

What works in counselling and psychotherapy relationships

Good Practice across the Counselling Professions 004

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Context

This resource is one of a suite commissioned by BACP to enable members, and other counselling and psychotherapy professionals to develop evidence-based good practice.

Using Good Practice across the Counselling Professions resources

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*.

The Good Practice across the Counselling Professions resources are not contractually binding on members but are intended to support practitioners by providing information on specific fields of work including good practice principles and policy applicable at the time of publication.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends discussion of practice dilemmas with a supervisor and/or consulting a suitably qualified and experienced legal or other relevant practitioner.

In this resource, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy.

The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

Introduction

Counselling and psychotherapy are specialised ways of listening, responding and building boundaried relationships to enhance clients' emotional and psychological wellbeing. Research and practice that isolates therapeutic methods from the relationship have been shown to be ineffective (Norcross et al., 2019). This has fuelled a divide (Reeves, 2012) between medicalised and relational models, and has generated evidence-based guidance that is inaccurate, misleading and divisive in its promotion of particular therapies over others (Norcross and Lambert, 2019).

This resource aims to provide a narrative overview of the most recent research, contextualise and highlight key elements of effective therapeutic practice with a focus on relational aspects (Norcross et al., 2019). It aims to help therapists develop effective research informed practice, to build common ground between therapy models, promote collaborative practice and help to develop a unifying, pluralistic perspective within the profession.

1 Current landscape

Medicalised models of counselling practice have been perpetuated through the use of diagnosis, medical language (e.g. symptoms, disorders, illness, treatment) and targeted interventions (Johnstone, et al., 2018), alongside a steady increase in the prescribing of mental health medication (Iacobucci, 2019). Many relational therapies that are incompatible with a positivist medical paradigm have been excluded. For example, the National Institute for Health and Care Excellence guideline for Eating Disorders (2017) assessment guidance effectively excludes models that have a fundamental conflict with diagnosis, case formulation and treatment predictors (Gillon, 2013).

Significant concern has been raised about lack of validity with psychological diagnosis; bodies that have highlighted this include the United Nations Human Rights Council (2017), The Critical Psychiatry Network (2013), and the British Psychological Society (2014).

More substantial criticism suggests that the DSM-5 is 'totally wrong, an absolute scientific nightmare' (Johnstone et al., 2018, p.12) whilst the DSM-5 (2013) taskforce has explicitly admitted to fundamental issues with its own diagnostic criteria (ibid). A growing body of research evidence (Johnstone et al., 2018) is influencing a significant shift in the field, as set out in the British Psychological Society's Division of Clinical Psychology (DCP) position statement:

'there is a need for a paradigm shift...towards a conceptual system not based on a "disease" model'. (DCP, 2013, p1).

Positioning therapy towards a more relational conceptualisation, regardless of therapeutic model is appropriate because as social beings:

'our relationships shape all aspects of our experience and behaviour, including "healing from distress"' (Johnstone et al., 2018, p.73).

If relationship is key to therapeutic effectiveness, what is needed is a focus on creating evidence-based guidance on the behaviours that cultivate it (Norcross et al., 2019). Identifying elements or ingredients of effective therapeutic relationships can help inform a genuinely transtheoretical and pluralistic perspective of good practice, that is inclusive of 'the whole scope of therapeutic understandings and methods, including pure form, integrative and eclectic' (Cooper, 2019 p.4).

2 Research

Research findings can be 'something we are in awe of and too afraid to question... [they] can also be like good friends: something that can encourage, advise, stimulate and help us.' (Johnstone et al., 2018). But research has recently become controversial, partly due to flaws in how science is applied to counselling (Dalal, 2018). For example, using a rating scale may trick us into believing that we are objectively measuring feelings, but the idea that feelings can 'be measured by asking people or by monitoring their brains' (Layard, 2005. p.6) '...is quite untrue' (Dalal, 2019. p.22).

Research that compares one approach to another and isolates techniques from relationship is also misleading (Norcross et al., 2019). Substantial research analyses show that technique and approach make little difference to outcomes and effectiveness (Cooper, 2008, Norcross et al., 2019).

So, if technique and approach are not influential factors in themselves, which factors are? Essentially, research shows that two of the most influential factors in effective therapy are relationship quality and therapist skill in creating it (Norcross & Lambert, 2019, p.6-7). Therefore, the need for practitioners to pay attention to relational factors is evident.

3 The therapeutic relationship

Research evidence shows it is the relationship that heals, and it is also the context through which therapy is experienced. For example, if you ask a child to clean their room, the outcome will likely depend on whether your relationship is warm and caring, on the child's motivation, and overall context (Norcross and Lambert, 2019 p.4). Similarly, a client's response may be affected by whether the therapeutic relationship is warm and caring, or cold and judgmental. Therapy is a complex reciprocal relationship, and context is important, with client factors such as motivation and mood also impacting on their responses.

The development and maintenance of the therapeutic relationship will vary in terminology, meaning, and interpretation according to different approaches. For example, the *therapeutic alliance* (also called the working alliance or alliance) is one conceptualisation of the therapeutic relationship. Generally accepted as transtheoretical, its ingredients include warmth, empathy, respect, and genuineness (Norcross and Lambert, 2019; Cooper, 2008).

