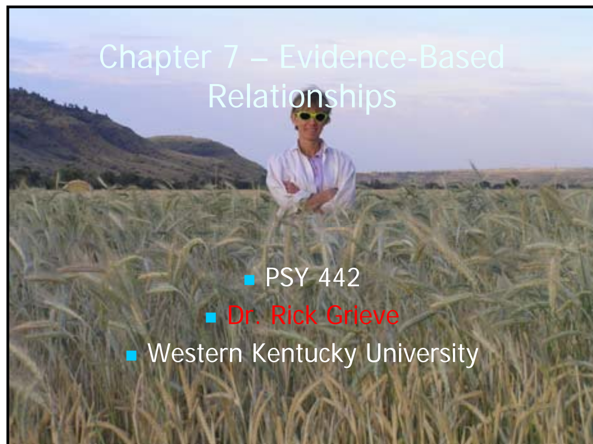
Chapter 7 – Evidence-Based Relationships
PSY 442
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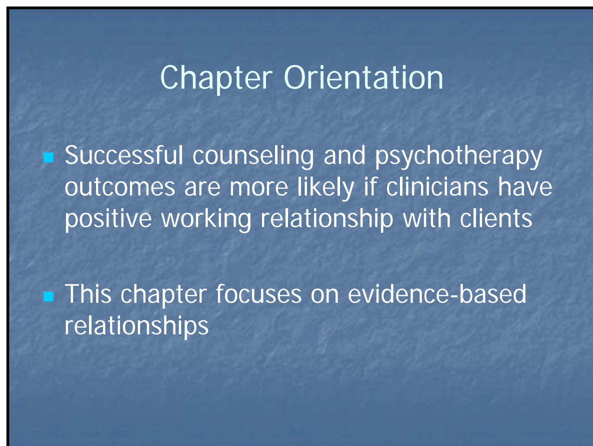
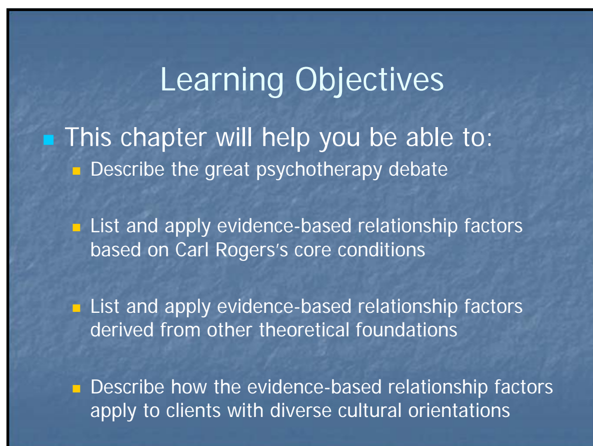

Chapter Orientation
Successful counseling and psychotherapy outcomes are more likely if clinicians have positive working relationship with clients
This chapter focuses on evidence-based relationships


Learning Objectives
This chapter will help you be able to:
Describe the great psychotherapy debate
List and apply evidence-based relationship factors based on Carl Rogers's core conditions
List and apply evidence-based relationship factors derived from other theoretical foundations
Describe how the evidence-based relationship factors apply to clients with diverse cultural orientations

The Great Psychotherapy Debate

- The Great Psychotherapy Debate is an argument about whether empirically supported treatments or evidence-based relationships are most important
  - Where do you find yourself in this debate?
  - Is there a place in the middle?

The Core Conditions

- Carl Rogers identified 3 conditions that were "necessary and sufficient" for positive therapeutic change
  - Congruence
  - Unconditional Positive Regard
  - Accurate Empathy

Congruence

- Clinicians should be honest, spontaneous, and real
- Congruence doesn't mean you say whatever you want to say
- It's important to examine your motives when using congruence
- Congruence contributes to positive outcomes

Unconditional Positive Regard

- UPR involves warm regard and respect for clients
- UPR is conveyed not so much by what you say, but by how you say it
- UPR is associated with positive outcomes
- What are some of the ways therapists can communicate congruence?

Unconditional Positive Regard II

- Get into small groups
- Discuss Case Example 7.2: *Intermittent Unconditional Positive Regard and Parallel Process*
  - How can you watch for your lapses in positive regard?
  - How can you watch for parallel process?

