### EBP and Relational Psychotherapy: There is an empirical foundation

**Evidence-based practice**

What is it? APA defines EBP as the integration of the best available research evidence, clinical wisdom, and client preferences/values. This session will focus on the first element, research evidence, as the other two elements are quite prominent in other aspects of our training.

1. **Broadly speaking, psychotherapy works.**

Reanalyses of older reviews, as well as newer meta-analytic

reviews of psychotherapy outcome, produce the broad finding of

therapy benefit across a range of treatments for a variety of

disorders. Indeed, psychotherapy is more effective than many

“evidence-based” medical practices, some of which are very costly

and produce significant side effects, including almost all interventions

in cardiology (e.g., beta-blockers, angioplasty, statins), geriatric

medicine (e.g., calcium and alendronate sodium for osteoporosis),

and asthma (e.g., budesonide), influenza vaccine, and

cataract surgery, among other treatments (Wampold, 2007).

Lambert, 2013, p. 43

Other stats in the same article:

2/3 get better in 20 sessions, ¾ in 50 sessions, but some get worse, up to 10% (not a trivial number)

1. **Broadly speaking, psychodynamic psychotherapy works**

Leichsenring and Rabung’s 2008 meta-analysis reviewed and summarized

23 studies of long-term psychodynamic psychotherapy

(defined as therapies with over 50 sessions), included an overall

sample size of 1,053 with a mean of 151 sessions (a median

of 73), and used both manualized and nonmanualized treatments.

This review found a large average ES of 1.8 in

between-group comparisons.

Roseborough, McLeod, and Bradshaw (2011), p. 55

A more recent meta-analysis by de Maat, De Jonghe, Schoevers, and Dekker

(2009) reported similar findings with an even larger sample.

These authors conducted a systematic literature review including

27 studies (N = 5,063) pertaining to long-term treatment

(defined akin to Leichsenring & Rabung, 2008, as 50 or more

sessions and one or more years) and found an average ES of .78

at termination and an even stronger ES (.94) at follow-up.

Roseborough, McLeod, and Bradshaw (2011), p. 55

Findings from a recent piece of original research:

N approx. = 1000, community setting. “Robust general improvement” (Roseborough, McLeod, and Bradshaw, 2011, p. 54), though more modest that some other studies.

[But much more needs to be clarified, e.g., what works for whom, what unique elements are needed in varying cultures and contexts, when is some other kind of treatment better, etc.]

1. **Psychodynamic psychotherapy has support with particular populations and diagnoses.**

**BPD**

Clarkin, Levy, Lenzenweger, and Kernberg (2007) on 3 treatments for BPD:

Yeomans, Levy, & Meehan (2012)

**Depression**

Abbas had good outcomes with *treatment resistant depression* via intensive short term dynamic therapy.

Division 12 List of empirically-supported treatments includes IPT (“well-supported) and brief dynamic therapy (“probably efficacious”) for depression.

Greenberg’s EFT for depression has significant empirical support.

Short term psychodynamic psychotherapy for depression

Twenty-one patients were assessed pre- and post-treatment through clinician ratings and patient self-report on scales representing specific DSM-IV depressive, global symptomatology, relational, social, and occupational functioning. Treatment credibility, fidelity, and satisfaction were examined, all of which were found to be high. All areas of functioning assessed exhibited significant and positive changes. These adaptive changes in functioning demonstrated large statistical effects. Likewise, changes in depressive symptoms evaluated at the patient level utilizing clinical significance methodology were found to be high. A significant direct process/outcome link between STPP therapist techniques and changes in depressive symptoms was observed. Hilsenroth, et al, 2003, p. 349

1. **Research on relational factors in development, resilience, and psychopathology**

Attachment, intersubjectivity, differentiation will all be addressed in separate sessions this fall. For now, please note the potential power and influence of these dimensions in development. For example

All of these measures [of compromised attachment/intersubjectivity] were reliably related to the incidence of borderline or conduct symptoms at age 19 (Lyons-Ruth, Holmes, & Hennighausen, 2005).

Lyons, 2007, p. 603

These findings suggest direct connections between traumatic attachment, inefficient right brain regulatory functions, and both maladaptive infant and adult mental health.

Schore, 2001, p. 201.

This research has consistently shown that

significant-other representations are activated and applied or transferred

to a novel target (e.g., new person) in everyday social

perception. That is, people tend to view others in ways that are

consistent with preexisting significant-other representations.

