

# Purposes, Processes, and Products of the Task Force on Empirically Supported Therapy Relationships

John C. Norcross

University of Scranton  
Department of Psychology  
University of Scranton  
Scranton, PA 18510-4596  
+1 570-941-7638 (voice)  
norcross@scranton.edu  
+1 570-941-7899 (fax)

## Author's Notes

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Correspondence concerning this article should be addressed to John C. Norcross, Ph.D., Department of Psychology, University of Scranton, Scranton, PA 18510-4596 or [norcross@scranton.edu](mailto:norcross@scranton.edu)

## Abstract

This article introduces the special issue of *Psychotherapy* devoted to evidence-based therapy relationships. It explicates the purposes, summarizes the processes, and introduces the products of the Division of Psychotherapy's Task Force on Empirically Supported Therapy Relationships. The dual aims of the Division 29 Task Force were to identify elements of effective therapy relationships and to determine efficacious methods of customizing or tailoring therapy to the individual patient. The article concludes by featuring the limitations of the Task Force's work and by responding to frequently asked questions about its objectives and conclusions.

Recent years have witnessed the controversial promulgation of practice guidelines and evidence-based treatments in mental health. The introduction of such guidelines has provoked practice modifications, training refinements, organizational conflicts, and strident rebuttals. For better or worse, insurance carriers and government policymakers are increasingly turning to such guidelines and compilations to determine which psychotherapies to approve and fund. Indeed, along with the negative influence of managed care, there is probably no more issue central to clinicians than the evolution of evidence-based practice in psychotherapy (Barlow, 2000).

Foremost among these initiatives in psychology was the APA Society of Clinical Psychology's Task Force efforts to identify empirically supported treatments (ESTs) for adults and to publicize these treatments to fellow psychologists and training programs. Since 1993 a succession of APA Division 12 Task Forces (now a standing committee) has constructed and elaborated a list of empirically supported, manualized psychological interventions for specific disorders based on randomized controlled studies that pass for methodological rigor (Chambless & Hollon, 1998; Chambless et al., 1996, 1998: Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Subsequently, ESTs have been applied to both older adults and children (e.g., Gatz et al., 1998; Lonigan, Elbert, & Johnson, 1998).

APA's Society of Clinical Psychology has not been alone in developing and promoting such guidelines, however. The APA Division of Counseling Psychology has issued their own principles of empirically supported interventions (Wampold, Lichtenberg, & Waehler, in press), and the APA Division of Humanistic Psychology (Task Force, 1997) published guidelines for the provision of humanistic psychosocial services. The Practice Guidelines Coalition, a developing organization sponsored by the Association for Advancement of Behavior Therapy and the American Association of Applied and Preventive Psychology, is creating clinical practice guidelines that are brief, evidence-based, multidisciplinary, and disorder-specific. In Great Britain, a Guidelines Development Committee of the British Psychological Society authored a Department of Health (2001) document entitled Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Practice Guidelines. In psychiatry, the American Psychiatric Association has published at least 10 practice guidelines, on disorders ranging from schizophrenia to anorexia to nicotine dependence.

All of the efforts to promulgate evidence-based psychotherapies have been noble in intent and timely in distribution. They are praiseworthy efforts to distil scientific research into clinical applications and to guide practice and training. They wisely demonstrate that, in a climate of accountability, psychotherapy stands up to empirical scrutiny with the best of health care interventions. And within psychology, they have attempted to proactively counterbalance documents that accord primacy to biomedical treatments for mental disorders and largely ignore the outcome data for psychological therapies (such as the Depression Guideline Panel, 1993). On many accounts, then, the extant efforts have addressed the realpolitik of the socio-economic situation (Messer, 2001; Nathan, 1998).

### **What's Missing?**

The ethical and professional commitment to evidence-based psychotherapy is widely, if not universally, accepted among mental health practitioners. It is similar to publicly prizing Mother and apple pie (Norcross, 1999). In principle, we are all committed to identifying, practicing, and promulgating those psychosocial treatments that "work." In principle.

