' experiences of therapy, Maluccio (1979) found that client dissatisfaction was often related to a failure to discuss, or agree, concrete and specific goals between therapist and client. In one 'failure' case, for example, a therapist attempted to help a couple work through their desire to control their son's life, while the parents wanted the therapist to induce their son to return to school. On the other hand, a number of studies have failed to find a relationship – or shown only a weak, non-significant relationship – between goal agreement and outcomes (Tryon and Winograd, 2002). Overall, Tryon and Winograd found that goal consensus and outcomes were

significantly, positively related on at least one measure in around 65 per cent of studies, though this was higher when just clients' ratings of agreement were focused on.

With respect to the relationship between client–therapist collaborative involvement and outcomes, the evidence here is stronger (Tryon and Winograd, 2002). As we have already seen, clients' motivation and involvement in therapy are among the strongest predictors of therapeutic outcomes (see Chapter 4), and around 90 per cent of studies find that collaborative involvement and outcome are significantly related on at least one measure (Tryon and Winograd, 2002). Overall, the Division 29 Task Force concluded that goal consensus and collaboration was one of the four 'demonstrably effective' elements of the therapeutic relationship (Steering Committee, 2002).

Therapist Interpersonal Skills

Empathy

What is it?

Empathy is most closely associated with the person-centred tradition, being one of the six conditions that Carl Rogers (1957) hypothesised to be necessary and sufficient for constructive personality change to occur. It also assumed central importance in the Self-psychology of psychoanalyst Heinz Kohut and, today, is generally considered by psychotherapy researchers as a pan-orientation concept, as Rogers (1957) originally intended it to be. Rogers (1980a: 142) defined empathy as the therapist's ability to enter the private perceptual world of the client – 'being sensitive, moment by moment, to the changing felt meanings which flow in this other person' – and this is the definition used by Bohart and colleagues (2002) in their Division 29 Task Force review of the research. It is important to note, however, that considerable debates and controversies have existed regarding the nature of empathy (see, for instance, Bohart and Greenberg, 1997; Gladstein and Associates, 1987), and it is probably best understood as a multi-dimensional construct, with cognitive, affective (emotional) and somatic (bodily) elements all intertwined (Cooper, 2001).

Empathy

Entering the private perceptual world of another and having an accurate, felt understanding of their experiencing.



Within the psychotherapy research literature, empathy has most frequently been measured through the Barrett-Lennard Relationship Inventory (BLRI), a measure developed by the person-centred scholar Godfrey Barrett-Lennard in the late 1950s (Barrett-Lennard, 1986). The BLRI asks clients, therapists or observers to rate the therapist on a

series of items from +3 (*Yes(!), I strongly feel that is true*) to –3 (*No(!), I strongly feel that it is not true*). Examples of the empathy items from this measure are:

- '[Name of therapist] nearly always knows exactly what I mean.'
- '[Name of therapist] understands me.'

Measured in this way, empathy has been shown to correlate strongly with the other Rogerian (1957) conditions of positive regard and congruence (Gurman, 1977). As discussed above, it has also been found to correlate strongly with measures of the therapeutic alliance, to the extent that some studies have suggested that the BLRI and the Working Alliance Inventory are really only measuring one, underlying factor (Salvio et al., 1992): a good/bad relationship dimension. However, in one of the most extensive reviews of this research to date, Gurman (1977: 511) concludes that empathy and the other BLRI scales, 'while overlapping to some extent, are consistently measuring different dimensions of the patient's perception of the therapeutic relationship'.

How Does it Relate to Outcome?

Based on the findings of forty-seven studies, Bohart and colleagues (2002) calculated that the correlation between levels of empathy and outcomes is around 0.32, equivalent to a Cohen's *d* of about 0.68. This is a medium to large effect size, and suggests that therapists' levels of empathy may make considerably more contribution to the outcomes of therapy than the specific techniques used, and may even be more significant than the therapeutic alliance, *per se*. This relative importance for clients of being understood by their therapists is particularly evident in studies which ask clients to rate the factors that they found most helpful in therapy (e.g. Lorr, 1965). Paulson and Worth (2002), for instance, found that clients with a history of suicidal behaviour rated 'feeling the counselor understood me' as one of the four most important aspects of their therapy (out of 65 items), with a mean score of 4.44 on a 1 (*not important*) to 5 (*extremely important*) scale. Conversely, one of the characteristics most consistently associated with negative outcomes is therapists' lack of understanding (e.g. Mohr, 1995). On the basis of such evidence, the Division 29 Task Force concluded that empathy is a 'demonstrably effective' element of the therapeutic relationship (Steering Committee, 2002).

Moderators and Mediators

Not only is there evidence that empathy is related to outcomes in the less relationally orientated therapies (e.g. CBT, Miller et al., 1980), but the review by Bohart and colleagues (2002) actually found a stronger relationship between empathy and outcomes in the cognitive-behavioural therapies (equivalent to an effect size of about 1.12) than in the experiential/humanistic therapies (equivalent to an effect size of about 0.52). Why this is the case is not clear, but it may be that empathic understanding is particularly important to provide the ground for more technical interventions. Bohart and

colleagues (2002) also found that empathy was more predictive of outcomes for inexperienced, as compared with more experienced, therapists, perhaps because the former group tended to vary more in empathy overall. However, some reviews of the evidence suggest that not all clients respond favourably to explicit empathic expressions. In particular, Beutler and colleagues (cited in Bohart et al., 2002: 100) suggest that clients 'who are highly sensitive, suspicious, poorly motivated, and reactive against authority perform relatively poorly with therapists who are particularly empathic'. Also, what is experienced as empathic may be different for different clients. While some clients, for instance, have been found to experience cognitive-type responses as most helpful (for instance, 'The therapist really seemed to *understand* what I was saying'), others have been found to experience affective-style responses as most meaningful (for instance, 'I really think he *felt* my despair') (Bachelor, 1988).

Positive Regard

What is it?