A rich body of research shows that a stronger alliance is associated with better outcomes (Norcross and Lambert, 2019). Consisting of three components;

- Agreement between therapist and client on therapeutic goals
- Agreement on therapeutic tasks
- The bond developed between them (Bordin, 1975).

The *real relationship* is also a conceptualisation of the therapeutic relationship. A psychoanalytic concept, it has two elements; *genuineness*, and *realism*, which refer to both therapist and client and how they perceive and relate to each other (Gelso et al., 2019). The real relationship describes the authentic and congruent relating between client and therapist. It is undistorted by transference material and experienced *realistically* (Gelso et al., 2019) rather than as a projection of past conflicts, conditions of worth, dysfunctional schemas, or distortions.

Regardless of approach and conceptualisation, developing an effective therapeutic relationship takes skill and understanding. Therapists possessing certain qualities or taking particular actions can positively influence its development.

Factors contributing to the therapeutic relationship and effectiveness (Norcross et al., 2019) include:

- Client factors
- Therapist factors
- Therapy methods; technique, interventions or approach.

3.1 Client factors

A large influence on the effectiveness of therapy comes from client contributions. Estimates vary from 30% (Norcross and Lambert, 2019) to 75% when clients' attitudes and expectations are taken into account (Cooper, 2018).

Influencing factors also include context and events that happen outside of therapy. For example, a motivated, emotionally robust client with strong support is more likely to have a positive therapeutic outcome compared to a client with long-term depression, low motivation and no external support.

3.2 Therapist factors

Therapist contributions are a substantial influence and include elements such as charisma and warmth.

Experience is also a factor, evidence suggests some therapists are more competent than others, and that more experienced, psychologically robust therapists tend to have better outcomes (Norcross et al., 2019; Cooper, 2008).

Even when self-help interventions have little therapist contact, relationship factors such as warmth, still make a measurable difference to outcomes (Norcross et al., 2019).

3.3 Techniques and approaches

The evidence shows that formulaic application of 'one size fits all' (Norcross and Wampold, 2019, p.5) therapy models is unhelpful and that no single approach or intervention is effective for all clients and situations (Norcross et al., 2019). Different clients need different things at different times, and individualising therapy to each client has the greatest positive effect on outcomes (ibid). Methods do also matter and increasingly so with more distressed clients (Norcross et al., 2019, p.3), but individualising and collaboration are key.

The evidence shows that all bona fide approaches are roughly equivalent in effectiveness (Cooper, 2008, p.52), and that therapists with good relationship building skills have better outcomes, regardless of modality (Norcross et al., 2019). Therefore, a key focus on relational aspects is essential to good practice.

4 Common ground

All effective therapists and therapy models share a number of common features or ingredients, for example empathy (Norcross et al., 2019). Identifying these can help to conceptualise similarities and differences between approaches and can also help to analyse specific segments of therapy such as contracting, or ruptures.

Some 'ingredients' describe therapist qualities or behaviours, whilst others relate to factors or influences contributed by the client, although both are undoubtedly intertwined. Although terms used may vary, or may be specific to a particular theory, the essential ingredients and definitions described here are common across all modalities.

5 Ingredients

5.1 Relating to therapist factors

5.1.1 Collaboration and goal consensus

Definition: Collaboration is the active, respectful, co-operative process of client and therapist working together to identify and achieve therapeutic goals.

Definition: Goal consensus describes the explicit agreement between client and therapist on the aims of therapy.

Goal consensus and collaboration help improve therapeutic outcomes (Shick Tryon et al., 2019). Active collaboration empowers clients, it illustrates the need for direct communication about therapy with clients (Levitt et al., 2016. Also see Commitments 3c and 3d) and is crucial to effective therapy.

Differences exist between approaches, for example CBT may be explicitly goal oriented, whilst narrative or psychodynamic therapy are process orientated. In non-directive therapies such as humanistic, collaboration may be seen as a deeply fundamental principle of a co-created therapeutic relationship, whereas a CBT therapist might see collaboration as one aspect of therapy. However, regardless of therapeutic approach, explicit discussion is key to good practice.

5.1.2 Empathy

Definition: Having a felt sense and understanding of a client's thoughts, feelings, experience and meaning from the client's perspective.

Empathy is a foundational ingredient of effective therapy, consistent across all modalities, and client levels of distress (Elliot et al. in Norcross and Lambert, 2019). Person-centred therapy regards empathy as an active *communicative attunement* to a client's moment-by-moment experience, (Elliot et al. in Norcross and Lambert, 2019) and a principled and non-directive element (Sanders, 2006). In CBT, empathy is instrumental, a technique for building *rappport* prior to a specific treatment.

Person-empathy, favoured by psychodynamic approaches describes an understanding of how a client's past experiences shape current experiencing (Elliot et al. in Norcross and Lambert, 2019).

Recently, neuroscience describes empathy as three subprocesses:

- *Emotional simulation* – brain activated mirroring of emotional elements of bodily experience
- *Perspective-taking* – a more deliberate, conceptual process
- *Emotion regulation* – soothes distress when experiencing another's pain, mobilising compassion (Elliott al, in Norcross ad Lambert, 2019).