In application, the controversies reside in the definitions and details of identifying those evidence-based or empirically supported therapies. The internecine conflicts occur around what material is validated and what qualifies as evidence, a process described as decision rules.

Many researchers and practitioners find the decisions rules in these early efforts to be seriously incomplete or inapplicable. Examination of the Society of Clinical Psychology Task Force's initial decision rules is illuminating and representative. Those treatments designated as "empirically validated" -- or the more recent, accurate, and felicitous phrase "empirically supported" -- were restricted to manualized therapies for a fixed number of sessions. The treatments were brand name or pure-form. (For scholarly reviews of the contributions and criticisms of ESTs, refer to several special issues of journals, e.g., Elliott, 1998; Glass & Arnkoff, 1996; Kazdin, 1996; Kendall, 1998). Three decision points are particularly applicable here, beginning with the EST lists as oddly person-less.

### The Person of the Therapist

The EST lists and most practice guidelines depict disembodied therapists performing procedures on Axis I disorders. This stands in marked contrast to the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience. Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact is that the therapist as a person is a central agent of change. The

curative contribution of the person of the therapist is, arguably, as empirically validated as manualized treatments or psychotherapy methods (Hubble, Duncan, & Miller, 1999).

Multiple and converging sources of evidence indicate that the person of the psychotherapist is inextricably intertwined with the outcome of psychotherapy. Luborsky and colleagues (1986) reanalyzed the results of four major studies of psychotherapy outcome to determine the variance accounted for by therapist effects, finding that it generally overshadowed that attributed to treatment differences. A subsequent meta-analysis of therapist effects in psychotherapy outcome studies showed consistent and robust effects - 5% to 9% in one of the best estimates (Crits-Christoph et al., 1991). In reviewing the research, Wampold (2001, p. 200) concluded "a preponderance of evidence indicates that there are large therapist effects . . . and that the effects greatly exceed treatment effects." Despite impressive attempts to experimentally render individual practitioners as controlled variables, it is simply not possible to mask the person and the contribution of the therapist.

### The Therapy Relationship

Second, and most relevant for our purposes, have been the decisions to validate the efficacy of treatments or technical interventions, as opposed to the therapy relationship or therapist interpersonal skills. This decision both reflects and reinforces the ongoing movement toward high-quality comparative outcome studies on techniques or brand-name therapies. "This trend of putting all of the eggs in the "technique" basket began in the late 1970s and is now reaching the peak of influence" (Bergin, 1997, p. 83).

But both clinical experience and research findings underscore that the therapeutic relationship accounts for as much as the outcome variance as particular treatments. Quantitative reviews and meta-analyses of psychotherapy outcome literature consistently reveal that specific techniques account for only 5% to 15% of the outcome variance (e.g., Beutler, 1989; Lambert, 1992; Shapiro & Shapiro, 1982; Wampold, 2001), and much of that is attributable to the investigator's therapy allegiance (Luborsky et al., 1999). Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing, and teaching. Henry (1998, p. 128) concludes that the panel would find the answer obvious, and empirically validated. As a general trend across studies, the largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical research.

In my more strident moments, I have adapted Bill Clinton's unofficial campaign slogan: "It's the relationship, stupid!" Although most treatment manuals and practice guidelines mention the importance of the therapy relationship, few specify what therapist qualities or in-session behaviours lead to a curative relationship. As practice guidelines and treatment manuals are increasingly required in training, research, and practice, there is a real and imminent danger that the therapy relationship, therapist interpersonal skills, and patient matches will be overlooked.

### The Patient's (Nondiagnostic) Characteristics

Third, most practice guidelines and evidence-based compilations unintentionally reduce our clients to a static diagnosis or problem. The impressive, 90-chapter *Treatments of Psychiatric Disorders* (Gabbard, 2000), to take one prominent example, is hailed as the "cumulative knowledge base of psychiatric treatment," yet the entire two volumes are organized exclusively around diagnoses. Virtually all

practice guidelines are directed toward single, categorical disorders. DSM diagnoses have ruled the evidence-based roost to date.