Positive regard is known by a number of names in the literature, including 'unconditional positive regard', 'non-possessive warmth', 'therapist affirmation', 'acceptance', 'prizing', 'caring', 'unconditionality' and 'warmth' (Farber and Lane, 2002). Rogers (1957: 98), from whose work the concept is derived, defines unconditional positive regard as the extent to which 'the therapist finds himself experiencing a warm acceptance of the client's experience as being a part of that client'. However, Barrett-Lennard (1986; 2003), whose Relationship Inventory has been one of the principal means of measuring positive regard, distinguishes between 'level of regard' (the extent to which the therapist experiences positive feelings towards the client, such as respect, caring and appreciation) and 'unconditionality' (the extent to which the therapist's attitudes or feelings towards the client 'hold steady' regardless of what the clients shows of his or her inner experiencing). Analyses of Barrett-Lennard Relationship Inventory (BLRI) scores indicate that this is a valid distinction (Gurman, 1977). Indeed, while considerable overlap seems to exist between level of regard, empathy and congruence, unconditionality is only moderately correlated with the other variables (Gurman, 1977).

Positive regard

A warm acceptance of the other and their experiences without conditions.



How Does it Relate to Outcome?

Reviews of the research indicate that positive regard – as measured by ratings on such items as 'Shows a real liking and affection for me' (Lorr, 1965) – is generally but not

always, associated with positive outcomes. Farber and Lane (2002), for instance, found significant positive relationship in about half of the studies; while Orlinsky and colleagues (2004), as discussed above, found them in about 56 per cent. These percentages increase substantially, however, when only clients' ratings of therapists' positive regard are taken into account. Indeed, many studies of the factors that clients find helpful in therapy indicate that the experiencing of a warm and positively regarding relationship with a likeable therapist are amongst the most valued aspects of therapy (e.g. Conte et al., 1995) (see Box 6.2), right from the very initial contact (Bedi et al., 2005). Conversely, unhelpful and hindering therapeutic experiences have been associated with therapists who have a 'bored, rote, cold, or impersonal manner of relating, a sense of arrogant superiority ...; lack of compassion, warmth and understanding; lack of respect' (Glass and Arnkoff, 2000: 1470). Therapists' feelings of irritation, anger and boredom have also been rated as non-helpful by clients (Feifel and Eells, 1963). Given the number of non-significant findings, however, and also the relatively modest effect sizes that tend to exist between positive regard and outcomes, the Division 29 Task Force (Steering Committee, 2002) concluded that it was a 'promising and probably effective' element of the therapeutic relationship.

Box 6.2 Going 'the extra mile': genuine care in counselling and psychotherapy

In a recent presentation entitled 'Relational depth from the point of view of the client', John McLeod (2006) argued that clients may particularly value a sense that their therapists *genuinely care* about them. This is something more than experiencing positive regard in the therapeutic hour; it is a feeling of really mattering to their therapists: that they are genuinely interested in their wellbeing and have been willing to 'go the extra mile' for them (see McMillan and McLeod, 2006). Such a hypothesis is borne out in much of the research (e.g. Jones et al., 2003). In their study of 'critical incidents' that led to the formation or strengthening of a positive therapeutic alliance, for instance, Bedi and colleagues (2005: 318) found that 'service beyond normal expectation' was mentioned by about 40 per cent of clients. One client, for instance, recalled 'The therapist said, "Call anytime, or just come in anytime, and there will be someone here, even if I'm not here." Does this mean that therapists should abandon their boundaries? Given the need for therapists to behave in ethical ways, and to 'look after themselves', obviously not. But letting clients know how much they are cared for, and being willing to be flexible around boundaries, may sometimes be important contributors to positive therapeutic outcomes.

Moderating and Mediating Variables

Like other relational factors, there are some indications that positive regard is associated with outcomes irrespective of therapeutic orientation. In one particularly interesting study, Neimeyer and Strupp (1994) looked at the qualities associated with more effective

and less effective psychodynamic therapists – a way of working which is generally associated with a more neutral style of relating. The researchers found that more effective therapists, in contrast to the less effective therapists, scored significantly higher on such variables as warmth, friendliness and affirmation; and significantly lower on such variables as attacking, blaming, rejecting, belittling, ignoring and neglecting.

Congruence

What is it?

Also termed 'genuineness', 'authenticity', 'openness', or 'realness', congruence is the third of Rogers' (1957) necessary and sufficient conditions for constructive personality change. For Rogers (1957: 96), congruence means that 'within the relationship, [the therapist] is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a façade, either knowingly or unknowingly.' More recently, Lietaer (1993) has distinguished between two sides of congruence: an inner one and an outer one. The inner side, which Lietaer (1993: 18) labels 'congruence', refers to the degree to which the therapist has conscious access to, or is receptive to *all* aspects of his flow of experiencing'. By contrast, the outer side, which Lietaer labels 'transparency', refers 'to the explicit communication by the therapist of his conscious perceptions, attitudes and feelings'. Like the other Rogerian conditions, a principal way in which congruence has been measured has been through the Barrett-Lennard Relationship Inventory (BLRI). Examples of congruence items are:

- 'I feel that [name of therapist] is genuine with me.'
- '[Name of therapist] is willing to say whatever is on his/her mind with me, including feelings about either of us or how we are getting along.'

Congruence

Being freely and deeply oneself in a relationship, with one's experiences accurately represented in awareness.



How Does it Relate to Outcome?

