Better relationships with patients lead to better outcomes

apa.org/monitor/2019/11/ce-corner-relationships

In terms of psychotherapy outcomes, the relationship between patient and psychologist matters—a lot. That's the main takeaway from a new collection of meta-analyses released by an APA task force charged with examining the latest evidence on relationship factors in therapy.

Based on its 16 meta-analyses on aspects of the therapy relationship, the APA Task Force on Evidence-Based Relationships and Responsiveness concludes that a number of relationship factors—such as agreeing on therapy goals, getting client feedback throughout the course of treatment and repairing ruptures—are at least as vital to a positive outcome as using the right treatment method.

"Anyone who dispassionately looks at effect sizes can now say that the therapeutic relationship is as powerful, if not more powerful, than the particular treatment method a therapist is using," says University of Scranton professor John C. Norcross, PhD, ABPP, chair of the APA task force, which was co-sponsored by APA Div. 17 (Society of Counseling Psychology) and Div. 29 (Society for the Advancement of Psychotherapy). "We now know that some of these therapeutic elements not only predict but probably cause improvement," he says (see "What the evidence shows").

A good relationship, the research finds, is essential to helping the client connect with, remain in and get the most from therapy. "It's primary in the sense of being the horse that comes before the carriage, with the carriage being the interventions," says Simon Fraser University emeritus professor Adam O. Horvath, PhD, who studies the therapy alliance.

The meta-analyses are reported in the December 2018 issue of *Psychotherapy* (Vol. 55, No. 4) and in two related books due out later this year (see "Resources"). In addition, APA Div. 29 is hosting 10 webinars on the findings.

The *Monitor* explores some of the key findings of the meta-analyses and how psychologists can use them in therapy to help maximize treatment outcomes.

Fostering mutuality and collaboration

One big shift in psychotherapy in recent years is toward greater mutuality—the notion that psychotherapy is a two-way relationship in which the therapist and client are equal partners in the therapy process. Therapists make this stance apparent in an ongoing way by, for

example, disclosing their feelings when appropriate and actively inviting feedback from patients about how therapy is going. “It’s about making a commitment to be a partner, in a sense, rather than the director or commander in the relationship,” says Horvath.

Related to mutuality is another strong relationship builder: collaboration, or working together to define and actualize therapy goals, including the direction the therapy relationship is taking.

Research supports the benefits of both mutual and collaborative approaches. For example, one meta-analysis of 21 studies identified by the task force finds that when therapists share their feelings about the patient or the therapy relationship—a mutual approach known as “immediacy”—the patient’s mental health functioning and insight improve (*Psychotherapy*, Vol. 55, No. 4, 2018). Another meta-analysis of 107 studies finds that therapy outcomes are enhanced when the therapist and patient agree and collaborate on patient goals (*Psychotherapy*, Vol. 55, No. 4, 2018).

Being flexible and responsive

Also critical to outcomes is a therapist’s ability to tailor treatment to patients’ individual characteristics, such as their cultural background, therapy preferences, attachment style, religious or spiritual beliefs, gender identity and sexual orientation—“to select different methods, stances and relationships according to the patient and the context,” as Norcross puts it. (The topic of responsiveness is explored in nine meta-analyses reported in the November 2018 issue of the *Journal of Clinical Psychology*, Vol. 74, No. 11.)

Responsiveness is also related to understanding clients as individuals—being attuned to their personality traits, conflicts, quirks and motivations, says Orya Tishby, PsyD, a clinical lecturer and researcher at The Hebrew University of Jerusalem, who co-edited “Developing the Therapeutic Relationship” (APA, 2018).

“If the relationship is really good, you can tell the difference between when your patient might be acting out or resisting, and when your suggestions aren’t working for some other reason,” Tishby says.

She gives the example of a patient who is being treated for social phobia but has difficulty following through with an exposure protocol, such as initiating a conversation with a stranger. The patient keeps deferring the task to the following week, while telling the therapist he understands the importance of moving forward.

