

RUNNING HEAD: EBPR CUSTOMIZING THE THERAPY RELATIONSHIP

Evidence-Based Psychotherapy Relationships:
Customizing the Treatment Relationship to the Individual Patient

The Division of Psychotherapy Task Force on Empirically Supported Psychotherapy
Relationships

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EVIDENCE-BASED PSYCHOTHERAPY RELATIONSHIPS:
CUSTOMIZING THE TREATMENT RELATIONSHIP TO THE INDIVIDUAL
PATIENT

In 2000, the Division of Psychotherapy of the American Psychological Association created a task force, chaired by John C. Norcross, Ph.D., to identify, operationalize, and disseminate information on evidence-based psychotherapy relationships. The two aims of the Division of Psychotherapy Task Force were to: 1) identify elements of effective psychotherapy relationships; and 2) identify effective methods of tailoring psychotherapy to the individual patient on the basis of his/her (nondiagnostic) characteristics. That is, the Task Force members sought to answer the two pressing questions of “What works in general in the psychotherapy relationship?” and “What works best for this particular patient?”

The Task Force reviewed an extensive body of empirical research and generated a list of evidence-based relationship elements and a list of means for customizing psychotherapy to the individual patient. For each, it judged whether the element was *demonstrably effective* or *promising and probably effective*. The criteria for making these judgments were the number of supportive studies, the consistency of the research results, the magnitude of the positive relation between the element and outcome, the directness of the link between the element and outcome, the experimental rigor of the studies, and the external validity of the research base. The research reviews and clinical practices were compiled in *Psychotherapy Relationships That Work* (2002) and summarized in a special issue of *Psychotherapy* (Norcross, 2001).

This CE module summarizes the research on customizing the psychotherapy relationship for the individual patient. That is, “What relationship stances work best for this patient, with this nondiagnostic characteristic, under these circumstances.” Patient characteristics as a means of customizing therapy were:

<u>Demonstrably Effective</u>	<u>Promising and Probably Effective</u>	<u>Insufficient Research</u>
Resistance	Coping Style	Attachment Style
Functional Impairment	Stages of Change	Gender
	Anaclitic/sociotropic and Introjective/autonomous dimensions	Ethnicity
	Expectations	Religion/Spirituality
	Assimilation of Problematic Experiences	Preferences
	Religion and Spirituality	Personality Disorder

Of course, these patient characteristics are not necessarily predictive of psychotherapy success themselves. More client resistance and the presence of personality disorders, for two examples, predict *worse* outcomes. We mean that these patient characteristics are effective as means of tailoring, adapting, or customizing treatment specifically to the individual in ways that improve the effectiveness of psychotherapy. Different folks frequently need different strokes, and the following paragraphs the evidence-based means of doing so in psychotherapy.

THE DEMONSTRABLY EFFECTIVE ELEMENTS

RESISTANCE

(Beutler et al., 2001a)

Classical psychoanalytic theory characterized resistance as an inherent and unconscious striving to avoid uncomfortable thoughts and feelings. Social psychology proposes the theory of “psychological reactance,” where a perceived threat to one’s autonomy motivates an individual to restore the threatened freedom. A patient’s resistance, therefore, represents the refusal to cooperate as a form of opposition to the psychotherapist’s influence.

There is strong and consistent evidence that patient resistance impedes positive treatment outcome, and psychotherapists are advised to induce as little resistance as possible. However, the

empirical research also suggests that resistance as a trait-like patient characteristic moderates the effectiveness of directive versus nondirective psychotherapeutic approaches. Patients with low trait-like resistance are most likely to benefit from the directive interventions of cognitive or behavioral approaches. More resistant patients have poorer outcomes to authoritative and directive approaches and may do better with psychodynamic, self-directed, or relationship-oriented approaches.

As such, resistance is a patient characteristic that moderates the effects of psychotherapist directiveness. This moderating effect illustrates the importance of *aptitude by treatment interactions (ATIs)*, which investigate how specific patient attributes interact with specific treatments to effect psychotherapy outcome. These studies explore the role of patient moderators in order to determine which approach works best for which patient.