In his later works (e.g. Rogers, 1980b), Rogers came to believe that congruence was the most important of the three therapist-provided 'conditions'. However, the research is generally more ambivalent. In the most extensive review of the literature to date, Klein and colleagues (2002) found that, in around two-thirds of the seventy-seven results reviewed, no significant relationship existed between levels of congruence and outcomes, with only one-third of studies showing positive results. Similarly, Ordine and

colleagues (2004), in their classic review of the research, found only around 38 per cent of results showing a significant positive relationship between congruence and outcomes, although this was somewhat higher when only clients' and therapists' ratings (and not observers') were taken into account. Studies which ask clients to describe the most important aspects of their therapy also tend not to indicate strong links between congruence and outcomes, with therapists' 'realness', 'genuineness' or 'openness' rarely cited as key elements of the therapeutic work (e.g. Burckell and Goldfried, 2006; Feifel and Eells, 1963). However, it is interesting to note that, in some studies, therapists' 'trustworthiness' has emerged as one of their most important characteristics (Burckell and Goldfried, 2006; Conte et al., 1995), suggesting that this may be a more important factor than congruence, *per se*. In part, the low correlation between congruence and outcomes may also come about because genuineness is a relatively 'high-frequency' event in therapy. That is, therapists are experienced as relatively genuine most of the time, such that the likelihood of a significant co-variation between experiencing the therapist as congruent and positive experiences is likely to be small. It may also be, however, that some clients do not like a congruent, 'natural' therapist style. One client in the Maluccio (1979) study, for instance, equated professional competence with formality and structure. Hence, she experienced the 'informal and spontaneous' style of her therapist as 'overly casual' and, lacking confidence in his ability to help her, withdrew from therapy after a few sessions. Overall, however, the Division 29 Task Force (Steering Committee, 2002) concluded that congruence was a 'promising and probably effective' element of the therapeutic relationship.

Therapists' Clinical Skills

Management of Countertransference

What is it?

'Countertransference' was first remarked on by Freud in 1910, and over the last century has been defined in the psychodynamic field to varying degrees of breadth, from 'the therapist's unconscious, conflict-based reactions to the patient's transference', to the much more general and contemporary 'all of the therapist's emotional reactions to the patient' (Gelso and Hayes, 2002: 267). Hayes and Gelso (2001: 1042), two of the leading researchers in the countertransference field, attempt a mid-point between these poles, defining it as 'therapists' reactions to clients that are based on therapists' unresolved conflicts'. Countertransferential reactions can be thought of as either *acute* (i.e. irregular and uncharacteristic reactions to specific clients) or *chronic* (i.e. habitual needs and behavioural patterns of the therapist); and they can also be thought of as existing as either an *internal* state or as an *external* expression (Gelso and Hayes, 2002). *Positive* countertransferential behaviours (for instance, being overly friendly to a client to meet one's own needs for affection) can also be distinguished from *negative* countertransferential behaviours (for instance, excessively criticising a client because they resemble

one's mother). See Box 6.3 for research findings on countertransference and transference in therapy, outside of its immediate relationship to outcomes.

Countertransference

Therapists' reactions to clients that are based on therapists' unresolved conflicts.

Transference

The process of transferring to and repeating early patterns of behaviour with present-day partners.

Box 6.3 The process of counselling and psychotherapy: transference and countertransference

Transference can be defined as the process of transferring to and repeating early patterns of behaviour with present-day partners (Cutler, 1958: 349). Consistent with the psychodynamic assumption that this is a principal element of the therapeutic encounter, research indicates that parallels *do* exist between how clients relate to their therapists and their patterns of relating to significant others in their lives (Luborsky et al., 1990).

A qualitative study of psychodynamic therapists' recollections of transference in cases of successful long-term therapy (Gelso et al., 1999) found that mothers were cited as the source of transference in all cases, with fathers also cited as sources in the majority of cases. In terms of transference themes, fear or mistrust of the therapist was evident in all cases, with wishes for a 'good parent' or dependency wishes evident in most. Development of transference issues was typically stimulated by both changes in the structure of therapy, such as an increase in therapy fees, and by events in the clients' lives outside of therapy, such as the death of a parent. In terms of how transference issues were dealt with, therapists used a range of classic psychoanalytic strategies, such as offering interpretations and focusing on the relationship, but also seemed to use less traditional methods, such as teaching clients about transference and self-disclosing. As with other research (Luborsky et al., 1990), resolution tended to be characterised by greater insight and mastery over the transference rather than the transference patterns actually going away.

With respect to countertransference, a qualitative study of seasoned therapists found that this phenomenon was identified in about 80 per cent of sessions (Hayes et al., 1998). Most commonly, its origins were attributed to family issues; with the therapists' needs and values, such as a need to be needed or narcissistic tendencies, also identified as common sources. In terms of what triggered the countertransference reaction, the most common response was to do with perceptions of the client (for instance, that he was becoming dependent). Other triggers included the content of the clients' material, comparisons between the client and others, the clients' progress (or lack of) in therapy, emotional arousal, and changes in the therapy structures or procedures (for instance, missed sessions).

As indicated above, countertransference was described as taking both 'positive' and 'negative' forms, with therapists describing it in terms of both greater nurturing and identification with their clients, and also greater desires for distance and negative feelings. Research has also shown that male therapists may be more likely to distance themselves when countertransference is aroused, while female therapists are more likely to become over-involved (Hayes and Gelso, 2001). Therapists who have more 'integrated' personalities tend to have less countertransference reactions (Hayes and Gelso, 2001), and the same has been shown for therapists who have greater awareness of their feelings (Robbins and Jolkovski, 1987). Interestingly, however, greater awareness of *theory* only seems to lead to reduced countertransference when therapists also have high awareness of their feelings (Latts and Gelso, 1995; Robbins and Jolkovski, 1987). By contrast, therapists who have high theoretical awareness but low awareness of feelings actually show *more* countertransference responses than therapists who were low on both dimensions, suggesting that intellectual insight without emotional awareness may be more hindering than helpful.

Because of its 'unconscious' nature, countertransference tends not to be empirically assessed through therapists' or clients' ratings, but through the ratings of experienced external judges. The Inventory of Countertransference Behaviours (Friedman and Gelso, 2000), for instance, asks therapists' supervisors or observers to rate practitioners from 1 (*to no extent*) to 5 (*to a great extent*) on a range of items – for instance, 'The therapist rejected the client in the session' and 'The therapist talked too much during the session' – with higher overall scores taken as an indication of higher levels of countertransference.

In terms of its relationship to other relational factors, Ligiéro and Gelso (2002) found that negative countertransference was associated with lower scores on all three dimensions of the Working Alliance Inventory, with some indications that positive countertransference was also associated with a weaker client-therapist bond.

How Does it Relate to Outcome?

