Psychotherapy Relationships & Treatment Adaptations That Work: Evidence-Based Responsiveness

John C. Norcross, PhD
Clinical experience and controlled research consistently demonstrate that the therapy relationship accounts for as much outcome as the particular treatment method. This keynote address will review the meta-analytic research and clinical practices compiled by an interdivisional APA task force on (1) effective elements of the therapy relationship, (2) effective means of adapting treatment to the individual patient, and (3) discredited relationship behaviors. Discover how research and practice converge in relational responsiveness that demonstrably improves treatment efficacy and efficiency.
Learning Objectives

1. Apply at least 3 therapist relational behaviors that improve the effectiveness of psychotherapy
2. Describe 3 patient matching dimensions that enhance treatment outcomes
3. Avoid the use of discredited relationship behaviors that contribute to dropout and failure
International Juggernaut of EBP

♦ Effort to base clinical practice on robust, primarily research, evidence
♦ IOM definition: Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.
♦ Response to clarion call for accountability
♦ Demands for EBPs are here to stay and will escalate in future
Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

www.apa.org/practice/ebp.html or May 2006 American Psychologist
Patient Characteristics, Culture, & Prefs

Clinical Expertise

Best Available Research

EBP Decisions
EBPs have profound implications for practice, training, research, and policy.

No one is arguing for the converse (non-evidence based practices).

What is privileged as “evidence-based” will determine, in large part, what treatment is conducted, what is taught, what is funded.

EBPs are noble in intent, but ripe for misuse and abuse.
Fundamental Questions

♦ EBPs are wrapped in methodological, clinical, and epistemological issues that cannot be ignored

♦ A truly evidence-based approach demands that we examine and follow the evidence, even if it is critical of certain EBP initiatives

♦ Does EBP map well onto psychotherapy?
Thought Experiments

What accounts for the success of psychotherapy?

What accounts for the success of your personal therapy?
Many things account for success

Including the patient, the therapist, their relationship, the treatment method, and the context

But when pressed, approx 90% of you will answer “the relationship”
What’s Missing from EBPs?

◆ The person of the therapist
◆ The patient’s (transdiagnostic) characteristics
◆ The therapy relationship

Do treatments cure disorders, or do relationships heal people?
Aims of EBRs

1. Identify elements of effective therapy relationships
2. Identify effective methods to tailor or adapt therapy to the individual patient
3. Identify ineffective relationship behaviors
Two Iterations of EBRs

Task Force I: sponsored by APA Division of Psychotherapy (2000 – 2002); combo of literature reviews and meta-analyses

Task Force II: jointly sponsored by APA Division of Clinical Psychology and Division of Psychotherapy (2009 – 2011); only meta-analyses
PSYCHOTHERAPY RELATIONSHIPS THAT WORK

EVIDENCE-BASED RESPONSIVENESS

SECOND EDITION

EDITED BY

JOHN C. NORCROSS

SAMHSA's National Registry of Evidence-based Programs and Practices

NREPP
Evaluation Criteria

- Number of empirical studies
- Consistency of empirical results
- Independence of supportive studies
- Magnitude of association between the relationship element and outcome
- Evidence for causal link between relationship element and outcome
- Ecological or external validity of research
## Primer on Effect Size (ES)

<table>
<thead>
<tr>
<th>$d$</th>
<th>Cohen’s Standard</th>
<th>Type of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.90</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.80</td>
<td><strong>Large</strong></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.70</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.60</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.50</td>
<td><strong>Medium</strong></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.40</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.30</td>
<td></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.20</td>
<td><strong>Small</strong></td>
<td>Beneficial</td>
</tr>
<tr>
<td>.10</td>
<td></td>
<td>No effect</td>
</tr>
<tr>
<td>.00</td>
<td></td>
<td>No effect</td>
</tr>
</tbody>
</table>
Conclusions

✧ The therapy relationship makes substantial & consistent contributions to outcome independent of the type of tx

✧ Practice and treatment guidelines should address therapist behaviors and qualities that promote the therapy relationship

✧ Efforts to promulgate best practices or EBPs without the relationship are seriously incomplete and potentially misleading
Conclusions II

♦ The relationship acts in concert with tx methods, patient chars, & clinician qualities in determining effectiveness

♦ Adapting or tailoring the relationship to patient characteristics (in addition to diagnosis) enhances effectiveness

♦ These conclusions do *not* constitute practice standards
What Works in General
(therapist behaviors; associations with treatment outcomes reported as $r$ but converted to $d$)
Effective Elements of Therapy Relationship

- Alliance in Adult Individual Therapy
- Alliance in Youth Therapy
- Alliance in Family Therapy
- Cohesion in Group Therapy
- Empathy
- Collecting Client Feedback
- Goal Consensus
- Collaboration
- Positive Regard/Support
Alliance in Individual Therapy
(Horvath, Del Re, Flückiger, & Symonds)