State-like expressions of resistance, from expressions of dissatisfaction to overt displays of anger with the psychotherapist, can be managed by 1) acknowledging the patient's concerns, 2) discussion of the therapeutic relationship, and 3) renegotiation of the goals and roles of the therapeutic relationship. These methods can help diffuse the anger and infuse a sense of control and autonomy.

Finally, paradoxical interventions, such as discouraging rapid change, symptom prescription, and symptom exaggeration, can be used to reduce resistance and facilitate outcome.

FUNCTIONAL IMPAIRMENT (Beutler et al., 2001b)

ATI's are important in determining which approach works best for which patient. One of the most robust treatment-matching dimensions that predict psychotherapy outcome is functional impairment. Functional impairment refers to a complex dimension that reflects the

severity of problems as assessed by self-report of patients' internal states and observations ratings of reduced functioning. Social support is the most researched aspect of functional impairment. These studies indicate that it is the availability of supportive relationships and a person's subjective experience of feeling supported that play a role in treatment outcome.

Functionally impaired individuals had lower rates of improvement and poorer outcomes. These studies also found that the negative prognosis of highly impaired individuals can be moderated by adjusting aspects of treatment as follows: 1) use of interpersonal or multiperson approaches, 2) use of psychoactive medication, and 3) increasing the frequency and length of psychotherapeutic treatment. Social support is an indirect measure of impairment. The presence of social support and other indices of low levels of impairment are associated with positive treatment outcomes and lower rates of relapse.

Although there is strong support for adjusting treatment to match a patient's level of functional impairment, there are problems in teaching psychotherapists to use this information effectively and consistently in planning and carrying out treatment. Furthermore, exact cut-off points on measures of functional impairment and exact procedures for assigning patients to different treatments are not certain.

COPING STYLE (Beutler et al., 2001b)

Another robust treatment-matching dimension identified by ATI studies is coping style. *Coping style* refers to an individual's habitual patterns of behavior and state-like reactions to new or problematic situations, for example, personality qualities, temperaments, and discrete behaviors observed under stress. The externalizing and internalizing styles consistently emerge as one of the most robust dimensions of coping styles. Externalizers are described as impulsive,

action- or task-oriented, gregarious, aggressive, hedonistic, stimulation-seeking, and lacking in insight. Internalizers are described as shy, retiring, self-critical, withdrawn, constrained, over-controlled, self-reflective, worried, and inhibited.

The research on coping style and psychotherapy outcome focused on coping style as a moderator of treatment effects. The majority of these studies demonstrated that interpersonal and insight-oriented therapies are most effective with internalizing patients, and symptom and skill building therapies are most effective with externalizing patients

THE PROMISING AND PROBABLY EFFECTIVE ELEMENTS

STAGES OF CHANGE

(Prochaska & Norcross, 2001)

The transtheoretical model specifies a process of behavior change that progresses over through a series of six stages. Individuals in these stages are characterized as follows:

1. *Precontemplation*: No awareness of problems and patients present for treatment because of pressure from others.
2. *Contemplation*: Awareness of a problem but no commitment to take action.
3. *Preparation*: Intention to take action in the near future.
4. *Action*: Overt changes to modify behavior, experiences, and environment in order to overcome problems.
5. *Maintenance*: Work to prevent relapse and consolidate the gains attained during the action stage.

Different processes of change are effective for different stages. Experiential, cognitive, and psychodynamic orientations are generally most useful during precontemplation and contemplation stages, while existential and behavioral orientations are most useful during action and maintenance stages.

Therapist stances vary for different stages. Patients in precontemplation may require a *nurturing parent* who joins with a resistant and defensive youngster; in contemplation, a *Socratic teacher* who encourages independent insights into their condition; in preparation, the

experienced coach who can provide or review the patient's game; in action and maintenance, a *consultant* who is available to provide expert advice and support when action is not progressing as smoothly as expected.