This choice flies in the face of clinical practice and research findings that a categorical, non-psychotic Axis I diagnosis exercises only a modest impact on treatment outcome (Beutler, 2000). While the research indicates that certain psychotherapies make better marriages for certain disorders, psychological therapies will be increasingly matched to people, not simply diagnoses. In the behavioural medicine vernacular, it is frequently more important to know what kind of patient has the disorder than what kind of disorder the person has.

As every clinician knows, different types of patients respond more effectively to different types of treatments and relationships. Different folks do require different strokes. Clinicians strive to offer or select a therapy that accords to the patient's personal characteristics, proclivities, and worldviews - in addition to diagnosis. The differential effectiveness of different therapies may well prove to be a function of cross-diagnostic patient characteristics, such as treatment goals, coping styles, stages of change, personality dimensions, and reactance level.

Moreover, practice guidelines and EST lists do little for those psychotherapists whose patients and theoretical conceptualisations do not fall into discrete disorders (Messer, 2001). Consider the client who seeks more joy in his/her life, but who does not meet diagnostic criteria for any disorder, whose psychotherapy stretches beyond 20 sessions, and whose treatment objectives are not easily specified in measurable, symptom-based outcomes. Current evidence-based compilations have little to contribute to his/her therapist and his/her treatment (see O'Donohue, Buchanan, & Fisher, 2000, for general characteristics of ESTs). Not all psychotherapies or practitioners embrace an action-oriented model in which treatment is rendered to a patient.

All of this is to say that extant lists of empirically supported treatments and practice guidelines give short shrift - some would say lip service - to the person of the therapist, the individual patient's characteristics, and their emergent relationship. Current attempts are thus seriously incomplete and potentially misleading, both on clinical and empirical grounds.

### **Purposes of the Task Force**

Within this context, in 1999 I commissioned an APA Division of Psychotherapy Presidential Task Force to identify, operationalize, and disseminate information on empirically supported therapy relationships. We aimed to identify empirically supported (therapy) relationships rather than empirically supported treatments - or ESRs rather than ESTs. Specifically, the dual aims of the Division 29 Task Force were to:

- \* Identify elements of effective therapy relationships
- \* Determine efficacious methods of customizing or tailoring therapy to the individual patient on the basis of his/her (nondiagnostic) characteristics

This special issue of Psychotherapy summarizes the findings, conclusions, and recommendations of the Task Force's four-year work.

Compared to extant efforts, the Division 29 Task Force focused on relationship qualities and therapist stances, as opposed to treatment techniques, and adopted broader decision rules as to what qualifies as evidence for inclusion, including both effectiveness and efficacy studies. In addition, we addressed the crucial research on matching therapy relationships to client features beyond discrete Axis I diagnoses.

Table 1 summarizes the salient differences in decision rules between our APA Division 29 Task Force and previous efforts, notably the Division 12 Task Forces.

## **Processes of the Task Force**

### Definitions

One of our first process challenges was to define the psychotherapy relationship. We adopted Gelso and Carter's (1985, 1994) operational definition: "The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed." This definition is quite general, and the phrase "the manner in which it is expressed" potentially opens the relationship to include everything under the therapeutic sun (see Gelso & Hayes, 1998, for an extended discussion). Nonetheless, it was concise, consensual, theoretically neutral, and sufficiently precise for our use.

A related challenge was to establish the inclusion and exclusion criteria for the elements of the therapy relationship. We readily agreed that the traditional features of the therapy relationship -- the alliance in individual therapy and cohesion in group therapy, for example - and the Rogerian facilitative conditions - empathy, positive regard, and genuineness/congruence - would constitute core elements. We further agreed that discrete, relatively nonrelational techniques were not part of our purview, but that a few relational methods would be included. Therapy methods were considered for inclusion if their content, goal, and context were inextricably interwoven into the emergent therapy relationship. We settled on therapist self-disclosure and relational interpretations because these methods are deeply embedded in the interpersonal character of the relationship itself. But which relational techniques to include and which to exclude under the rubric of the therapy relationship bedevilled us, as it has the field.