According to analytical thinking, the more therapists can manage their countertransference reactions – i.e. the more they can reduce the probability of countertransference reactions occurring, or, if countertransference reactions do occur, the more they can reduce the likelihood of it adversely affecting the therapy (Goldfried et al., 1997) – the better the therapeutic outcomes should be. Unfortunately, very few studies have empirically examined this hypothesis. In probably the most relevant to date, Gelso and colleagues (2002) found a positive relationship between supervisors' ratings of therapists' abilities to manage countertransference and ratings of clients' outcomes. More specifically, clients' outcomes were related to the therapists' abilities to manage their own anxiety, levels of self-integration, and to the therapists' abilities to conceptualise client dynamics in terms of the therapeutic relationship and clients' pasts. In a similar study, Hayes and colleagues (2001) found that therapists who were judged by their supervisors to be more 'self-integrated' behaved in less avoidant ways with their clients. That is, they were less likely to inhibit, discourage or divert their clients from exploration or expression of a theme. Hayes

and Gelso (1997) also found that greater levels of countertransference behaviour were associated with lower levels of client satisfaction and self-reported gain. However, this only seemed to be the case in the least successful therapy cases. In other words, when therapy was going well, countertransference did not seem to be a particular issue, but when therapy was otherwise going badly, high levels of countertransference seemed to be highly predictive of even poorer outcomes. Findings such as these suggest that therapists who are more able to manage their countertransference reactions may have better client outcomes, and the Division 29 Task Force (Steering Committee, 2002) concluded that management of countertransference was a 'promising and probably effective' element of the therapeutic relationship.

Self-Disclosure

What is it?

The practice of self-disclosure is 'one of most controversial therapist interventions' (Hill and Knox, 2002: 255). In particular, while humanistic and existentially orientated therapists have emphasised the need for practitioners to be transparent, real and open with their clients (e.g. Rogers, 1957; Yalom, 2001), more psychodynamically orientated therapists have cautioned against too much personal openness, fearing that it will impede clients' capacities to develop transference to their therapists (Hill and Knox, 2002). Consistent with this, research indicates that humanistic and behavioural therapists are most likely to self-disclose, and analytical therapists least (Edwards and Murdock, 1994). Given this polarisation, considerable research has been undertaken into the effects of self-disclosures on both the process and outcomes of a therapeutic encounter, though much of it has been of an 'analogous' nature (i.e. based on 'artificial' therapist-client dyads, or raters' perceptions of therapists, rather than bona fide therapeutic relationships).

Self-disclosures can be defined as 'therapist statements that reveal something personal about the therapist' (Hill and Knox, 2002: 255). In this respect, they overlap considerably with the external aspect of congruence ('transparency', see above). However, in contrast to transparency, self-disclosures are an *event* rather than a *quality*; and, by definition, are verbal, whereas transparency may include many non-verbal elements.

Self-disclosure

Therapist statements that reveal something personal about the therapist.

Self-involving statements

A form of self-disclosure, in which the therapist expresses a personal response to the client in the here-and-now.



Within the literature, a distinction is frequently made between 'self-involving' statements (or 'immediacy'), and 'self-disclosures' (or 'self-revelations') (e.g. Hanson, 2005). Self-involving statements are expressions of the therapist's personal response to the client in the here-and-now: for instance, 'Every time you raise your voice I start to feel anxious.' Self-disclosures, on the other hand, are statements of factual information on the part of the therapist that are about his or her existence outside of the therapeutic relationship: for instance, 'When I left University I also had no idea what I was going to do.' Within the literature, *positive* self-disclosures (for instance, 'I feel very warm to you when you share that') have also been distinguished from *negative* self-disclosures (for instance, 'I feel really critical of you when you describe how you are with your son') (Andersen and Anderson, 1985; Hill and Knox, 2002). Because of their event-like nature, self-disclosures tend to be identified and assessed in the research by external observers, rather than by therapists or clients.

How Does it Relate to Outcome?

In probably the most relevant and carefully conducted study to date, Barrett and Berman (2001) compared the outcomes of two conditions: one in which therapists (mainly of a CBT and supportive psychotherapy orientation) were instructed to increase their self-disclosures in response to similar client self-disclosures, and one in which they were told to restrict their disclosure of personal information. By the end of therapy, the researchers found that clients in the increased disclosure condition reported significantly less symptom distress. These clients also liked their therapists more, and several other analogous studies have shown that the more therapists self-disclose, the more they tended to be rated as likeable, warm and attractive by observers (Dowd and Boroto, 1982; Nilsson et al., 1979; VandeCreek and Angstadt, 1985). Given that clients' feelings of affirmation towards their therapists are predictive of positive outcomes (Orlinsky et al., 2004), this could be taken as further evidence of the therapeutic value of self-disclosures.

Studies which ask clients to rate different therapist responses also provide some further evidence that self-disclosures can be of value. Hill and colleagues (1988), for instance, found that self-disclosures were rated by clients as *the* most helpful therapist response mode, with ratings that were superior to such other responses as interpretation, paraphrasing and open questioning. (Interestingly, therapists in this study gave self-disclosures the *lowest* rating on helpfulness.) Of all the response modes, self-disclosures were also most strongly related to clients' levels of experiencing which, as we will see in Chapter 7, is also linked to outcomes. In another study, Bedi and colleagues (2005) found that around 30 per cent of clients, when asked to describe incidents that were critical to the formation or strengthening of the therapeutic alliance, gave instances of self-disclosure: for example, 'The therapist said, "You know what? I can really understand that. I've gone through that experience too."' In a third study of this type, Hanson (2005) found that self-disclosures were more than twice as likely to be rated as helpful than unhelpful by clients, while non-disclosures (i.e. times when therapists did not



reveal personal information about themselves when it might have been appropriate) were twice as likely to be rated as unhelpful than helpful. Consistent with the findings of the Bedi et al. study, Hansen found that self-disclosures were experienced as particularly helpful – and non-disclosures particularly unhelpful – because of their effect on the therapeutic alliance.