Empirical studies on the transtheoretical model focus on the association of specific stage to treatment outcomes and dropout, and treatment efficacy. None of the empirical studies have directly and prospectively matched psychotherapist relational style to treatment outcome. Research findings support the following recommendations: 1) assess the stage of a patient's readiness and tailor the therapeutic relationship and interventions accordingly; 2) since the vast majority of patients are not in the action stage, immediately implementing action-oriented treatment plans will result in poorer outcomes; 3) a realist goal for treatment is to help a patient move from one stage to the next; 4) understanding the patient's stage of change can help the psychotherapist prescribe an appropriate relational stance; 5) individuals who are ready to move into the action stage may not profit from therapeutic approaches that increase awareness, while individuals in the contemplation and preparation stages may not profit from behavioral interventions; 6) proactive and stage-based interventions should be considered when developing population treatment programs.

ANACLITIC (SOCIOTROPIC) AND INTROJECTIVE (AUTONOMOUS) DIMENSIONS
(Blatt et al., 2001)

Some studies suggest that psychotherapy outcome may be moderated by the effect of patients' personality traits that affect their interpersonal relationships. The anaclitic-introjective distinction posits that personality develops along two paths. The anaclitic, or relatedness line, involves the development of the capacity to establish mature, mutually satisfying relationships. The introjective, or self-definitional line, involves the development of a differentiated, cohesive,

and positive self-identity. In normal development, these two lines evolve in an interactive, mutually facilitating fashion.

Patients with analclitic disorders are typically preoccupied with interpersonal issues of trust, caring, intimacy, and sexuality. They tend to use avoidant mechanisms, such as withdrawal, denial, and repression. Patients with introjective disorders are more ideational and preoccupied with establishing, protecting, and maintaining a viable self-concept. They tend to use counteractive defenses, such as projection, rationalization, intellectualization, doing and undoing, reaction formation, and overcompensation.

Investigators from different theoretical perspectives have defined subtypes of depression in similar terms of that emphasize disruptions in interpersonal relationships or disruptions in self-esteem. Psychoanalytic investigators discuss anaclitic and introjective depression as dependent/self-critical, dominant other/dominant goal oriented, and anxiously attached/compulsively self-reliant. In a similar manner, cognitive-behavioral formulations differentiate between sociotropic, or socially dependent, and autonomous, or self-critical depressive subtypes.

Research suggests that introjective patients changed more readily as evidenced by the intensity of their clinical symptoms and their cognitive functioning, as assessed by thought disorder on the Rorschach and measures of intelligence. They responded better to psychoanalysis than psychotherapy. Analclitic patients changed more slowly and in more subtle ways as indicated by changes in their interpersonal relationships and in representations of the human figure on the Rorschach. They responded better to psychotherapy than psychoanalysis.

Since introjective patients tend to be perfectionistic, they are likely to project their harsh and punitive representations of significant others onto the psychotherapist. Psychotherapists need to be aware of the ways in which patients perceive them early in the course of treatment.

Psychotherapists should also be alert to ways in which patients actively generate a negative social environment outside of treatment. Perfectionism interferes with both the therapeutic alliance and patients' ability to establish and maintain supportive social relations thereby limiting the potential benefits of psychotherapy.

EXPECTATIONS AND PREFERENCES

(Glass et al., 2001)

Patient expectations and preferences about psychotherapy prior to initiating treatment may affect outcome. These include 1) expectations about treatment outcome, 2) expectations about the role of the patient and the psychotherapist, and 3) preferences for type of treatment and psychotherapist.

Outcome Expectations

Patients present with positive, ambivalent, or negative expectations about whether psychotherapy can help them. Outcome expectation is one of the key nonspecific or common factors, and the mobilization of hope is a central factor in treatment. Research findings indicate that patient expectations were positively related to outcome. Expectations about outcome were the best predictor of the therapeutic alliance after the first session. Outcome expectancy can affect treatment outcome even in non-treatment control groups.