We unanimously acknowledged the deep synergy between techniques and the relationship. They constantly shape and inform each other. Both clinical experience and research evidence (e.g., Rector, Zuroff, & Segal, 1999; Rounsaville et al., 1987) point to a complex, reciprocal interaction between the interpersonal relationship and the instrumental techniques. The relationship does not exist apart from what the therapist does in terms of technique, and we cannot imagine any techniques that would not have some relational impact. Put differently, techniques and interventions are relational acts (Safran & Muran, 2000).

The research reviews were based on the results of empirical research linking the relationship element to psychotherapy outcome. This definition deliberately included both quantitative and rigorous qualitative studies. Outcome was broadly and inclusively defined, encompassing proximal in-session outcomes as well as distal treatment outcomes. Authors were asked to specify the outcome criteria if a particular study did not employ a typical end-of-treatment measure of symptom or functioning.

### Decision-Making

The Steering Committee's early deliberations were not easy or unanimous. Democracy is messy and inefficient; science is even slower and painstaking. We debated and, in most instances, voted on terminology, on the division of the therapy relationship into manageable parts, and on the minimal criteria for empirical evidence linking a relationship quality to psychotherapy outcome.

How does one divide the indivisible relationship? For example, is support similar enough to positive regard to be combined or is it conceptually and technically distinct enough to deserve a separate chapter and research review? We struggled on how finely to slice the therapy relationship. We agreed, as a group, to place the research on support in the positive regard chapter, but we understand that psychodynamic practitioners may understandably take exception to collapsing these relationship elements. More generally, we opted to divide the research reviews into smaller chunks so that the research conclusions were more specific and the practice implications more concrete.

In our deliberations, several members of the Steering Committee advanced a favourite analogy: the therapy relationship is like a diamond, a diamond composed of multiple, interconnected facets. The diamond is a complex, reciprocal, and multidimensional entity. The Task Force endeavoured to separate and examine many of these facets.

What sort of evidence is sufficient to declare that a relationship element is, in fact, associated to treatment outcome? Some on the Steering Committee wanted to see some true experimental evidence or persuasive, unconfounded lagged correlational evidence that elements of the therapy relationship contribute to treatment outcome. Other members of the Steering Committee scoffed at the value or possibility of such methodological rigor in the area of the therapy relationship where the "variables" cannot be readily controlled or manipulated.

Upon review of the quantity and quality of the empirical research, the Steering Committee characterized the strength of the research on the relationship element as either *demonstrably effective*, *promising and probably effective*, or *insufficient research to judge*. This tripartite categorization emerged from our review of the research; fewer categories would have resulted in crude and incomplete characterizations, and more categories would have accorded more precision than warranted by the findings. Some elements were clearly established as effective on the basis of the size and regularity of supportive studies. Other elements were promising - few studies or lots of conflicting studies or supportive but flawed studies. Still other elements were just tantalizing or preliminary. Accordingly, we christened these as insufficient research to judge. (Of course, these categorizations refer solely to the empirical evidence linking relationship elements and outcome, and not to the "treatability" of patients with specific characteristics.)

In sum, we employed a systematic and stepwise approach to identifying and interpreting the evidence. First, the Steering Committee identified potential relational and matching elements with sufficient empirical research and practical importance. Second, we consulted extant reviews and gathered expert opinions before commissioning chapters on those elements. Third, at least three scholars independently reviewed the evidence as compiled by the chapter authors and provided numerical ratings on six evaluative criteria. Fourth, the Steering Committee reviewed the ratings, deliberated by e-mail, and voted using an expert consensus method. The decisions were made both empirically and consensually - the Steering Committee examined the empirical research and then followed consensus.