When the therapist questions the patient in an empathic manner, the patient tells her he’s highly anxious about being rejected by a stranger but also feels uncomfortable not complying with treatment. The therapist then suggests breaking down the task in a way that feels more

comfortable to the patient; they also discuss the patient's concern about the therapist's possible reactions to his lack of compliance.

In a case like this, "taking therapy at a slower pace and periodically checking in with the patient makes for more attuned and effective therapy," says Tishby.

Using feedback

Another important way to boost the therapeutic relationship—as well as patient outcomes—is by gathering patient feedback and incorporating it into treatment.

A widely studied and validated tool used by psychologists is the Outcome Questionnaire-45.2 (OQ®-45.2), developed by Brigham Young University professor Michael Lambert, PhD. Patients complete the 45-question instrument before each session to assess psychological symptoms such as depression, anxiety and substance use, as well as problems in interpersonal functioning and social roles. Any score indicating a propensity toward suicide, violence or substance use is a red flag that calls for immediate follow-up, while high scores on one or more of the subscales suggest key areas for treatment focus, Lambert explains. Other psychologists have since developed shorter measures for the same purpose, notably the Outcome Rating Scale and the Session Rating Scale, developed by Scott D. Miller, PhD, Barry L. Duncan, PsyD, and colleagues.

Research shows that such measures are most useful in identifying patients who are likely to drop out of therapy prematurely—between 20 and 40 percent of therapy clients, according to research. To guard against early dropout or the worsening of a patient's condition, Lambert developed an additional 40-item measure that assesses specific aspects of the alliance, the breakdown of which is a key factor in patient deterioration, research also finds. In a meta-analysis of 24 studies, Lambert and colleagues found that when clinicians used the OQ-45.2 and other feedback systems, clients at risk for problems were less likely to get worse and twice as likely to experience positive clinical change, compared with clients who received treatment as usual from the same therapists (*Psychotherapy*, Vol. 55, No. 4, 2018).

Of course, feedback alone doesn't mean improvement—therapists must put that feedback into action. For guidance on addressing their blind spots and learning from their mistakes, some psychologists are turning to "deliberate practice." Taught in a variety of training venues, deliberate practice entails taking information from feedback or supervision and working on problem areas with the help of videos, coaches, mirrors and other tools (see the *Monitor*'s January 2018 "CE Corner" for more information).

Although more research is needed, studies show significant improvements in outcomes over time when therapists incorporate feedback and deliberate practice into their work (see *Psychotherapy*, Vol. 53, No. 3, 2016).

Repairing ruptures

Many factors can break down the therapy alliance, such as disagreement on treatment goals, the patient's misinterpretation of something the therapist has said or a mistrust of the therapeutic process. Research shows that resolving these difficulties, known as therapy ruptures, can lead to better outcomes (*Psychotherapy*, Vol. 55, No. 4, 2018).

Ruptures fall into two general categories, says psychotherapy researcher J. Christopher Muran, PhD, a professor at Adelphi University who directs the Mount Sinai Beth Israel Brief Psychotherapy Research Program at the Icahn School of Medicine at Mount Sinai in New York. Confrontation ruptures are marked by patients' external expressions of anger, such as accusations or sharp questioning of the therapist. Withdrawal ruptures occur when patients pull away from the therapist or from an aspect of themselves—for example, when they fear the therapist's criticism or are afraid to delve into a painful topic. Clues that clients may be heading toward such ruptures include retreating into silence and not fully engaging in treatment.

Handling any rupture begins by recognizing one is occurring, Muran says. Not surprisingly, that's easier when a rupture is marked by confrontation rather than withdrawal, so therapists should watch out for the quieter forms, he advises. The next step is to address a rupture by, for example, providing a rationale for a task patients may be struggling with or renegotiating patients' goals so they feel more aligned with the direction of therapy. A more intensive strategy is to encourage a mutual discussion that addresses the rupture directly. Facing an uncomfortable conflict and working through it can aid the patient's growth—and the therapist's, says Muran.