It would be wrong to assume, however, that the above studies indicate that the more therapists self-disclose, the better the outcomes are likely to be. In the Barrett and Berman (2001) comparative study above, for instance, the frequency of self-disclosures in the 'increased' condition was still fairly limited, with an average of fewer than five self-disclosures per session, and an average time of less than fifteen seconds per disclosure. Also, studies which directly correlate the amount of self-disclosure with outcomes generally fail to find a positive relationship (Orlinsky et al., 2004), although Hill and Knox (2002) suggest that the definition and ways of assessing self-disclosures in these studies tend to be vague and inconsistent. Even so, such findings are not particularly surprising: in contrast to generic interpersonal skills such as empathy or positive regard, no one has ever suggested that therapists should simply self-disclose as much as possible. Rather, what has been suggested is that a judicious and moderate use of self-disclosure can be of value to clients (e.g. Yalom, 2001), and this is what analogous studies indicate, with therapists who disclose at moderate being often levels viewed most favourably by observers (Watkins, 1990). Based on such research, the Division 29 Task Force (Steering Committee, 2002) concludes that self-disclosure is a 'promising and probably effective' element of the therapeutic relationship.

Mediators and Moderators

With respect to whether self-involving or self-disclosing statements are more helpful, results here are mixed. On the one hand, there is research to indicate that clients rate self-involving therapists as significantly more expert and trustworthy than self-disclosing therapists, and that such immediate disclosures stimulate more client self-reflection (McCarthy and Betz, 1978). Other studies, however, have not confirmed these findings (e.g. Dowd and Boroto, 1982); and a study by Knox and colleagues (1997) found that clients, when asked to give an example of a therapist self-disclosure that had been helpful to them, consistently described non-immediate self-disclosures, such as revelations about the therapist's past history of drug use. What is clear, however, is that positive self-involving statements tend to be rated more positively than negative self-involving statements (e.g. Andersen and Anderson, 1985). The evidence would seem to suggest, then, that positive self-involving statements are regarded most favourably by clients, certainly more than negative self-involving statements, and probably more than both positive and negative self-disclosing statements (Watkins, 1990). Finally, there is some evidence to indicate that disclosures of relatively non-intimate material by therapists (such as professional issues and demographic details) are viewed more positively than disclosures of more intimate material, such as personal feelings and sexual issues (Edwards and Murdock, 1994; Watkins, 1990).

IMPLICATIONS FOR PRACTICE

Based on their review of the empirical literature, Hill and Knox (2002: 262) make the following suggestions regarding self-disclosing in therapy:

- Disclose infrequently.
- It is usually more appropriate to disclose less intimate material, such as professional background, than intimate material, such as religious beliefs.
- Use disclosures to validate the client's reality, normalise, strengthen the alliance, or to offer alternative ways to think or act.
- Avoid disclosures that are for your own needs, remove the focus from the client, interfere with the flow of the session, burden or confuse the client, are intrusive, or blur the client-therapist boundaries.
- Self-disclosures may be particularly appropriate as a response to similar client disclosures, normalising and reassuring clients.
- Carefully observe how clients respond to disclosures and ask about their reactions, using this information to judge the appropriateness of further disclosures – be responsive to the needs of individual clients.

In addition, the research indicates that positive self-involving statements may be of particular value to clients: for instance, 'I get such a sense of excitement and energy when you talk about your future.'

Feedback

What is it?

Feedback can be defined as information provided to a person, from an external source, about the person's behaviour or the effects of that behaviour (Claiborn et al., 2002). Conceptually, feedback overlaps quite considerably with self-involving forms of self-disclosures (see above), but the term tends to be used to refer to less personal disclosures of information, and more 'objective' appraisals of another's behaviour. In contrast to self-disclosure and the other relational factors discussed in this chapter, it is also a relatively new concept in the counselling and psychotherapy field, coming from such areas as electrical engineering and performance appraisal (Claiborn et al., 2002).



Feedback

Information provided to a person, from an external source, about the person's behaviour or the effects of that behaviour.

Claiborn (2002) outlines four types of feedback that may take place in therapy:

- *Observation or description* of clients' behaviours: for instance, 'I can really see you shaking when you come into the room.'
- *Emotional reactions* to clients' behaviour (this is closest to self-involving statements): for instance, 'I find myself getting frustrated every time you arrive at sessions 30 minutes late.'
- *Inferences* about something not directly observable: for instance, 'I get a sense that you really don't like visiting your parents.'
- *'Mirroring'* – i.e. presenting clients with a sample of their behaviour: for instance, by inviting them to watch a recording of their interactions in a group.

Like self-involving statements, feedback can also be a 'positive' (e.g. affirming or supportive), or have a more negative tone (e.g. critical, Claiborn et al., 2002).

How Does it Relate to Outcome?

Studies which look at the relationship between feedback and outcomes in individual therapy have primarily focused on the impact of descriptive behavioural feedback and mirroring within cognitive and behavioural practice. Leitenberg and colleagues (1975), for instance, examined the effects of providing phobic clients with feedback on how long they had managed to endure anxiety-evoking situations. The researchers found that precise feedback on performance led to dramatic increases in rates of improvement. In another study, Rapee and Hayman (1996) found that socially anxious clients could make more realistic (i.e. more positive) assessments of their performances after viewing themselves on video. Research from the US also indicates that clients who are given feedback on psychological test scores, and who are invited to participate actively in assessment procedures, experience greater gains than those in control conditions (Finn and Tonsager, 1997; Goodyear, 1990). Based on such findings, Claiborn and colleagues (2002) conclude that feedback can be a powerful intervention, and the APA Division 29 Task Force (Steering Committee, 2002) conclude that it is a 'promising and probably effective' element of the therapeutic relationship.