These and other decisions were arrived at by expert opinion, professional consensus, and review of the empirical evidence. But these were all human choices - open to cavil, contention, and future revision.

### **Products of the Task Force**

The Division 29 Task Force on Empirically Supported Therapy Relationships has generated three products. First, we have prepared and published a synopsis of our work in this special issue. Second, the entire research reviews and detailed therapeutic practices are being published in a book,

Psychotherapy Relationships that Work (Norcross, 2002). Third, members of the Task Force are presenting a series of addresses, workshops, and symposia on its conclusions and recommendations. Presentations to date have been made at conferences of the American Psychological Association, the Society for Psychotherapy Research, the Society for the Exploration of Psychotherapy Integration, and the International Society for Clinical Psychology.

The goals of these products are identical: to disseminate evidence-based means of improving the therapy relationship and effective means of customizing that relationship to the individual patient. A frequent lament of mental health researchers is that their best research results often remain unused by practitioner and policymakers alike. The dissemination and uptake problem is a genuine concern for us as well. We plan to reach stakeholders by distributing the results in their preferred communication formats. For researchers, a scholarly book and academic presentations. For practitioners, a professional journal and clinical workshops. Our fervent hope is that the Task Force's multiple products and communication formats will increase awareness and use of effective elements of the therapy relationship.

The Task Force and its products would not have been possible without organizational and individual support. Organizationally, the Board of Directors of the American Psychological Association's Division of Psychotherapy approved and funded the Task Force on Empirically Supported Therapy Relationships. Individually, Wade Silverman, the 1999 Division president and *Psychotherapy* editor, was an ongoing source of encouragement and advice. Finally, the Task Force's Steering Committee assisted in canvassing the literature, defining the parameters of the project, organizing the special issue, selecting the contributors, and reviewing early drafts of the articles. The Steering Committee consisted of:

Steven J. Ackerman (student member)  
Lorna Smith Benjamin (University of Utah)  
Larry E. Beutler (University of California - Santa Barbara),  
Charles J. Gelso (University of Maryland)  
Marvin R. Goldfried (SUNY - Stony Brook)  
Clara Hill (University of Maryland)  
Michael J. Lambert (Brigham Young University)  
David E. Orlinsky (University of Chicago)  
Jackson P. Rainer (liaison to Publication Board)

### **Organization of the Special Issue**

This special issue is divided into four parts. Part I consists of this introductory article and a general research summary of the centrality of the therapeutic relationship to treatment outcome. Parts II and III are composed of research summaries on the therapist's relational contributions, those in general (Part II) as well as those on tailoring the therapeutic relationship to individual patients (Part III). Our goal is to identify both relationship elements applied generally in psychotherapy and therapist stances applied to specific circumstances and clients.

All of the articles in Parts II and III are adapted from lengthier chapters that followed guidelines in order to facilitate comprehensiveness, comparison, and ease of reader use. Each article defines the relationship or patient characteristic, provides a clinical example, reviews the empirical research, and highlights therapeutic practices ensuing from the research results.

The order of articles is in approximate rank order of the empirical strength of the research on the respective therapist elements or patient-matching characteristics. In Section II, the alliance is demonstrably effective, with the quality of relational interpretations exhibiting the weakest link with outcomes in the research literature. In Section III, the research results on the effectiveness of matching the therapy relationship to the magnitude of patient's resistance is robust, whereas research on the positive outcome effects of ethnicity- and gender-matching is rare.

Part IV of this issue consists of a single article, coauthored by the Task Force's Steering Committee. It presents the Task Force conclusions, including a list of empirically supported relationship elements, and our practical recommendations, divided into general, practice, training, research, and policy recommendations. The "list" characterizes the relationship elements as demonstrably effective, promising and probably effective, or insufficient research to judge. These decisions were made by the Steering Committee on the strength of the empirical evidence. The evidentiary criteria encompassed the number of supportive studies, the consistency of the research results, the magnitude of the positive relationship between the element and outcome, the directness to outcome, the experimental rigor of the studies, and the external validity of the research base.