Patients need to hope that treatment will help, and their expectations should be addressed immediately. Psychotherapists should respond to patients' skepticism in an empathic manner, conveying expertise and sincere enthusiasm. Helpful statements include, "It's really good that you sought help for this," and "What you're concerned about is exactly the kind of thing psychotherapy can help with."

Role Expectations

Patients present for treatment with expectations about how psychotherapists and psychotherapy work. Discrepancies between these expectations and actual behaviors can compromise the therapeutic relationship and the effectiveness of specific interventions. Patients appear to want psychotherapists who are sincere, understanding, sympathetic, competent, and optimistic but also realistic about their problems. Research found significant or mixed association between role expectancy and outcome, although these studies had substantial methodological problems.

Psychotherapists need to assess patient expectations. Although distorted expectations can be addressed through information and education, these expectations sometimes reflect aspects of patients' dynamics, such as of unrealizable goals. A useful approach is for the psychotherapist to investigate the patient's perspective, inform the patient of the psychotherapist's perspective, negotiate differences, and let the patient choose. Both explicit educational methods and implicit communications from the psychotherapist can help the patient prepare for treatment.

Preferences

Patient preferences refer to what they want from their psychotherapist or psychotherapy in contrast to what they expect. Three types of preferences are role preference (active versus passive psychotherapist), preference for type of psychotherapy (one type of psychotherapy over another), and preference for demographic features of the psychotherapist (gender, race, ethnicity, age, etc.). The research on the relationship of various types of patient preferences to treatment outcome is sparse and do not support the hypothesis that preferences are significantly related to outcome.

Psychotherapists should attend to the preferences of their patients at the start of treatment. Psychotherapists can educate patients about psychotherapy so as to facilitate informed choices about patient-therapist matches.

ASSIMILATION OF PROBLEMATIC EXPERIENCES

(Stiles, 2001)

The assimilation model addresses psychotherapy outcome as changes in particular *problematic experiences* such as painful memories, threatening feelings, or destructive relationships that bring a patient to treatment. Successful psychotherapy follows a treatment course of the patient recognizing, reformulating, understanding, and eventually resolving the problematic experiences. This model customizes the therapeutic relationship by accommodating to the degree of assimilation.

The model is summarized as a course of eight stages:

0. *Warded off/dissociated*. Patient is unaware of the problem.
1. *Unwanted thoughts/active avoidance*. Patient prefers not to think about the experience.
2. *Vague awareness/emergence*. Patient is aware of a problematic experience but cannot formulate the problem clearly.
3. *Problem statement/clarification*. Content includes a clear statement of a problem-- something that can be worked on.
4. *Understanding/insight*. The problematic experience is formulated and understood in some way.
5. *Application/working through*. The understanding is used to work on a problem.
6. *Resourcefulness/problem solution*. The formerly problematic experience has become a resource used for solving problems.
7. *Integration/mastery*. Patient automatically generalizes solutions.

The metaphor of *voice* describes the process of assimilation as the traces of past experience that are internalized as active agents capable of communication. Unassimilated voices are dissociated and problematic, while assimilated voices are available as resources. The

community of voices is the interlinked and assimilated traces of past experiences within a person. In psychotherapy, an unassimilated voice establishes contact with the community, negotiates an understanding, and is assimilated into the community, for example, when sudden outbursts of rage (a problem) are gradually assimilated and transformed into appropriate assertiveness (a resource). The process of contact between the problematic voice and the community can be described as building a meaning bridge.

Evidence for the assimilation model is based primarily on the intensive analysis of case studies using tapes of psychotherapy transcripts. A qualitative approach, assimilation analysis, identifies problematic experiences, extracts multiple passages about these problems, and studies how their expression changes from one session to the next. More traditional hypothesis-testing studies also support the model. For example, a ATI was found, indicating how problems at low levels of the model that are poorly formulated might be best treated with exploratory approaches, which search for underlying conflicts, while problems at intermediate levels that are more articulated may be more effectively addressed by prescriptive approaches, such as cognitive or behavioral therapies.