5.1.3 Responsiveness

Definition: being responsive to the individual capacities and preferences of each client.

Being responsive and adapting therapy to each client improves outcomes (Norcross et al., 2019) and is 'crucial because the relationship is unique ... not some pre-set 'type of intervention'' (Wilkins, 2017).

Adapting doesn't mean a blending of stances or play-acting. Responsiveness means individualising therapy, meeting a client where they are at, a co-creating. This may happen automatically, for example a competent therapist may be quieter with a reserved client but more active with a confident client.

5.1.4 Positive regard

Definition: An authentic caring, and warm acceptance of a client and their experiencing.

Positive regard is an important factor (Farber et al., 2019), considered by some as curative (Bozarth, 1998). Clients' experience affirms the potency of authentic acceptance; "I had the feeling that the counsellor accepts these feelings, and then these feelings disappeared" (Timulak & Lietaer, 2001, p. 68).

Common terms include:

- *Acceptance*
- *Positive regard*
- *Unconditional positive regard*
- *Affection*
- *Affirmation*
- *Caring*
- *Respect*
- *Warmth*
- *Validation*
- *Prizing.*

Differing conceptualisations of positive regard exist along with differing views of its importance. In person-centred therapy, *unconditional positive regard* is seen as the absence of conditionality vital to non-directivity in providing a curative counterbalance to a client's internalised conditions of worth (Rogers, 1951). For example, "That seems pretty courageous to me" would affirm with no specific directional intention other than to prize or validate. In CBT a *positive affirmation* such as "I am courageous" might be used with a deliberate intention to change negative thought patterns (Hoffmann, 2013).

5.1.5 Congruence

Definition: Being authentic and self-aware with one's experiencing accurately represented in awareness.

Genuineness, and in particular a client's experience of a genuine therapist is necessary for effective therapy (Shick Tryon et al., 2019).

Common terms include:

- *Genuineness*
- *Authenticity*
- *Realness.*

As a relational quality it is crucial to developing trust and consists of interrelated aspects of inner (self-awareness) and an outer (communication) (Lietaer, 1993).

Congruence, the capacity to be real without façade, is a personal quality (intrapersonal) and an experiential quality in the relationship (interpersonal) (ibid).

5.1.6 Self-disclosure and immediacy

Definition:

Self-disclosure – A therapist statement that intentionally reveals something personal about themselves.

Immediacy – To process or discuss the therapy relationship in the here-and-now.

Self-disclosure and immediacy, used with good judgment for the benefit of the client often result in improved outcomes (Cooper 2018, Hill et al., 2019).

Comments that reveal something about the therapist outside of therapy can be helpful and can include feelings or experiences, for example "When I feel anxious, I find meditation relaxes me". A disclosure that doesn't relate to a client's therapeutic process or is conversational in nature such as "I really enjoy going to that local meditation class" is unhelpful.

Self-disclosure tends to not generate further discussion, whereas with *immediacy* disclosures statements or questions about or within the therapeutic relationship can result in further exploration of the relationship (Hill et al., 2019).

Statements of therapist feelings, such as "I feel angry at what happened to you" or asking a client how they feel in the moment, for example "I wonder if you feel angry at me right now?" are examples of immediacy.

Immediacy and self-disclosure are highly individual, occurring in the moment, in relation to a specific context, with an intention of being of use to the client or relationship. Generally, immediacy is considered helpful by most models, although for different reasons. Some relational psychoanalysts view disclosing and talking about the relationship as facilitating the therapeutic process, providing an opportunity to resolve misunderstandings and ruptures (Knox, 2011). CBT therapists might view self-disclosure and immediacy as beneficial to addressing difficulties in the relationship, whereas humanistic therapists are likely to see immediacy as curative (Hill et al., 2019).

5.1.7 Emotional expression

Definition: A subjective experience of feeling and expression that occurs in response to an event, trigger, or perception.

Emotion is contextual, and the experience and expression of feeling is influenced by expectations, culture, norms, rules and values.

Working with emotion is a feature of all approaches and appears to be important to therapeutic change (Greenberg, 2016).

Feeling happy, sad, afraid, surprised, disgusted and angry are *primary emotions*, whilst feeling guilty, proud, ashamed or embarrassed, more complex *secondary emotions* (Ekman, 2007).

Affect refers to a quick, vivid and prominent experience of emotion, whereas mood describes a more sustained, diffuse experience colouring perceptions, and giving rise to primary emotions (ibid). *Emotional processing* (organising, experiencing, expressing feelings and returning to a balanced state) tends to be linked to better therapeutic relationships, positive change and outcomes (Cooper, 2008, Peluso and Freund, 2019).

5.1.8 Managing countertransference

Definition: Recognising and managing reactions and responses, often unconscious, that arise from past experiences and conflicts.

Countertransference is a psychodynamic concept, recognised to some degree, by all modalities.