### **Limitations of the Task Force**

A single task force can accomplish only so much work and cover only so much content area. As such, the products of the Task Force possess a number of necessary omissions and unfortunate truncations that we wish to publicly acknowledge at the outset.

The products of the Task Force suffer, first, from a series of omissions. We have not systematically reviewed the research evidence pertaining to the therapy relationship in couples and family therapy. Nor have we specifically provided research reviews on the therapy relationship with children or older adults. Research findings from studies with children and older adults have, however, been incorporated into the reviews of the respective therapist behaviours and client characteristics. In addition, we have not and could not canvas every possible therapist relationship behaviour. Three therapist contributions to the relationship not covered are confrontation, credibility, and the provision of a rationale or explanation. One element of relational matchmaking neglected is a limited number of therapy sessions, which clinically seems to impact the therapy relationship.

A converse concern with the Task Force's work is content overlap. We may have cut the "diamond" of the therapy relationship too thin at times, leading to a profusion of highly related and possibly redundant constructs. Goal consensus, for example, correlates highly with parts of the therapeutic alliance, but these are reviewed in separate articles. The stages of change and assimilation of problematic experiences both track the patient's change over the course of therapy; in fact, they were originally planned to appear in the same co-authored article, but it did not functionally come to pass. Thus, to some the content may appear swollen; to others, the Task Force may have failed to make necessary distinctions.

Another lacuna in the Task Force work is that we may have neglected, relatively speaking, the productive contribution of the client to the therapy relationship. We decided not to commission a separate chapter on the client's contributions, and by doing so, we may be understandably accused of an omission akin to the previous error of leaving the relationship out at the expense of technique. The Task Force work tends to be "therapist-centric" in minimizing the client's relational contribution and self-healing processes.

A prominent limitation across the Task Force research reviews is the modest causal connection between the relationship element and treatment outcome. Causal inferences are always difficult to make concerning process variables such as the therapy relationship. Does the relationship cause improvement or simply reflect it? Is the relationship produced by something the therapist does or is it a quality brought to therapy by patients? The interpretation problems of correlational studies (third variables, reverse causation) render such studies less convincing than experiments. It is methodologically difficult to meet the three conditions to make a causal claim: nonspuriousness, covariation between the process variable and the outcome measure, and temporal precedence of the process variable (Feeley, DeRubeis, & Gelfand, 1999). A central limitation of our research base is the failure to convincingly demonstrate causal, as opposed to correlational, linkages between relationship elements and treatment outcomes.

Finally, an interesting drawback to the present work - and psychotherapy research as a whole - is the paucity of attention paid to the disorder-specific and therapy-specific nature of the therapy relationship. It is too early to aggregate the research on how the patient's primary disorder or the type of treatment impacts the therapy relationship, but there are early links. For example, in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study, higher levels of the working alliance were associated with increased retention in supportive-expressive therapy, but in cognitive therapy, higher levels of alliance were associated with decreased retention (Barber et al., 2001). In the treatment of anxiety disorders (GAD and OCD), the specific treatments seem to exhibit many times the effect size than for the therapy relationship, but in depression, the relationship appears more powerful. The therapeutic alliance in the NIMH Treatment of Depression Collaborative Research Program, in both psychotherapy and pharmacotherapy, emerged as the leading force in reducing a patients' depression (Krupnick et al., 1996). The therapeutic relationship probably exhibits more causal impact in some disorders and in some therapies than others. As with research on specific treatments, it may no longer suffice to ask "Does the relationship work?" but "How does the relationship work for this disorder and this therapy"

### **Frequently Asked Questions**

The Division of Psychotherapy's Task Force on Empirically Supported Therapy Relationships has provoked considerable interest and enthusiasm in the professional community. At the same time, it has led to misunderstandings and reservations. I will conclude by addressing frequently asked questions (FAQs) about the Task Force's objectives and results.