The assimilation model suggests both a generic treatment goal of facilitating the patient's progress along the continuum, and a series of specific subgoals, corresponding to individual levels. Interventions require appropriate responsiveness to patients' requirements as they change during treatment. Markers of assimilation levels are events during psychotherapy that are linked to those levels and could guide psychotherapists in facilitating the problem's movement to the next level. Research has yielded over two dozen candidate markers, for example, fear of losing control as a marker for level 1, the emergence of unwanted thoughts. The assimilation model emphasizes the role of the interaction between psychotherapist and patient as the factor that

facilitates the movement from one level to the next. How the psychotherapist leads versus follows the patient result in different courses of movement through the stages.

ATTACHMENT STYLE
(Meyer & Pilkonis, 2001)

Adult attachment styles describe people's comfort and confidence in close relationships, their fear of rejection and yearning for intimacy, and their preference for self-sufficiency or interpersonal distance. Attachment styles are formed in response to experiences with caregivers and significant others, and they reflect internal working models of self in relation to others.

Research on the relationship between attachment styles and psychotherapy has focused on three main areas. First, studies on the relationship between patient attachment and psychotherapy outcome indicate that under some conditions, securely attached patients may benefit more than others from treatment. Nevertheless, more severely impaired patients in long-term intensive treatment who have a dismissive attachment style may show the greatest amount of relative improvement. Second, patients' attachment styles influence the treatment alliance since their mental representations of self and others may predict how their therapists respond to them during treatment and how effective they are at establishing relationships. Third, the attachment style of the psychotherapist influences the treatment process and outcome. More anxious psychotherapists tended to respond less empathically, perhaps fearing rejection. Also, complementary attachment styles were advantageous: preoccupied patients did better with dismissive case managers, and dismissive patients did better with preoccupied case managers.

The available research on attachment styles has the following implications for clinical practice. 1) Psychotherapists who identify problematic working models gain information about specific treatment goals. For instance, in working with a patient showing signs of dismissing-

avoidant attachment (positive self and negative other model), the goal would be to increase the positivity of the "other" model. Given the importance of cultural differences, attachment-related therapy goals must be adjusted accordingly. In cultures where communal integration is valued, dependency-related traits may not be maladaptive. 2) Psychotherapists should be aware that patients' attachment styles pull for different interventions and influence the quality of the therapeutic alliance. Preoccupied patients may pull for emotional-experiential interventions, but may benefit from cognitive-behavioral strategies. Similarly, avoidant patients pull for rational cognitive interventions but may benefit from emotional engagement. 3) Although there is no data on modification of a patient's attachment style as a treatment goal, treatment planning could be framed in terms of using of specific interventions related to problematic attachment styles, for example, using behavioral interventions to bolster the self-esteem of preoccupied patients. 4) Assessment of psychotherapists' attachment styles could be used to match psychotherapists to patients, since therapists styles can influence the treatment process.

RELIGION AND SPIRITUALITY (Worthington & Sandage, 2001)

Since many patients use religious and spiritual convictions as a means of coping with life stressors and emotional struggles, psychotherapists need to assess these beliefs. Religion refers to the search for the sacred within formal institutions, while spirituality refers to personal experiential dynamics. Although these are usually connected, for many, spirituality is distinct from formal religion, and psychotherapists need to understand how to use both religious and spiritual language in treatment.

Religion and spirituality may manifest in psychotherapy in the following ways:

1) Patients may request explicitly religious psychotherapy and may question the psychotherapist about his or her religious beliefs and values. 2) Some patients may be opposed to religious influence and its use in treatment. 3) If the psychotherapist's approach to religion and spirituality is implicit or if some aspects of a patient's convictions are troublesome to the psychotherapist (e.g., Satanism or White Supremacy religions), referrals to another psychotherapist may be needed. 4) Psychotherapists need to understand the interaction of culture and ethnic diversity with religion and spirituality. 5) Marital conflicts may be voiced as differences in values about religion and spirituality.