Mediators and Moderators

As with self-disclosures, research indicates that positive feedback is experienced as more acceptable and helpful to receivers than negative feedback (Goodyear, 1990); indeed, there is evidence that negative feedback delivered in high proportions can reduce clients' sensitivity to an entire session (Kivlighan, 1985). However, based on the research, Claiborn and colleagues (2002: 226) write that: 'As the working alliance becomes established and the goals of the client (and thus the criteria for judging the

effectiveness of the client's behavior) are clear, negative feedback is likely to be accepted as accurate and useful, as well.' Similarly, negative feedback also seems to be more acceptable when it is preceded by positive feedback (Claiborn et al., 2002; Kivlighan, 1985) or sandwiched between it (Morran et al., 1998); and there is evidence that, in groups, those who do the best are those who receive high levels of both positive and negative feedback (Kivlighan, 1985). A study by Thelen and Lasoski (1980) also suggests that mirroring feedback is most helpful when therapists provide 'focusing comments': i.e. when the therapist actively attempts to direct the person's attention to the crucial aspect of their behaviour. Different individuals also seem to process feedback in different ways. In particular, clients with low self-esteem and who are more depressed tend to 'hear' feedback more negatively; and there is also evidence that clients may vary in their desire for feedback, with different implications for how they hear positive and negative information.



IMPLICATIONS FOR PRACTICE

When giving challenging feedback to clients, it may help:

- to give positive feedback first
- to ensure that a safe and trusting therapeutic relationship has been established
- to make the aims and function of giving the feedback clear to the client
- to share the feedback in a collaborative, rather than didactic manner, and to be open to the possibility that the feedback may be wrong or unhelpful
- to bear in mind that clients with low self-esteem or who are in a depressed mood may hear feedback more negatively than it is intended.

Repairing Alliance Ruptures

What is it?

The concept of 'alliance ruptures' may be unfamiliar to many counsellors and psychotherapists, but within the psychotherapy research field it is one of the most innovative and exciting areas of development, principally through the work of Jeremy Safran and colleagues in New York (see Safran and Muran, 2000a). Informed by psychodynamic, cognitive, humanistic and relational thinking, the work on alliance ruptures starts from the premise that a strong therapeutic alliance, as suggested above, is a key ingredient of effective therapy. Hence, 'a tension or breakdown in the collaborative relationship between patient and therapist', as Safran and colleagues (2002: 236) define alliance ruptures, has the potential to detrimentally affect the therapeutic work. Such a rupture could involve disagreements over the goals or tasks of the therapeutic work, or a breakdown in the therapeutic bond. For instance, a client might become frustrated

and angry with a therapist who offers her non-directive reflections when she wants guidance and advice (task); or a therapist may notice herself becoming more and more distant from a client because she experiences the client as critical and patronising (bond). Safran and Muran (2000b: 240) identify two main sub-types of ruptures: confrontation and withdrawal. 'In confrontation ruptures, the client directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy. In withdrawal ruptures, the client withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process.' Safran and colleagues (2002) report that alliance ruptures are a fairly common occurrence in therapy, with one study identifying their presence in 11–38 per cent of sessions.

Alliance rupture

A tension or breakdown in the collaborative relationship between client and therapist.



How Does it Relate to Outcome?

Safran and colleagues (2002) suggest that repairing alliance ruptures is not only important to allow the therapeutic work to continue, but because learning to overcome breakdowns and tensions in relationships is a critical developmental task. At the present time, however, little direct evidence supports the contention that improvements in therapy are related to the capacity to repair alliance ruptures. Nevertheless, a substantial body of indirect evidence exists. First, as we have seen above, there is good evidence that outcomes in therapy are related to a strong therapeutic alliance. Second, as also discussed above, the fact that a high–low–high pattern of alliance development seems particularly predictive of good outcomes suggests that experiencing ruptures in the alliance, and then overcoming them, may be a particularly helpful aspect of therapy. Third, a brief relational therapy, developed by Safran and colleagues (2002) with a particular emphasis on repairing alliance ruptures, has been shown to have significantly lower drop-out rates (20 per cent) than either CBT (37 per cent) or psychodynamic therapy (46 per cent). Fourth, there is some evidence to suggest that, when therapists act to address alliance difficulties and misunderstandings rather than avoiding them, clients have better outcomes, are less likely to drop-out of therapy, have better alliances, and experience more of a feeling of resolution (Foreman and Marmar, 1985; Rhodes et al., 1994). As suggested by Safran and colleagues (1990), greater resolution of rupture events also seems to come about when therapists respond to their clients in an accommodating way (for instance, by apologising or by changing their behaviour). On the basis of such findings, the APA Division 29 Task Force (Steering Committee, 2002) concluded that repairing alliance ruptures is a 'promising and probably effective' element of the therapeutic relationship.

IMPLICATIONS FOR PRACTICE



Safran and colleagues (1990: 159) offer the following general principles for therapists for resolving alliance ruptures.

- Attend to the rupture. Indicators of a rupture may include the following client behaviours:
 - overt expression of negative sentiments
 - indirect communication of negative sentiments or hostility
 - disagreement about the goals or tasks of therapy
 - compliance
 - 'avoidance manoeuvres', such as skipping particular topics
 - self-esteem enhancing operations, such as self-justification
 - non-responsiveness to interventions.
- Develop an awareness of how you feel in relation to the rupture.
- Take responsibility for your part in it and talk about that with your client – avoid using transference interpretations to put all of the responsibility on to the client.
- Try to empathically understand the client's experience.
- Maintain the stance of a participant/observer rather than getting hooked in to a dysfunctional cycle.

Where ruptures emerge over the goals and tasks of therapy, it may also be useful to review and discuss with clients what it is that they are trying to achieve in therapy, and how that might most effectively be achieved (Safran et al., 2002). If necessary and appropriate, revise the goals and tasks of therapy accordingly.

Transference Interpretations

What Are They?

Transference interpretations are rooted in the psychodynamic and psychoanalytic tradition, and can be considered a sub-set of interpretations: 'going beyond what the client has overtly recognised, including establishing connections between statements or events, pointing out themes, patterns, or causal relationships in the patient's behaviour or personality, or giving alternative meanings for old behaviours or issues' (Hill, 1978, in Crits-Christoph and Gibbons, 2002: 287). Transference interpretations can be understood as those interpretations 'that help the patient to understand the link between their interactions with the therapist and the interactions they experience with others' (Connolly et al., 1999: 487). Crits-Christoph and Gibbons (2002), in their APA Task Force Review of the literature, focus more broadly on 'relational interpretations', which include both transference interpretations and interpretations of other relational experiences (for instance, parallels between how a client relates to his or her spouse and his or her father). For the purposes of this book, however, this section will focus primarily on transference interpretations, with relational interpretations covered more extensively in Chapter 7.