*What is the relationship of the APA Division 29 Task Force to the Division 12 Task Force (now the standing Committee on Science and Practice)?*

Questions abound regarding the connection of the Division of Psychotherapy (29) and the Society of Clinical Psychology (12) Task Forces, probably because they are both divisions of the American Psychological Association. Organizationally, the Task Forces are separate creatures, reporting to different divisions. Their respective foci obviously diverge: one looking at therapist contributions to the relationship and patient responsiveness, the other looking at treatment methods for specific disorders. However, they do share several task force members (Paul Crits-Christoph and Larry Beutler), a publisher (Oxford University Press), and goals (to identify and promulgate evidence-based practices) in common.

The aims of the Division of Psychotherapy Task Force and the aims of previous evidence-based initiatives can be conceptualised in three ways. First, the work of the Division of Psychotherapy Task

Force represents a *continuation* of previous efforts in that all attempt to apply psychological science to the identification and promulgation of effective psychotherapy. It is a complementary continuation of the elusive search for evidence-based psychotherapy. Second, the Division of Psychotherapy Task Force constitutes an *expansion* of extant work in that we enlarge the focus to empirically supported therapist behaviours and emergent therapeutic relationships. And third, the Division 29 Task Force represents, in several ways, a *reaction against* previous decision rules that tend to represent psychotherapy as the disembodied, manualized treatment of Axis I disorders

*Are you saying that techniques or methods are immaterial to psychotherapy outcome?*

Absolutely not. The empirical research shows that both the therapy relationship and the treatment method make consistent contributions to treatment outcome. It remains a matter of judgment and methodology on how much each contributes, but there is virtual unanimity that both the relationship and the method (insofar as we can separate them) "work." Looking at either treatment interventions or therapy relationships alone is incomplete. We encourage practitioners and researchers to look at multiple determinants of outcome, particularly client contributions.

*But are you not exaggerating the effects of relationship factors and/or minimizing the effects of treatments in order to set up the importance of your work?*

This may be true, but we think not and hope not. With the guidance of Task Force members and external consultants, we have tried to avoid dichotomies and polarizations. Focusing on one area - the psychotherapy relationship - in the Task Force may unfortunately convey the impression that it is the only area of importance. This is certainly not our intention.

Relationship factors are important, and we need to review the scientific literature and provide clinical recommendations based upon that literature. This can be done without trivializing or degrading the effects of specific treatments.

*What, then, is the association between techniques and therapy relationship?*

We conceive the association broadly and atheoretically. We find any hard and fast distinctions between them untenable. Further, we do not desire to impose any singular theoretical vision of their association upon our colleagues.

For historical and research convenience, we have made distinctions between relationships and techniques. Words like "relating" and "interpersonal behaviour" are generally used to describe *how* therapists and patients behave towards each other. In contrast, terms like "technique" or "intervention" are used to describe what is done in therapy, especially what is done by the therapist. In research and theory, we often treat the how and the what - the relationships and the interventions, the interpersonal and the instrumental - as separate categories. In reality, of course, what one does and how one does it are complementary and inseparable. To separate the interpersonal dimension of behaviour from the instrumental may be acceptable in research, as done in this special issue, but disregarding the connection may be a fatal flaw when the aim is to extrapolate from research results to clinical practice. Thus, while we focus here on important associations between treatment outcome and qualities of the therapist-patient relationship, we never forget that what the therapist does is also influential and inseparable (Orlinsky, 2000).

*Isn't your report just warmed over Carl Rogers?*

No. While Rogers' (1957) facilitative conditions are represented prominently in the research base, they comprise less than 25% of the research we critically review. More fundamentally, we have moved past simplified notions of a limited and invariant set of necessary relationship conditions. Monolithic theories of change and one-size-fits-all therapy relationships are out; tailoring the therapy to the unique patient is in.