Research on the association of religion and spiritual values to psychotherapy process and outcome is sparse. Survey findings indicate that psychotherapists value spirituality in their personal and professional lives. Studies found that patients' strong religious commitments predicted (a) preference for value-similar psychotherapists; (b) pretherapy expectations of psychotherapy; (c) reactions to psychotherapists' challenges about behavior, beliefs, and values; (d) estimation of patient continuation in psychotherapy after a challenge; and (e) perception of counselors. The literature on patient spirituality indicated that patients were more likely to raise spiritual issues in treatment than their psychotherapists, and patients with higher levels of spiritual experience preferred to discuss these matters. Patients in most forms of successful psychotherapy tend to move towards their psychotherapists' values. Although there is evidence that patient-therapist similarity is positively associated with independent clinician ratings of improvement, there is evidence that matching the religiosity of psychotherapists and patients is not crucial to outcome. Studies of religiously accommodative psychotherapies, that is, psychotherapy approaches that "accommodate" standard therapies to the values of highly religious patients, provided some support for their efficacy, especially with depressed patients.

The research supports the following recommendations: 1) Psychotherapists' standard assessment of religion and spirituality should include both denominational information and information about religious values and spiritual experiences. Highly religious and spiritual patients may have strong feelings about how these issues are managed in treatment, want to discuss these issues in treatment, and they may respond negatively if their values are challenged. 2) Religion-accommodative therapies are available and effective, primarily for the treatment of depression. 3) Research on matching psychotherapist-patient religiosity has yielded mixed results. Religious matching appears to be more important when patients strongly value salvation and when psychotherapy does not involve the use of religiously accommodative interventions.

PATIENT DIVERSITY (Lam & Sue, 2001)

Advocates for such diverse groups as women, ethnic minorities, gay, lesbian, and bisexual individuals, and individuals from lower social classes have argued for customizing the psychotherapeutic relationship by matching patients with psychotherapists from similar backgrounds so that patients may feel more comfortable, understood, and be more self-disclosing. The research on the treatment of populations that are considered oppressed, underserved, or inappropriately served addresses three questions: 1) Is there evidence that diverse populations have poorer outcomes in treatment than mainstream populations? 2) Does matching of psychotherapists with similar backgrounds improve outcomes? 3) Are outcomes better when population-specific strategies are used with diverse populations?

Gender

The majority of studies found no differences in psychotherapy outcomes between women and men. Matching psychotherapists and patient on the basis of gender may be related to patient

satisfaction ratings, psychotherapist ratings of patient improvement, and indirect measures of outcome, such as length of treatment and dropout. Less is known about the relationship between gender match and direct measures of outcomes. Finally, there is no definitive evidence on the superiority of feminist therapies over traditional therapies, although a feminist approach may be more appropriate for women who have experienced domestic violence or abuse.

Ethnic Minorities

The limited studies on the effectiveness of psychotherapy with ethnic minorities indicate that minorities tend to exhibit either similar or worse treatment outcomes than Whites. Ethnic match is associated with indirect treatment outcomes, but not direct outcomes. Finally, there is some support for ethnic-specific treatments for Latino Americans and preliminary support for American Indian patients, although studies are sparse for African-Americans and Asian Americans.

Sexual Orientation

Although the available studies indicated that psychotherapy is effective for gay men, there is little empirical research on the effectiveness of treatments for lesbians and bisexuals, or the effectiveness of gay affirmative psychotherapies. Patient-psychotherapist match may be more important for lesbian and gay patients dealing with issues of their sexual orientation. Sexual orientation match is partially supported: females of both orientations have not been shown to produce differential effects on patients, whereas heterosexual males are thought to have a negative influence on lesbian and gay patients.