- Quality and strength of the collaborative relationship (bond, goals, tasks)
- Alliance ≠ relationship
- Across 201 adult studies (≈ 14,000 patients), median $d$ between alliance and tx outcome = .57, a medium but very robust association
- Medium effect, but average $d$ for psychotherapy vs. no treatment is .80
Complicated by developmental considerations

Across 29 studies of child & adolescent therapy ($N = 2,202$ clients and $892$ parents), the mean $d$ between the alliance and tx outcome $= .39$

Strength of alliance–outcome relation did not vary with type of treatment

Therapist-youth & therapist-parent alliance showed same association of .39 with outcome
Alliance in Family Therapy
(Friedlander, Escudero, Heatherington, & Diamond)

♦ Multiple alliances interact systemically
♦ On individual level (self-with-therapist) as well as group level (couple-with-therapist)
♦ Across 24 studies (7 couple, 17 family, \( N = 1,461 \)), average \( d \) between alliance and tx outcome = .53
♦ Similar \( d \) for couple therapy and family therapy
Cohesion in Group Therapy
(Burlingame, McClendon, & Alonso)

♦ Parallel of alliance in individual therapy
♦ Refers to the forces that cause members to remain in the group, a sticking-togetherness
♦ Meta-analysis \((k = 40, N = 3,323)\) found \(d = .52\) between group cohesion and tx outcome
♦ Leaders with interpersonal orientation evidenced the highest ES \((d > 1.0)\) in cohesion-outcome link
Empathy
( Elliot, Bohart, Watson, & Greenberg)

♦ Therapist’s sensitive understanding of client’s feelings and struggles from client’s view
♦ Meta-analysis of 57 studies (224 effects, $N = 3,599$), mean $d$ of .60 between empathy-outcome
♦ Slightly higher ES for CBT than for person-centered or psychodynamic
♦ Among highest effect size in the relationship (9% of outcome variance)
♦ Favor the client’s perspective
Collecting Client Feedback
(Lambert & Shimokawa)

The Process: Inquire directly about client’s progress; compare those data to benchmarks; provide that feedback immediately to therapist; address explicitly with client in-session.

The Research: Meta-analysis of 9 RCTs (6 using OQ, 3 using PCOMS) shows its use associated $d = .49 - .70$ with tx outcome and reduces by about half the chances of at-risk patients experiencing deterioration.
Goal Consensus & Collaboration
(Tyron & Winograd)

- Frequently but not necessarily part of alliance measures
- Meta-analysis of 19 recent studies ($N \approx 2,260$) on collaboration: $d$ of .70 with tx outcome
- Meta-analysis of 15 recent studies ($N \approx 1,300$) on goal consensus: $d$ of .72 with tx outcome
- Either accounts for 10% of outcome variance
Positive Regard/Support
(Farber & Doolin)

♦ “it means a 'prizing' of the person...it means a caring for the client as a separate person”
♦ Meta-analysis of 18 rigorous studies (1,067 patients): mean $d = .57$ (moderate effect)
♦ Patient’s rating proves best predictor of tx outcome; use the patient’s perspective
♦ Positive regard evinces higher ES with racial/ethnic minority clients
Promising but Insufficient Research to Judge

- Congruence/Genuineness
- Repairing Alliance Ruptures
- Managing Countertransference
Congruence/Genuineness
(Kolden, Klein, Wang, & Austin)

- Probably the most fundamental of Roger’s facilitative conditions, but most studies riddled with inadequate methods and small Ns
- Nonetheless, a meta-analysis of 16 studies (N = 863 patients) yielded a mean $d$ of .48 for the congruence-outcome association
- Higher ESs obtained for group therapy and older, more experienced therapists
Repairing Alliance Ruptures
(Safran, Muran, & Eubanks-Carter)

♦ Most patients experience a breakdown in alliance but most do not tell us about ruptures unless asked
♦ In 3 studies, the relation of rupture-repair episodes with treatment outcome = .48
♦ In 8 studies, training in rupture resolution improved outcomes ($d = .52$ vs no training)
♦ Repairs facilitated by therapist responding non-defensively, attending directly to relationship, adjusting behavior, & collecting feedback
Managing Countertransference
(Hayes, Gelso, & Hummel)

♦ Research confounded by small number of quant studies and disparate definitions of CT

♦ Meta-analysis of 10 studies shows $d = -0.32$ between CT and therapy outcomes

♦ In 7 studies, mean $d = 1.2$ between CT management and therapy outcome

♦ Successful CT management entails: self-insight, self-integration, anxiety management, empathy, and conceptualizing ability
Are There Others?