Handling negative emotions

Patients probably wouldn't be in psychotherapy if they didn't have negative feelings to work through. Unfortunately, it can be difficult for clinicians to have to address patients' negative states repeatedly. Some therapists become frustrated, which can be taken by patients to mean there's something wrong with them, says Stony Brook University professor Marvin Goldfried, PhD, co-editor of "Transforming Negative Reactions to Clients: From Frustration to Compassion" (APA, 2012).

In such cases, therapists should examine their reactions and be alert to feelings of distraction, boredom or the urge to end the session. They should also be aware that clients pick up on therapists' feelings through their facial expressions, posture, tone of voice and lack of eye contact.

"We should go from any blame to the realization that they are stuck in some uncomfortable way of living," Goldfried says, "and have compassion for that."

Therapists should also pay attention to countertransference issues, notes psychotherapy researcher and University of Maryland emeritus professor Charles J. Gelso, PhD, author of "The Therapeutic Relationship in Psychotherapy Practice: An Integrative Perspective" (Routledge, 2019) and co-author of "Countertransference and the Therapist's Inner Experience: Perils and Possibilities" (Erlbaum, 2007).

Gelso describes his reaction to a client who was talking about the way she parented her daughter. "All of a sudden I started making suggestions, which was completely unlike me—I just started jumping in and being an adviser," he says. By examining his feelings, he realized his patient was provoking his ambivalence about his own parenting ability. He went on to share those reactions with her, and they moved back into a discussion of her own parenting issues.

Such self-insight can lead to better outcomes, according to the task force report on three meta-analyses by Jeffrey Hayes, Gelso and colleagues (*Psychotherapy*, Vol. 55, No. 4, 2018). Andrés Pérez-Rojas, PhD, Gelso and colleagues have also developed a measure that helps psychotherapy trainees cultivate such self-awareness and manage their countertransference reactions (*Psychotherapy*, Vol. 54, No. 3, 2017).

Promoting effective endings

When it's time to end therapy, research by Norcross and colleagues finds that eight actions tend to promote better patient outcomes: having a mutual discussion about how the therapy went, discussing the patient's future functioning and coping, helping the patient use new skills beyond therapy, framing personal development as an ongoing process, anticipating post-therapy growth, talking specifically about what it means to end this course of therapy, reflecting on patient gains, and expressing pride in the patient's progress and in the mutual relationship (*Psychotherapy*, Vol. 54, No. 1, 2017).

As with other key moments in therapy, the psychologist should discuss termination openly, even if a patient is simply toying with the idea—for example, if the patient actually wants to stay but is scared to dive into a difficult topic, Tishby adds. Such conversations may include talking about those feelings or about changing aspects of treatment to better accommodate the patient, she says.

When it's clear to both therapist and patient that it's time to stop, use the last few sessions to discuss any issues that have not received closure and summarize the progress that's been made, says Tishby. Therapists shouldn't be afraid to share some of their own feelings: If you are saddened by the ending of a relationship, for example, share that with your patient and how much you've valued your work together, she advises.

Over time, Tishby has come to respect patients' wishes to leave even when she thinks more work could be done, she adds.

"You shouldn't simply assume that if they want to leave, they're resisting something," she says. "Sometimes therapists and patients do have gaps in their goals."

Resources

Developing the Therapeutic Relationship: Integrating Case Studies, Research, and Practice
Tishby, O., & Wiseman, H. (Eds.) APA, 2018

Psychotherapy Relationships That Work
Norcross, J.C., & Lambert, M.J. Psychotherapy, 2018 [introduction to special issue]

Psychotherapy Relationships That Work: Vol. 1. Evidence-Based Therapist Contributions
(3rd ed.) Norcross, J.C., & Lambert, M.J. (Eds.) Oxford, 2019

Psychotherapy Relationships That Work: Vol. 2. Evidence-Based Therapist Responsiveness
(3rd ed.), Norcross, J.C., & Wampold, B.E. (Eds.) Oxford, 2019