Interpretations

Therapist statements which go beyond what the client has overtly recognised, to suggest new understandings of experiences.

Transference interpretations

Interpretations that try to help the client understand the link between their interactions with the therapist and the interactions they experience with others.

How Do they Relate to Outcome?

Research that looks at the relationship between interpretations and outcomes has focused on two main variables: *frequency* of interpretations ('concentration') and *quality* of interpretations ('correspondence' or 'correctness') (Piper et al., 1993). With respect to the first of these variables, research over the last twenty years (primarily conducted by psychodynamically orientated researchers) has indicated that higher frequencies of transference interpretations are actually associated with *poorer* outcomes in therapy, particularly for certain groups of clients (see below) (e.g. Høglend, 1993). In the most extensive study of this type, for instance, Piper and colleagues (1991) found a correlation of 0.37 between proportion of transference interpretations and general symptoms and distress at outcome (equivalent to a Cohen's *d* of about 0.80 – a large effect) and a similarly negative relationship with quality of the therapeutic alliance. There is also evidence that greater focus on transference is associated with higher rates of drop-out, with clients who drop out more likely to be exploring transference issues in their final sessions than completers (Piper et al., 1999; see Box 6.4). Crits-Christoph and Gibbons (2002: 298) conclude their review of this research by stating that 'High levels of transference interpretations should be avoided'; while Orlinsky and colleagues (2004: 342), drawing on a similar body of evidence, write that the use of transference interpretations in brief psychotherapies 'probably should be abandoned'. Interestingly, too, while Orlinsky and colleagues' (1994) extensive review of the research found that a focus on life problems and on core personal relationships tended to be associated with positive outcomes, a focus on here-and-now involvements in therapeutic interactions was not.

Box 6.4 The process of therapy: transference and drop-out

For clients who dropped out of psychodynamic therapy where there was a high transference focus, Piper and colleagues (1999) identified a consistent pattern of interactions in the pre-termination sessions:

- 1 The patient made his or her thoughts about dropping out clear, usually early in the session.
- 2 The patient expressed frustration about the therapy sessions. This often involved expectations that were not met and the therapist's repeated focus on painful feelings.
- 3 The therapist quickly addressed the difficulty by focusing on the patient-therapist relationship and the transference. Links were made to other relationships.
- 4 The patient resisted the focus on transference and engaged in little dynamic exploration (work). Resistance was often active, for example, verbal disagreement, and sometimes passive, for example, silence.
- 5 The therapist persisted with transference interpretations.
- 6 The patient and therapist argued with each other. They seemed to be engaged in a power struggle. At times the therapist was drawn into being sharp, blunt, sarcastic, insistent, impatient, or condescending.
- 7 Although most of the interpretations were plausible, the patient responded to the persistence of the therapist with continued resistance.
- 8 The session ended with encouragement by the therapist to continue with therapy and a seemingly forced agreement by the patient to do so.
- 9 The patient never returned.

As with the research into alliance ruptures (see above), Piper and colleagues (1999) conclude that persistent use of transference interpretations does not resolve impasses; and that, faced with the threat of premature termination, therapists may be better advised to allow clients to save face and conclude the therapy more amicably.

As with the research on self-disclosures (see above), however, it is questionable how informative or surprising this correlation between frequency of transference interpretations and outcomes is. After all, has any psychodynamic theorist ever suggested that therapists should simply make as many transference interpretations as possible? A better indicator of the value of such interpretations, then, might be the relationship between accuracy of interpretations and outcomes. Here, accuracy of interpretations tends to be assessed by rating the extent to which therapists' interpretations correspond to expert clinicians' ratings of the client's central relationship patterns, as judged from session transcripts. What such research shows is that more accurate relational interpretations (both transference and otherwise) *do* tend to be related to better therapeutic outcomes (Crits-Christoph et al., 1988) as well as to a stronger therapeutic alliance (Crits-Christoph et al., 1993). This seems to be particularly the case when therapists accurately interpret what clients seem to want from others, and how they perceived others as reacting (Crits-Christoph et al., 1988). In summary, then, the research suggests that a low frequency of accurate relational interpretations can be helpful (Piper et al., 1993), and the APA Division 29 Task Force (Steering Committee, 2002) concluded that relational interpretations are a 'promising and probably effective' element of the therapeutic relationship.

Mediators and Moderators

One key issue in the research on transference interpretations is their efficacy in relation to clients' 'quality of object relations'. This is defined as a client's 'enduring tendency to establish certain types of relationships, ranging from primitive to mature' (Piper et al., 1993: 588). Here, 'primitive' means that the person reacts to perceived separation or rejection with intense anxiety and affect (similar to insecure attachment), while 'mature' means that the person can enjoy equitable relationships characterised by love and tenderness (similar to secure attachment, Piper et al., 2001). Overall, what the research seems to indicate is that clients with more primitive styles of relating tend to do poorly at high and moderate levels of transference interpretation but can handle very low levels; while clients who have relatively mature styles of relating can benefit from low and moderate levels of transference interpretations, and only have difficulties at high levels (Connolly et al., 1999). In other words, high rates of transference interpretations may be particularly counterproductive for clients who have poor relational abilities (Crits-Christoph and Gibbons, 2002) and also possibly depressed clients (Castonguay et al., 2006); although a more recent study has directly challenged this conclusion (Høglend et al., 2007).