Social Class

Social class is not related to direct treatment outcomes. There is evidence that low-income patients are less likely to stay in treatment and more likely to drop out prematurely than

higher-income patients. There is no systematic research on social class matching with psychotherapy outcome. There is preliminary evidence for the use of active, directive psychotherapies with lower-income patients. Psychotherapists tend to have biases towards low socio-economic status populations.

In general, treatment outcome studies using diverse populations are sparse methodologically flawed. Matching patients and psychotherapists with similar backgrounds may be important in some but not all cases. For example, ethnic match is particularly important for first generation ethnic minority patients who are unacculturated. A final issue to consider is freedom of choice. Some patients do have preferences for these psychotherapist characteristics that should be honored as resources allow.

PERSONALITY DISORDERS (Benjamin & Karpiak, 2001)

Personality disorders are a major source of long-term impairment. They are comorbid with other clinical syndromes, utilize a disproportionate amount of mental health resources, and show a diminished response to treatment. In the past decade, effective treatments have been documented. Although the role of the psychotherapy relationship on treatment outcome has not been specifically studied, the available evidence suggests that relational factors influence the process and outcome of treatment.

Dialectical behavior therapy (DBT) and the Day Treatment Programs (DTP) are two effective treatments for personality disorders. Central to both approaches are the relationship factors of acceptance of and respect for the patient. An additional relationship factor in both approaches is the explicit emphasis on the dialectic between acceptance and change in DBT where the psychotherapist accepts the patient as is, but also expects and facilitates change, and

the clear limit setting of DTP in the context of an accepting and respectful environment. The literature indicates that there are many effective interventions for treating personality disorders, but they require at least one year of treatment.

Research that directly assesses the effect of the psychotherapy relationship on treatment outcome in personality disorder is limited to one study that reported fewer parasuicidal episodes in the week following DBT. Several studies found that the psychotherapy relationship was associated with indirect measures of treatment outcome. For example, setting contracts succeeds in keeping individuals with borderline personality disorder in treatment longer, and interpretive psychotherapy were less effective than supportive psychotherapy in treating schizotypal personality disorders.

The available studies suggest that validation, limit setting and a good psychotherapy alliance are important to the successful treatment of personality disorder. Although the psychotherapy relationship is theoretically central to effective treatment, data are not yet available that relate specific elements of the psychotherapy relationship to treatment outcome.

INTEGRATING RESEARCH AND PRACTICE

Although the Division of Psychotherapy task force on evidence-based psychotherapy relationships identified a vast research base, its efforts represent the initial steps in organizing that literature that require regular updates. Furthermore, since the identified elements are not subject to randomized clinical trials, it is difficult to determine causal relationships between the elements and treatment outcomes. Finally, research on the effectiveness of the psychotherapy relationship is limited by the *responsiveness problem*. Therapists' respond in many ways to the emerging context of the treatment situation, which influence their choices of treatment, case

formulation, the strategic use of particular techniques, and adjustments within those techniques (Stiles, Honos-Webb, & Surko, 1998). Sensitive and flexible psychotherapists are responsive to the different needs of their clients and will vary their use of relationship elements to individual cases. A psychotherapist may decide not to self-disclose to one patient and in another case decide that self-disclosure is appropriate with both cases having favorable treatment outcomes.

Statistically, there is no association of self-disclosure to outcome when both cases are considered. That is to say, when data on individual cases are grouped or when cumulative studies are considered, therapist responsiveness to individual cases may confound the association of relationship elements with treatment outcomes, resulting in no statistical association - or even negative associations. The statistical results of associations between the relationship and outcome are frequently suspect.

Relationship elements and treatment techniques are frequently presented as distinct, even mutually exclusive. The relationship describes *how* therapists and patients behave towards each other, while techniques describe *what* is done by the therapist. While this distinction may be useful for research purposes, it is a serious error when extrapolating from research results to clinical practice. The value of a treatment method is inextricably bound to the relational context in which it is applied. (See the 2005 special issue of *Psychotherapy* on the interplay of techniques and therapeutic relationship).

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