*An interpersonal view of psychotherapy seems at odds with what managed care and bean counters ask of me in my clinical practice. How do you reconcile these?*

It is true that the dominant image of psychotherapy today, among both researchers and reimbursers, is as a mental health treatment. This "treatment" or "medical" model inclines people to define process in terms of technique, therapists as providers trained in the application of techniques, treatment in terms of number of contact hours, patients as embodiments of psychiatric disorders, and outcome as the end result of a treatment episode (Orlinsky, 1989).

It is also true that the Task Force members believe this model to be restricted and inaccurate. The psychotherapy enterprise is far more complex and interactive than the linear "Treatment operates on patients to produce effects" (Bohart & Tallman, 1999). We would prefer a broader, integrative model that incorporates the relational and educational features of psychotherapy, one that recognizes both the interpersonal and instrumental components of psychotherapy, one that appreciates the bi-directional process of therapy, and one in which the therapist and patient co-create an optimal process and outcome.

Finally, it is incontestably and sadly true that psychotherapy research to date has exerted a negligible effect on reimbursement decisions.

*Won't these results contribute further to deprofessionalising psychotherapy? Aren't you unwittingly supporting efforts to have any warm, empathic person perform psychotherapy?*

Perhaps some will misuse our conclusions in the way you fear, but that is neither our intent nor commensurate with the research. It trivializes psychotherapy to characterize it as simply "a good relationship with a caring person." The research shows an effective psychotherapist is one who employs specific methods, who offers strong relationships, and who customizes both discrete methods and relationship stances to the individual person and condition. That requires considerable training and experience; the antithesis of "anyone can do psychotherapy."

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

Relational flexibility conjures up many concerns, but two of particular import in this question: the limits of human capacity and the possibility of capricious posturing (Norcross & Beutler, 1997). Although the psychotherapist can, with training and experience, learn to relate in a number of different ways, there are limits to our human capacity to modify relationship stances.

Can one authentically differ from one's preferred or habitual style of relating? There is meager research on this question. What does exist suggests that experienced therapists are capable of more malleability and "mood transcendence" than might be expected. In Gurman's (1973) research, for example, expert therapists appeared to be less handicapped by their own "bad moods" than were their less skilled peers. From the literature on the cognitive psychology of expertise, Schacht (1991) affirms that experienced psychotherapists are disciplined improvisationalists who have stronger self-regulating skills and more

flexible repertoires than novices. The research on the therapist's level of experience suggests that experience begets heightened attention to the client (less self-preoccupation), an innovative perspective, and in general, more endorsement of an "eclectic" orientation predicated on client need (Auerbach & Johnson, 1977). Indeed, several research studies (see Beutler, Machado, & Neufeldt, 1994) have demonstrated that therapists can consistently use different treatment models in a discriminative fashion.

The question of whether they can shift back and forth among different relationship styles for a given case is still unanswered. We expect, however, that this is possible. When doing so, we caution therapists to be careful that the blending of stances and strategies does not deteriorate into play-acting or capricious posturing.

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

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

*Are these intended as practice standards?*

No. These are research-based conclusions that can lead, inform, and guide practitioners toward evidence-based therapy relationships and responsiveness to patient needs. They are not intended as legal, ethical, or professional mandates. As we state in the Conclusions: "The preceding conclusions do not by themselves constitute a set of practice standards, but represent current scientific knowledge to be understood and applied in the context of all the clinical data available in each case."

*Well, aren't these the official positions of the Division of Psychotherapy or the American Psychological Association?*

No. Neither is true.

*Isn't it premature to launch a set of research-based conclusions on the therapy relationship and patient matching?*

Science is not a set of answers. Science is a series of processes and steps by which we arrive closer and closer to elusive answers. Considerable research over the past three decades has been conducted on both the general elements of the therapy relationship and the particular means of adapting it to individual patients. It is premature to proffer the last word or the definitive conclusion; however, it is time to codify and disseminate what we do know. We look forward to regular updates on our conclusions.

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

Precisely. And the Task Force products show specifically how to do so on the basis of the empirical research.

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