What also seems clear from the research is that transference interpretations are most effective when embedded in the context of a strong therapeutic alliance and supportive interventions, and may be dangerous when the therapeutic alliance is not sufficiently formed, serving to further weaken an already tenuous bond (Bond et al., 1998). Given that clients with more severe forms of psychological distress, such as those diagnosed with borderline personality disorder, may find it particularly difficult to establish strong therapeutic alliances (see Chapter 4), particular caution with such clients would seem warranted. Indeed, Bond and colleagues (1998: 302) write that, with clients diagnosed with more severe personality disorders, 'transference interpretations are very high-risk interventions', and suggest the use of more supportive techniques, 'especially during the early phases of therapy until a firm alliance has been established'.

Finally, there is the question of whether transference interpretations are more effective than non-transference relational interpretations. Some interesting light is thrown on this in the study by Høglend and colleagues (2007) which compared the effectiveness of two forms of psychodynamic therapy: one in which the therapists were instructed to address transactions in the therapist-client relationship and to make transference interpretations, and one in which such techniques were proscribed and therapists could only refer to relational patterns outside of therapy. Overall, the researchers found that both forms of therapy were about equally effective, though those with more severe forms of pathology did better in the transference condition than in the non-transference condition, while the reverse was true for those with less severe forms of pathology (see above). This means that, overall, interpretations focused on the immediate therapeutic relationship may be no more helpful than those that are not, but different clients may respond to these different kinds of interventions in different ways.

Table 6.1 Summary of conclusions of Division 29 Task Force by category and in descending order of magnitude of relationship (Norcross, 2002b)

	Magnitude of the relationship	Evidence of causality	Number of studies
<i>Demonstrably effective</i>			
Goal consensus and collaboration	3.7	2.0	3.7
Therapeutic alliance	3.0	1.7	5.0
Empathy	3.0	2.0	4.0
<i>Promising and probably effective</i>			
Management of countertransference	3.3	2.7	2.0
Feedback	2.7	1.5	2.7
Positive regard	2.3	2.0	4.0
Congruence	2.3	1.3	3.0
Self-disclosure	2.3	1.0	2.0
Relational interpretations	2.3	1.3	2.0
Repair of alliance ruptures	2.0	1.3	2.0

Note: Ratings of all factors are on a 1 (*low*) to 5 (*high*) scale. 'Number of studies' indicates relative size, rather than the actual number of studies.

Conclusion

Table 6.1 presents a summary of the conclusions reached by the Division 29 Task Force on the effectiveness of the relational factors reviewed in this chapter. Also included in this table are informal ratings by members of the Task Force on the apparent magnitude of the relationship between the factors and therapeutic outcomes, the evidence that this relational factor would actually seem to be responsible for bringing about these outcomes, and the number of studies conducted – a rough indicator of the reliability of the evidence.

Summary of Key Findings

- The quality of the therapeutic relationship is closely associated with therapeutic outcomes, across both relationally orientated and non-relationally orientated therapies.
- The strength of the therapeutic alliance – in particular, the extent to which clients and therapists agree and collaborate on the goals and tasks of therapy – has consistently been shown to relate to therapeutic outcomes, and seems important to establish prior to more challenging interventions.
- Therapists' levels of empathy are closely associated with the outcomes of therapy.
- Therapists' levels of positive regard are modestly related to the outcomes of therapy.
- In some instances, therapists' levels of congruence have been found to relate to the outcomes of therapy.

- There are indications that therapists' abilities to manage countertransference reactions are related to therapeutic outcomes.
- Moderate amounts of self-disclosure, particularly as positive self-involving statements, may be more helpful to clients than systematic non-disclosure.
- Feedback, particularly positive feedback, can be useful to clients.
- Indirect evidence indicates that the capacity to repair alliance ruptures is associated with positive therapeutic outcomes.
- High frequencies of transference interpretations should be avoided, particularly as a means of dealing with alliance ruptures or with highly dysfunctional clients; but low concentrations of accurate interpretations may be helpful.

RECOMMENDED READING

Norcross, J.C. (ed.) (2002) *Psychotherapy Relationships that Work: Therapists' Contributions and Responsiveness to Patients*. New York: Oxford University Press. Essential reading for therapists of all orientations, with chapters that clearly and comprehensively summarise the empirical data for each of the relational factors discussed in this chapter.

QUESTIONS FOR REFLECTION

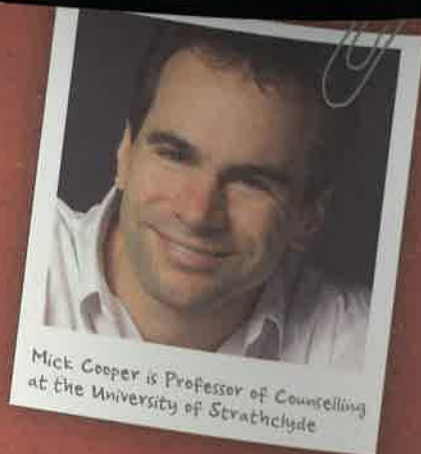
- 1 If you have been a client in counselling or psychotherapy:
 - What aspects of the relationship with your therapist, if any, were helpful for you?
 - What aspects of the relationship with your therapist, if any, were unhelpful for you?
 - Is this consistent with the empirical research findings?
 - What other aspects of the relationship, based on your experience, might be considered helpful or unhelpful?
- 2 Based on your experience as a counsellor or psychotherapist (if you have any), how do you think your clients would answer these questions?
- 3 To what extent do you think that relational variables can be distinguished? Would you agree that, ultimately, clients experience their therapists along just one caring/involved relational dimension?
- 4 Based on the empirical evidence and/or your own experiences as a therapist, how important do you think it is that therapists are willing to 'go the extra mile' for their clients? How can this be reconciled with the need to maintain appropriate boundaries?
- 5 In 1957, Rogers concluded that the three 'core' conditions of empathy, congruence and unconditional positive regard were necessary for therapeutic personality development. What do you think Rogers would say today?

of findings and their implications
the 21st century.

mbert, Brigham Young University

ment. Mick Cooper brings together a
al in a relevant and interesting way.

Professor of Counselling, University



Mick Cooper is Professor of Counselling
at the University of Strathclyde

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his is therefore an ideal text for anybody studying or training in
psychotherapy.

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work for you; It is vital reading for anyone who wants the facts,
imple, clear and engaging way.



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