♦ You bet!
♦ We have neither completed the search nor exhausted the relationship behaviors associated with therapy success
♦ One example is therapist humor: non-aggressive, joining, defusing, laughter
♦ Insufficient controlled research to draw conclusions at this juncture
Limitations

- Content overlap among elements
- Patient’s contribution to the relationship
- Impossibility of causal conclusions – the M&M question (except for collecting feedback & repairing ruptures)
Decades of research and experience converge: the relationship works!

These effect sizes concretely translate into healthier and happier people.

To repeat: The therapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment.

But not the only thing that works.
What Works in Particular

(responsiveness/adaptations; experimental studies with outcomes reported as $d$)
What Every Clinician Knows

- No treatment works for all patients; what works for one patient may not work for another
- Paul's 1967 iconic question: *What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem?
- Only matching psychotherapy to a disorder is incomplete and not always effective
- Adapt or match to the transdiagnostic features of the individual patient and the singular context
Adapting/Tailoring Psychotherapy

- What works for specific patients; different strokes for different folks
- Call it adaptation, responsiveness, customizing, attunement, tailoring, matchmaking, prescriptive, individualizing
- Create a new therapy for each patient
- Tailor to the *particulars* of the patient according to the *general* research evidence
“It is much more important to know what sort of a patient has a disease than what sort of disease a patient has.”
Effective Means of Adapting the Relationship

- Reactance Level
- Culture
- Preferences
- Religion/Spirituality
- Stages of Change
- Coping Style
Reactance Level

(Beutler et al.)

- Refers to being easily provoked & responding oppositionally to external demands
- Meta-analysis of 12 select studies ($N = 1,102$) reveals large ES ($d = .82$) for matching therapist directiveness to patient reactance
- High-reactance patients benefit more from self-control methods, minimal direction, & paradoxical interventions
- Low-reactance clients benefit more from therapist directiveness and explicit guidance
Culture
(Smith, Rodríguez, & Bernal)

♦ Meta-analysis of 65 studies \((N = 8,620)\) evaluated the impact of culturally adapted txs vs. traditional (non-adapted) txs

♦ \(d = .46\) in favor of clients receiving culturally adapted treatments; “cultural fit” works

♦ Most frequent methods of adaptation: 84% incorporated cultural content/values, 75% used clients’ preferred language, 53% matched clients with therapists of similar ethnicity/race
Adapting to Culture

Elements of culturally adapted treatments

♦ language       ♦ client attributes
♦ metaphors      ♦ content
♦ concepts       ♦ goals
♦ methods        ♦ context

*Source*: Bernal & Sáez, 2006
Preferences
(Swift, Callahan, & Vollmer)

- Meta-analysis of 35 studies comparing outcomes of clients matched vs. non-matched to their preferences
- $d = .31$ in favor of clients matched to their tx, role, and therapist preferences
- Patients receiving preferences were a third less likely to drop out of tx prematurely ($OR = .59$)
- Treatment method, relationship style, therapist characteristics, tx length, etc.
- Inquire what client desires and what despises
3 Important Matching Caveats

♦ Accommodate *strong* preferences whenever possible

♦ Conduct all therapy in client’s native language if other than English (2X as effective as tx conducted in English)

♦ Target therapy to a specific cultural group instead of groups consisting of clients from various cultural backgrounds
Religion/Spirituality
(Worthington et al.)

♦ In 29 studies ($N = 3,290$), patients in R/S txs showed greater improvement than those in alternate secular psychotherapies on both psych ($d = .26$) and spiritual ($d = .41$) outcomes.

♦ In 11 rigorous dismantling designs, in which R/S and alternate txs shared same theoretical orientation and tx duration, no difference in psych outcomes but differences in spiritual outcomes ($d = .33$) favoring R/S therapies.
Stages of Change
(Norcross, Krebs, & Prochaska)

- Precontemplation, contemplation, preparation, action, & maintenance
- Meta-analysis of 47 studies: \( d = 0.70 - 0.80 \) for different change processes in different stages
- Stages reliably predict psychotherapy outcomes \((k = 39, N = 8,238, \ d = 0.46)\)
- Therapist optimal stance also varies with stage of change: Nurturing parent, a Socratic teacher, experienced coach, a consultant
Integration of Psychotherapy Systems within Stages of Change

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Precontemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Motivational interviewing</td>
<td></td>
<td></td>
<td>Behavior therapy, EMDR and exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Adlerian therapy</td>
<td>Rational-emotive behavior therapy, Cognitive therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sullivanian therapy</td>
<td>Transactional analysis</td>
<td></td>
<td>Interpersonal therapy (IPT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategic therapy</td>
<td>Bowenian therapy</td>
<td></td>
<td>Structural therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic therapy</td>
<td>Existential therapy</td>
<td></td>
<td>Gestalt therapy</td>
<td></td>
</tr>
</tbody>
</table>
Coping Style
(Beutler, Harwood, et al.)