Empathic Understanding

- Empathy is perhaps the most central of all therapy-related concepts
- Empathy includes: (a) emotional stimulation; (b) perspective-taking; and (c) emotional regulation
- Empathy has a robust effect on treatment outcomes

Empathic Understanding II

- Rogers's definition includes:
  - Therapist ability or skill
  - Therapist attitude or willingness
  - A focus on client thoughts, feelings, struggles
  - Adopting the client's frame of reference
  - Entering the client's private perceptual world
  - Moment-to-moment sensitivity to felt meanings
  - Sensing meanings of which clients are barely aware

Empathic Understanding III

- Empathy and Neuroscience; it likely involves:
  - Bilateral dorsomedial thalamus, insula, oxytocin
  - Prefrontal and temporal cortices
  - Orbitofrontal cortex and prefrontal and right inferior parietal cortices
  - And more . . .

Other Evidence-Based Relationship Concepts

- Transference
- Countertransference
- Working Alliance
- Repairing Relationship (Alliance) Ruptures
- Therapist Modeling
- Mutuality and Mutual Empathy

Transference

- Transference feels inappropriate and can be abstract, vague, and elusive
- It can be positive or negative
- It's like putting an old map on a new terrain
- It helps you glimpse a client's early relationship dynamics
- There's empirical support for focusing on transference in therapy

Countertransference (CT)

- CT is similar to transference, but involves clinicians projecting their issues onto clients
- Freud thought CT was always bad, but contemporary therapists see it as potentially informative
- There's evidence that not addressing CT can adversely affect treatment outcomes

Countertransference (CT) II

- Forms of CT
  - Classical: Freud's view. This CT is negative and should be "overcome"
  - Totalistic: Refers to all reactions therapists to clients; used to enhance therapy
  - Complementary: Emanates from specific client interaction patterns that "pull" therapists to respond in ways that others (outside therapy) respond to the client
  - Relational: Constructed from the combination of the unmet client and therapist needs

5 Minute Reflection

- Get with a partner or small group and discuss the concepts of transference and CT. Especially discuss people who are most likely to trigger your CT reactions.
- Report any insights you have back to the class

The Working Alliance (WA)

- The WA has three main components:
  - Goal consensus
  - Collaboration on tasks
  - Emotional bonding

The Working Alliance (WA) II

- When clinicians explicitly solicit feedback from clients on therapy progress (i.e., progress monitoring), both the working alliance and treatment outcomes improve
- Evidence strongly supports the positive influence of the working alliance on treatment outcomes

The Working Alliance (WA) III

- Recommendations:
  - Use role induction early
  - Ask clients what they want from the interview
  - Engage in collaborative goal-setting
  - Solicit feedback from clients
  - Respond to client anger with acceptance

Repairing Relationship (Alliance) Ruptures

- Relationship ruptures are defined as tensions or breakdowns in the clinician-client collaborative relationship (Safran & Muran)
- From a CBT perspective, Newman (2013) wrote:
  - "The importance of the therapist's competency in managing strains or ruptures in the therapeutic relationship cannot be overstated" (p. 57).

Repairing Relationship (Alliance) Ruptures II

- Rupture repair episodes are significantly associated with positive outcomes
- Rupture repair training is also linked to client improvements
- Two rupture types:
  - Withdrawal ruptures
  - Confrontation ruptures

Repairing Relationship (Alliance) Ruptures III

- Activity:
  - Review the rupture repair guidelines
  - Practice some of the wording
  - Make up your own words to capture the messages underlying rupture repair
  - Repeat
  - Report in

Therapist Modeling

- Modeling can also be viewed as identification and internalization
- When clinicians are positive, respectful, and reflective people with whom clients can identify and/or imitate, it contributes to positive outcomes.

Mutuality and Mutual Empathy

- Mutuality refers to a sharing process; it means power, decision making, goal selection, and learning are shared.
- Mutual empathy is defined as clients seeing-experiencing-knowing their emotional effect on their clinicians within a safe environment
- Can you imagine letting clients see your emotional responses? Discuss this.

Evidence-Based Multicultural Relationships

- Morales and Norcross (2010) wrote:
  - ". . . clinical practice without attending to culture cannot be characterized as EBP" (p. 824).
- But there's not much research to guide specific interviewer behaviors
- Discuss the guidelines at the end of Chapter 7