Conceptualisation of the phenomenon itself, and subsequent therapeutic practices vary. For example, in person-centred therapy countertransference can be conceptualised as therapist conditions of worth, and in CBT as automatic thoughts that evoke self-schemas (Vyskocilova and Prasko, 2013). Countertransference can be *chronic* or *acute*. A pattern that occurs repeatedly in response to the unresolved needs of the therapist, for example, being complimentary to a client to meet one's own need to be liked, is considered *chronic*. When acute, it can occur in response to a specific client or at a specific time, for example when a therapist avoids responding to a client because clinical material has touched an unresolved issue in the therapist (Hayes et al., 2019)

Therapists will have a range of human reactions to clients. What is important is that the therapist's internal and often 'out of awareness' reactions are recognised, usually through reflection and supervision, and that they are owned by the therapist.

5.1.9 Ruptures

Definition: Tension, disagreement or deterioration in the therapeutic relationship.

Repairing ruptures is a critically important aspect of therapy. Overcoming difficulties in relationships can be a significant reparative task, one linked with more positive outcomes (Eubanks et al., 2019). It is an exciting area of development, informed by relational, psychodynamic, cognitive and humanistic thinking (Cooper, 2008). Ruptures include tensions, minor misunderstandings, ambivalence, withdrawal, disagreements, and stuckness (Eubanks et al., 2019) and are categorised as:

- *Withdrawals* – avoiding questions, silence, self-criticism, and missing sessions.
- *Confrontations* – pressuring a therapist or expressing anger towards the therapist (Eubanks et al., 2019).

Interestingly therapists tend to mention ruptures more often than clients, which may be because of therapists' greater awareness of relational difficulties. (Eubanks et al., 2019).

CBT therapists, whose initial training does not include processing relationship dynamics and difficulties, would benefit from additional training in repairing ruptures (Eubanks et al., 2019).

5.1.10 Collecting feedback

Definition: Getting information from the client about their experience and outcomes of therapy.

The importance of asking clients what they think is and isn't helpful may seem obvious. However, engaging in feedback and monitoring have a measurable positive effect (Brattland et al., 2018). Feedback can be collected informally in conversation with a client, or formally with a questionnaire.

A pragmatic view of feedback and monitoring is wise. For example, therapy may have helped prevent a client from taking their life, although monitoring and feedback show little progress in therapy (Lambert et al., 2019). Improvement or deterioration in therapy can be due to external factors, and/or therapist factors, and it is helpful to use a system that allows for feedback on both.

5.2 Relating to client factors

5.2.1 Client preferences

Definition: The types of therapy and activities, emotional intensity, support, direction and challenge that clients prefer.

Finding out and responding to what a client wants have a positive effect on outcomes (Cooper & Norcross 2016, Swift, et al., 2019, Lindhiem et al., 2014) and is considered good practice across all modalities. Understanding what a client wants in terms of levels of challenge, therapist gender, cultural background, sexual orientation and even structural aspects such as times and settings can have a positive impact (Swift et al., 2019).

Clients tend to prefer more direction from therapy than therapists, highlighting the importance of explicit discussion (Cooper et al., 2019). Exploring preferences can be by using unstructured conversations in therapy or structured tools such as the Cooper-Norcross Inventory of Preferences (CNIP), (Cooper and Norcross, 2016). Having specific questions on a form may help clients be more open, or think about areas previously unconsidered (Swift et al., 2019).

5.2.2 Positive outcome expectation

Definition: A client's belief that they can improve, and that therapy will help.

A client's positive expectation is linked to better therapeutic relationships and improved outcomes and is influenced by various factors (Constantino et al., 2019b).

These include previous experiences of therapy, therapist actions, treatment credibility, motivation and perceived competence of therapist; factors that can change over time (ibid). Expectations can be positive, negative or ambivalent as in "I'm not sure this will work but I'll give it a try" (ibid).

5.2.3 Treatment credibility

Definition: A client's belief about how effective therapy will be.

A client's belief in the credibility of treatment is important. It is similar to outcome expectations but differs in that treatment credibility exists only after exposure (Constantino et al., 2019a). Clients' beliefs about the suitability of therapy influence treatment credibility, along with perceived therapist expertness, trustworthiness, the therapeutic relationship and experiences (Constantino et al., 2019a).

5.2.4 Resistance and reactance

Definition: A deliberate or subconscious avoidance of tasks and activities in therapy.

Resistance describes when a client resists or doesn't carry out tasks, whereas reactance expresses how they may respond in therapy by doing the opposite or becoming highly distressed. For example, a client might not do homework as a form of resistance whilst another responding with reactance may deliberately give wrong answers for homework (Edwards et al., 2019).

A CBT therapist might describe resistance and reactance as behavioural noncompliance, whilst psychodynamic models consider it as emerging from unresolved conflicts as part of the therapeutic process (ibid). Humanistic approaches view resistance as a response to therapist directiveness or a client's healthy defensive avoidance.

Resistance and reactance can be conceptualised as expressions of a client's fear in response to authority-based directiveness; 'resistance emerges through the therapists request for change' (Edwards et al., 2019, p.189).

Meeting resistance or reactance with confrontation or control results in poorer outcomes (Edwards et al., 2019) and collaborative, empathic relationships with improved outcomes.

5.2.5 Psychopathology – coping styles

Definition: The conceptualisation and categorisation of mental and emotional distress and its related symptoms.