- Habitual, enduring pattern: Externalizing vs. internalizing

- Meta-analysis indicates medium effect sizes ($d = .55$) for matching therapist method to patient coping style ($k = 12, N = 1,291$ patients)

- Interpersonal & insight-oriented txs more effective among internalizing patients

- Symptom-focused & skill-building txs more effective among externalizing patients
Promising but Insufficient Research to Judge

♦ Attachment Style
♦ Expectations
Attachment Style

(Levy et al.)

♦ In 14 studies involving 1,467 patients, relation between attachment anxiety and treatment outcome $d = -.46$

♦ Relation between attachment avoidance and tx outcome $d = -.03$. Nada

♦ Relation between attachment security and tx outcome $d = .37$

♦ Only a couple of matching studies
In 46 studies ($N = 8,016$), patient expectations for successful therapy were routinely associated with better tx outcomes $d = .24$

Therapist behaviors can cultivate positive expectancies both at pre-treatment and during the course of therapy

Pretreatment socialization and role inductions generally successful, but not many controlled studies

Expectations

(Constantino, Glass, Arnkoff, et al.)
Research Does Not Support

Routine matching of therapist-patient on

- Gender
- Ethnicity
- Religion/Spirituality

unless client expresses strong preference
Limitations

- Causal conclusions but possibility of investigator allegiance
- Probable overlap between matching dimensions (e.g., stages and reactance, culture and preferences)
Responsiveness Works!

♦ Amid torrent of meta-analytic statistics, take a mindful moment to consider implications
♦ Adapting therapy to the entire person improves success and decreases dropouts
♦ The power of responsiveness exceeds that associated with Tx Method A for Disorder Z
♦ Not clinical lore but established fact!
Let’s Get Geeky

Typical ES of 0 to .20 when there is a difference between tx methods
Typical ESs for the therapy relationship and responsiveness/adaptations
What *Doesn’t* Work
Discredited Relationships

♦ Progress by simultaneously using what works and avoiding what does not work

♦ Avoiding psychoquackery requires consensus on discredited practices

♦ Could simply reverse what works (e.g., authoritarian, unempathic, nonsupportive)

♦ Reviews of research literature and series of Delphi polls of experts
“Why Not Rely on RCTs?”

- Because most of these txs have not (& will not) be subjected to controlled research
- Bc of difficulty of “proving” the null hypothesis (no diff between tx and placebo)
- Bc there are few bona fide comparisons of alternative txs (most RCTs involve sham comparisons +/- researcher allegiance)
- Bc lack of consensual criteria for discredited or ineffective treatments
Examples of Probably Discredited

♦ **Treatments**: Orgone box, alien abduction, pyramids, past lives therapy, future lives therapy, rebirthing, primal scream, scared straight, DARE program

♦ **Tests**: Bender-Gestalt for neuropsych impairment, handwriting analysis (graphology), Luscher Color Test, Szondi, Blacky Test
Discredited Relationship Behaviors in Psychotherapy

- Confrontations (style, *not* content)
- Frequent interpretations
- Negative processes (e.g., hostile, blaming, pejorative, rejecting)
- Assumptions
- Therapist-centricity
- Ostrich behavior re: early ruptures
Coming Full Circle
Which Therapy Works Best?

♦ It depends!
♦ It depends on the therapy relationship at least as much as a particular method
♦ It depends in particular on the client
♦ Both diagnostic and nondiagnostic features
A Sea Change in Psychotherapy

Not What is my preferred theoretical orientation or treasured proficiency?

But What therapeutic approach best suits this particular client in this context?
Practice Recommendations

♦ Make the creation and cultivation of a therapy relationship a primary aim
♦ Adapt the relationship to patient chars in the ways shown to enhance outcome
♦ Routinely monitor patients’ responses to the therapy relationship and ongoing tx
♦ Concurrent use of EBRs and EBTs tailored to patient likely to generate best outcomes
Training Recommendations

♦ Training programs are encouraged to provide explicit and competency-based training in effective relationships

♦ Accreditation bodies are encouraged to develop criteria for assessing training in ESRs in their evaluation process

(Educating the mind without educating the heart is no education at all. – Aristotle)
Be a Scientist-Practitioner: Look at ALL of the Evidence

✓ Cultivate the therapy relationship
✓ Adapt/tailor tx to individual patient and context
✓ Simultaneously use (inclusively defined) EBPs and avoid (consensually identified) discredited practices
When We Successfully Do So

Ψ reclaim “psychology” in psychotherapy
Ψ transcend the limited and divisive “diagnosis only” approach to EBP
Ψ narrow the gap between research and practice
Ψ embrace the clinical reality that different patients respond differently
Ψ rediscover the individual differences that distinguish our field
Ψ we become even more effective!
References I


References II

References III