'Psychopathology' is a problematic, divisive conceptualisation whilst 'coping styles' is a transtheoretical and inclusive term. The medical model views psychological symptoms of distress as a dysfunction, a pathology or disorder requiring diagnosis and treatment with a specific intervention for that specific disorder (Johnstone et al., 2018).

Diagnosis is integral to some models such as CBT, where a 'case formulation' is developed by the therapist in relation to a client's presenting 'problem' (Fenn and Byrne, 2013). Psychoanalytic models tend to focus on symptoms and conditions rather than diagnostic categories.

Humanistic models view psychological symptoms as an adaptive response to an unhealthy environment or experience, in effect a style of 'coping' or 'processing' (Wilkins, 2017).

Examples of diagnostic categories, coping styles and terminology include:

- Attachment styles
- Anxiety disorders
- Obsessive Compulsive Disorders
- Attention Deficit Hyperactivity Disorder
- Post-Traumatic Stress Disorder
- Personality disorders
- Neuroticism
- Psychosis
- Difficult process
- Fragile process
- Psychotic process
- Dissociative process
- Conditions of Worth
- Denial and Distortion
- Incongruence
- Dysfunctional schemas. (Norcross & Wampole, 2019)

Regardless of approach, research findings that support a move towards more effective relationship-based practice (Norcross et al., 2019, (Johnstone et al., 2018), and recognition of this by commissioning bodies and organisations will promote more effective services. The ethical principles of 'Justice' and 'Beneficence' (*Ethical Framework*, 2018) encourage BACP members to help inform and challenge organisations delivering routine manualised treatments to develop services with a focus on evidenced-based relationships and collaborative models (Norcross et al., 2019).

5.2.6 Attachment – coping style

Definition: a psychological model describing a style or pattern of relating, developed from early childhood experiences.

Some clients with difficult early experiences can find relationships and intimacy difficult and may become distressed and confused when experiencing emotions in therapy (Norcross, and Lambert, 2019).

Attachment theory (Bowlby, 1969; Ainsworth et al., 1978) describes styles or patterns of relating; *secure, anxious-ambivalent/resistant, avoidant and disorganised*, that develop in response to a child's experience of receiving warmth and affection.

Person-centred theory conceptualises child development in terms of internalised values and beliefs, termed *conditions of worth* (Rogers, 1951). These create incongruence and are unique to an individual (Tickle and Joseph, 2017). Attachment style is considered important by therapy models that favour diagnosis (Norcross, and Lambert, 2019) and helps therapists understand how to relate to a client and predict how therapy might progress (Tickle and Joseph, 2017). For more process-oriented therapies, categorising clients in terms of attachment theory can be seen as a limiting and judgmental stance (ibid).

Recognition of attachment styles is a question of model, philosophical viewpoint and preference, not therapeutic competence.

5.2.7 Diversity – cultural competence

Definition: An appreciation of difference in terms of identities, culture, ethnicity, gender, sexualities, age, religion, disability, socioeconomic background, and potential implications.

We are committed to respecting clients by providing services that: 'endeavour to demonstrate equality, value diversity and ensure inclusion for all clients' (Good Practice, point 22a).

To work effectively with a diverse range of clients an appreciation of difference is needed (as is the interconnectivity of issues of difference within each person). Therapists must examine their own racism and prejudices and work to improve their sensitivity to issues of race and power (Jackson, 2018). Cultural competence improves therapeutic outcomes, whilst lack of cultural sensitivity can cause clients to feel frustrated (Soto et al., 2019).

Understanding a client's context is vital as 'socio-political factors like income, work, family life, community, political freedom and wider social values' (Cooper, 2019, p.8) directly influence mental health, whereas inequality and oppression can result in extreme psychological distress (Lago, 2017).

Religious and spiritual beliefs can shape a client's values, relationships and life but are often overlooked within the element of cultural competency (Hook, et al., 2019). Awareness of discourse around models of disability can be helpful (Haegele and Hodge, 2016), as an impaired client's view of the world can be shaped by societal attitudes towards disability, which play out within interpersonal relationships (Forber-Pratt et al., 2017). An impairment may be an important aspect of identity or seen in terms of a medical model focusing on diagnosis and treatment. Gender and sexual orientation are dynamic, culturally defined elements of identity. The potential for harm is greater when they are not explicitly addressed than when they are (Budge and Moradi, 2019, see GPaCP 001).

Understanding your own cultural and socioeconomic background is important as this influences the relationship, which if unaddressed may inhibit an effective therapeutic alliance (Cooper, 2008). The development of *cultural humility* – an interpersonal openness to understanding another's cultural identity – is rated as more important by clients than a therapist's shared similarities (Soto et al., 2019).

Explicitly exploring with clients whether they have a preference for a therapist of a particular gender, sexual orientation, race/ethnicity, religion, cultural background is important. Accommodating preferences is associated with improved outcomes and reduced rates of clients ending therapy prematurely (Swift, et al., 2018). However, it is possible that even when preferences cannot be accommodated, explicit discussion can promote a stronger alliance and reduce premature endings.

6 Relating findings to practice

By identifying and conceptualising common, effective ingredients of therapy we now highlight how they can contribute to specific segments of therapy.

6.1 Beginnings

Clients come to therapy in a variety of ways and settings. Many factors will influence the therapeutic relationship before a therapist has even met the client. For example, consider the different experience of two young mothers, each feeling depressed.

Sue is a lone parent referred by a GP for depression. She has waited several weeks to be seen at hospital to which she travels several miles by bus. Appointments are during the day and she takes time off work arranging childcare to attend.

Jenny contacted a private counsellor who is five minutes from her home and has evening appointments. Her mum offers to babysit, and Jenny is seen the following week.

Sue's context makes attending therapy difficult and tiring, which affects her capacity for engagement. Jenny by contrast may be able to engage more fully, potentially leading to a more positive outcome.

Some settings use diagnostic criteria, tools and multiple team members to assess clients prior to first meeting, whilst in settings, such as private practice, assessment and contracting may be carried out simultaneously by the same person.

Assessments and policies that promote formulaic interventions should be changed to reflect current good practice guidance towards providing responsive, evidence-based relationships (Norcross, and Lambert, 2019).

A commitment to fair and adequate provision of services, and the principles of 'Beneficence' and 'Justice' encourage practitioners to challenge policies and practices that are outdated or detrimental.

Collaborative assessments are likely to result in a stronger therapeutic alliance (Smith et al., 2015) and the initial meeting is an opportunity to develop an understanding of what the client wants, and to check that therapy is appropriate. It is an opportunity to discuss preferences (Swift et al., 2019), cultivate positive outcome expectation (Constantino et al., 2019b), and assess clients' view of treatment credibility (Constantino et al., 2019a).

6.2 Contracting

Contracting should address structural aspects (times, frequency, cost), boundaries (confidentiality) and therapeutic elements (what we will do and why) of therapy. Clear collaborative contracting is fundamental to building a strong therapeutic alliance (Flückiger et al., 2019, Shick Tryon et al., 2019). We are committed to carefully considering how we reach agreement with clients and contracting on the terms of our services (Good Practice, points 31a-e).

Data protection legislation also requires us to gain client permission at the beginning of therapy; for any records kept, who will see them, how long they will be kept, and what will happen to them at the end of the therapeutic process.

Asking about previous therapy experiences and collaboratively exploring whether a particular type of therapy offered is likely to be helpful is good practice.

Peter has made an appointment with Malika, a person-centred therapist. Malika asks why he's chosen person-centred therapy, and Peter explains that his friend found it helpful. Malika recognises that treatment credibility and positive outcome expectations are important. Peter wants to understand why he feels low and Malika agrees that person-centred therapy is likely to help with developing self-awareness. Peter is highly motivated but can only attend every two weeks. He says he would like homework to help therapy progress more quickly. Malika regards homework-setting as directive, but she wants to be responsive and accommodates his preferences.

Malika "It sounds like homework is important to you, I'm wondering what you have in mind?"

Peter "I'm not sure, maybe keeping a journal would help me figure things out more quickly."

Malika "That sounds like a great idea. Would it be helpful if we discussed this at the end of each session, to help you decide what you'd like to write about each week?"

Peter "That would be great."

By exploring and responding to preferences and agreement on goals and tasks, Malika is helping to build a stronger therapeutic alliance. Accommodating preferences in a way that does not compromise therapeutic approach is important, and by agreeing with Peter that he will choose a topic each week, Malika feels she can maintain the integrity of her approach.

Sharing your opinion whilst being supportive of a client's negative view can also help cultivate positive expectations; for example, 'I know that you aren't feeling hopeful right now but, based on what you've told me, I feel optimistic that therapy can help' (Constantino et al., 2019b).

6.3 Building the therapeutic relationship

Genuineness, empathy, positive regard and collaboration are key to developing a strong therapeutic alliance and a reliable predictor of improved outcomes (Flückiger et al., 2019).

Actions such as reflection, or mirroring are necessary to check accuracy, or express empathic understanding. Simply reflecting feelings or content, without attempting a deeper empathic understanding of experience or meaning can be unhelpful, resulting in superficial levels of communication (Elliot et al., in Norcross and Lambert, 2019).

Attentive and non-judgmental therapists are perceived as empathic compared to those who interrupt, advise and overly talk (Elliot et al. in Norcross and Lambert, 2019). Sometimes staying silent may be more responsive and empathic than an intrusive reflection. Empathic responses should be tentative and offered with humility, expressing an openness to being corrected. Clients vary in their response to empathy. Those who express feelings more easily may welcome it and be easier to empathise with, whereas fragile clients may find empathic responses intrusive or directive and focusing on feelings difficult (Norcross and Lambert, 2019).

It is good practice to avoid stereotyping, use inclusive language and cultivate curiosity. If a therapist learns cultural generalities about a group, immigrants for example, it may paradoxically reduce their active curiosity about the lived experience of the next client within that group (Soto, et.al., 2019). Actively communicating an inclusive attitude towards LGBT+ clients, can promote a more positive experience of therapy (Moradi and Budge, 2019; Barker, 2019). Religious and spiritual beliefs can be a source of struggle and confusion or support and comfort for clients (Hook, et al., 2019). An appreciation of belief can have a significant positive effect on psychological and spiritual outcomes, whilst neglecting a client's beliefs can be detrimental (Hook, et al., 2019).

Therapists can help to promote the development of the real relationship through ingredients such as congruence, transparency, empathy and positive regard (Gelso et al., 2005). A client's capacity to be genuine also has an influence. If both client and therapist are open, and accessible therapy will be more effective (ibid). Positive regard can help a client feel safe enough to engage in self-exploration, which can develop congruence and strengthen the real relationship (Levitt, et al., 2019).

Dana is 29 and lives with her wife, Jo. Dana's aunt recently died, and she has self-referred to a local counselling charity because she feels anxious and lacks confidence.

Dana has strong spiritual belief in an afterlife which helps her feel connected to her aunt.

She attended a school with a rich diversity of students and had counselling when she was being bullied. However, she found the counsellor judgmental and she didn't feel able to discuss her sexual orientation. Dana has been allocated to Ashraf.

Dana – "Sorry I'm late. Jo gave me a lift and the car broke down."

Ashraf – "No problem, I hope he got it fixed OK."

Dana – looks out of the window and doesn't answer

Ashraf – "I read on your referral form that you are not religious."

Dana – "No."

Ashraf – "That's good because I am an atheist too and it's good to know we agree on that"

Dana – nods

Ashraf – "I see that you recently lost your aunt, I am sorry to hear that. Were you close?"

Ashraf's initial assumption about Jo causes a rupture but Dana does not correct his assumption. His self-disclosure is unhelpful and lacks empathy. Dana felt judged and her behaviour becomes avoidant and she doesn't feel able to be open about her sexual orientation or her spiritual beliefs. There is no exploration of preferences or goal consensus, and Ashraf directs Dana towards exploring her bereavement. As therapy progresses Dana doesn't know what to talk about.

Ashraf's intention was to build a warm bond, but his behaviours caused a rupture and consequently impaired the development of a therapeutic relationship.

6.4 Therapeutic engagement

As therapeutic relationships develop engagement deepens, often characterised by identifiable moments of relational depth which can have a positive impact on therapy (Flückiger et al., 2019; Knox and Cooper, 2011).

Congruence contributes to moments of relational depth, a connection in therapy that clients describe as 'really real' and significant.

Being congruent doesn't mean disclosing indiscriminately. Disclosures should be relevant to the therapeutic relationship in a climate of empathy. Mature practitioners are more authentic, and their congruence more potent, suggesting the capacity and skill for relational congruence develops with experience (Kolden et al., 2019).

As trust deepens, clients' willingness to allow vulnerabilities to arise increases, resulting in greater potential for growth and change.

Immediacy often encourages the client to be more open, and to risk being more immediate with a positive effect on the therapeutic relationship (Hill et al., 2019). Immediacy can 'serve as a "corrective relational experience"' (Mearns and Cooper, 2005, p.48), whereby a client re-experiences emotions from a past experience in a way that promotes expression, processing and healing (Nakamura and Iwakabe, 2017).

Positive consequences of immediacy include gaining insight, improved communication and finding new solutions to problems. Clients also describe feeling "less anxious...less alone and 'less crazy'" (Hill et al., 2019, p.385).

Self-disclosure is helpful when it helps reassure or normalise an experience but can also be unhelpful or upsetting (Knox et al., 1997). Clients and therapists can see therapist self-disclosure differently. Clients may regard a disclosure as very helpful, whilst therapists, less so (Hill et al., 2019). Self-disclosure results in more improved mental health functioning and enhanced therapy relationships when compared to immediacy, possibly because immediacy tends to reveal underlying relationship tensions (Hill et al., 2019).

Both interventions require a therapist to make use of themselves as a therapeutic tool. However, therapists may feel vulnerable bringing their experiences, reactions and perceptions to the session rather than focusing exclusively on the client (Hill et al., 2019). There can be therapeutic value to therapist vulnerabilities and 'mistakes' that are transparently acknowledged with immediacy (Keys, 2003; Wosket, 1999). Modelling a healthy relationship gives the client 'permission' to express feelings such as anger towards the therapist and to have that anger validated.

6.5 Relationship difficulties

Difficulties or ruptures in the relationship can be both a potential obstacle and opportunity in therapy. An effective container for intense and transformative emotions, therapy gives clients the opportunity to experience and express difficult or overwhelming feelings without overpowering the therapeutic relationship (Peluso and Freund, 2019).

Incongruence in the therapist, emerging as defensiveness, denial and projected or transference feelings, can cause ruptures by reducing the capacity for empathy and acceptance and can damage a client (Lietaer, 1993). If a client becomes reactive or resistant, meeting this with exploration, empathy, and positive regard can promote therapeutic growth. However, positive regard and acceptance need to be genuine.

If perceived as fake by the client, then it is not present. Its absence may be regarded as judgmental causing alliance ruptures (Farber, et al., 2019).

The concept of acceptance in therapy can be misunderstood as implying approval of a behaviour. Acceptance in therapy simply demonstrates that, given the client's circumstances, (internal and/or external) you can understand their experience and respect their choices.

Overcoming difficulties is a critically important aspect of therapy and can be a significant reparative task, one that is associated with more positive outcomes (Eubanks et al., 2019).

Ruptures can generate strong feelings of confusion, incompetence, and guilt in clients and therapists. Developing a capacity to reflect on, explore and tolerate intense feelings (in supervision or own therapy) will build a therapist's ability to maintain positive regard and repair ruptures. Ruptures are best addressed openly, non-defensively acknowledging, and collaboratively exploring the difficulty. *Immediate strategies* focus on repair, whereas expressive strategies focus on exploring the rupture. Choice of which to use is a clinical one informed by circumstance and therapeutic approach (Eubanks et al., 2019).

Gerald a therapist, has cancelled a session at short notice. Monica arrives late for their next session;

Gerald: "How are you?"

Monica: "OK"

Gerald: "I notice you arrived late"

Monica: "At least I'm here!"

Gerald recognised a rupture and felt that exploring it might be helpful

Gerald: "You sound angry?"

Monica: "Yes, I guess I am, sorry"

Gerald: "You're angry at me about cancelling, and I can understand why, I think I might be angry at me too"

Monica's anger is accepted, and she can explore

Monica: "I felt like you didn't care. It reminded me of my dad"

Gerald: "I can see why you felt hurt and angry"

Monica: "Are you angry at me?"

Gerald: "Is that what happens, Dad cancels and then gets angry at you?"

Monica: "Yes!"

Repairing ruptures can be a deeply healing experience for the client and can strengthen the relationship. Unrepaired ruptures may be damaging, resulting in abrupt endings and poorer outcomes (McLaughlin et al., 2014).

6.6 Endings

Endings in therapy occur in various ways. They may be planned, unplanned or enforced by circumstances outside the control of client and/or therapist. Endings may be challenging for both client and therapist, evoking intense feelings of loss, separation or abandonment. They can also be empowering, and an important marker of change and achievement.

It's good practice to discuss endings at the beginning and throughout therapy. Letting a client know how many sessions are available (if time limited), discussing how an ending might be managed, and engaging collaboratively in decision-making about endings are important. Reflecting with clients on therapeutic change and progress can prompt discussions of readiness to end.

Whilst there is significant commonality in practice in managing endings across modalities (Finlay, 2019) there are some differences, for example CBT therapists reported discussing relapse and post-therapy monitoring more often than other models (Norcross et al., 2017).

There is a strong consensus on ending tasks or activities that are widely practised including:

- Processing feelings of both client and counsellor
- Recognising client's developing competence and change
- Explicitly talking about achievements and gains
- Discussing the ending
- Exploring what the future might be like
- Discussing future coping skills or strategies
- Framing development as continuing post-therapy
- Preparing for ending
- Expressing appropriate pleasure in client's progress.

(Norcross et al., 2017).

Experienced therapists manage endings similarly, regardless of therapeutic approach and have more planned endings than novices (ibid). This may be because of developed skill in talking about endings, or that they are better able to assess or intuit clients' readiness for ending.

Some endings may be final with no possibility of return, whereas others may appropriately 'leave the door open'. Clear communication about additional support, and future contact (or not) is crucial.

Summary

New evidence and understandings of the limitations and lack of validity with psychological diagnosis are leading to a legitimate shift towards the therapeutic relationship as a key factor, regardless of modality. Formulaic treatments are not effective, and a focus on the development of the therapeutic relationship is demonstrably more effective than the application of routine, 'one size fits all' interventions.

There is a diversity of conceptualisations of assessment and the therapeutic relationship, but regardless of modality, sensitivity to clients' emotional capacity, accommodating preferences when possible and a collaborative approach that is responsive to clients' needs are demonstrably effective.

A clear understanding of what a client wants from therapy, and explicit agreement on how to work together is essential. Regularly asking for feedback, paying attention to the development and maintenance of the therapeutic relationship and working non-defensively to repair ruptures promotes improved outcomes. Self-awareness and cultivating an active curiosity and appreciation of difference are essential to ensure ethical, inclusive, non-discriminatory, culturally sensitive practice.

In summary, a pluralistic perspective of good practice that is inclusive of all modalities is essential. The therapeutic relationship is key to effective therapy, and a focus on ingredients such as collaboration, empathy, and responding to client preferences are vital to ensuring ethical and effective therapeutic practice. The recognition that different clients need different things promotes a more pluralistic provision of therapy services.

About the author

Ani de la Prida is a psychotherapist and creative arts counsellor working in private practice. She is a university lecturer, supervisor and author and has worked on projects such as Counselling MindEd and SCoPEd. She delivers various workshops and is founder of the Association for Person-Centred Creative Arts.

Synopsis of sources

Main evidence sources are Psychotherapy Relationships That Work (3rd ed): Volume 1 Evidence Based Therapist Contributions (Norcross & Lambert, 2019) and Volume 2; Evidence Based Therapist Responsiveness (Norcross & Wampold, 2019).

These quantitative meta-analyses examine links between relational elements and therapeutic outcomes. Evidence is also included from a qualitative meta-analysis examining clients' experiences (Levitt, H.M., Pomerville, A., Surface, F.I., 2016).

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