Levy & Scala, 2012, p. 393.

This study examined the relationships among adult attachment, cultural orientation, and three areas of

psychosocial functioning (i.e., emotional expressiveness, social difficulty, and depressive symptoms)

with a sample of 112 Chinese American college students. Findings indicated that both attachment

avoidance and anxiety were significantly associated with indictors of psychosocial functions in the

directions predicted by the theory which provides support to the cross-cultural applicability of adult

attachment perspectives on Chinese American populations. In addition, endorsement of independent

cultural orientation was found to be negatively associated with both social difficulty and depressive

symptoms, and independent cultural orientation moderated the relation between attachment anxiety and

social difficulty.

Wang & Ratanasiripong, 2010, p. 101

1. **Research on relational factors in psychotherapy**

**Wampold (2007):** **The humanistic but effective treatment**

Three critical elements

1. a meaningful, emotional relationship
2. remoralization, renewed hope for change
3. a coherent framework which describes the problem and identifies constructive responses (rituals)

**General outcomes research**

30% variance in outcome attributed to therapeutic relationship, 40 % to client factors (such as expectancy, engagement) (Carter, 2006.)

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**Brief Relational Treatment**

At this point we have evidence that the treatment (Brief Relational Therapy, or BRT) is as effective as two more standard forms of brief psychotherapy for personality disordered patients (cognitive therapy and a more traditional form of brief psychodynamic therapy

based on the approaches of Strupp and Binder, 1984, and Luborsky, 1984). In addition, we have evidence that there are significantly fewer treatment dropouts in BRT than in the other two treatments. Moreover, we have preliminary evidence that BRT is more effective than the other two approaches for patients with whom therapists find it difficult to

establish a therapeutic alliance.

Safran, 2002, p. 171

**Treatment of BPD Yeomans, Levy, & Meehan (2012)**

All the treatments in a recent review of empirically-supported treatments for BPD have a strong relational bent.

(pp. 43-44)

Two main CBT approaches with empirical support (DBT, Schema-focused therapy) have specific relational components.

“Of note: all the evidence-based treatments represent modifications of standard CBT and in fact

tend to be integrative. Linehan and Young were both explicit about developing their modified and

integrative treatments because of their experience that standard CBT was not effective for BPD,

Data suggest that they were correct in this inference. In the Borderline Personality Disorder

Study of Cognitive Therapy (BOSCOT) trial, there were no differences between CBT and treatment

as usual on any of the primary outcome measures and on most secondary outcome measures.^"

Distress and dysfunction remained high even after 2 years of treatment, which suggests

that standard CBT is contraindicated for patients who suffer from BPD.” pp. 43-44

Three manualized psychodynamic treatments have shown efficacy for BPD: mentalization-based

therapy, transference-focused psychotherapy, and dynamic deconstructive therapy. In addition, 2

nonmanualized psychodynamic treatments have shown efficacy. Individual psychodynamic psychotherapy,

based on “Gunderson's model in combination with general psychiatric management,

was efficacious in a comparison with dialectical behavior therapy." Supportive dynamic

psychotherapy was efficacious in a trial with transference-focused psychotherapy and dialectical

behavior therapy.” p. 44

**Mentalization-based psychotherapy for BPD: relational modifications of dynamic technique**

Thus,with regard to dynamic therapies, this implies that there should be (a) a de-emphasis of “deep,” unconscious

interpretations in favor of conscious or near-conscious content; (b) a modification of therapeutic

aim, especially with severely disturbed patients, from insight to recovery of mentalization (i.e.,

achieving representational coherence and integration); (c) careful eschewing of descriptions

of complex mental states (conflict, ambivalence, unconscious) that are incomprehensible to a

person whose mentalizing is vulnerable; (d) avoidance of extensive discussion of past trauma,

except in the context of reflecting on current perceptions of mental states of maltreating figures

and changes in mental state from being a victim in the past versus one’s experiences now.

Fonagy, Luyten, & Strathearn, 2011, p. 57

the therapist is probably most helpful when interventions (a) are simple and easy to understand,

(b) are affect-focused, (c) actively engage the patient, (d) focus on the patient’s mind rather than

on his or her behavior, (e) relate to current event or activity—whatever the patient’s currently

felt mental reality (in working memory), (f) make use of the therapist’s mind as a model (by

therapists disclosing their anticipated reaction in response to the event being discussed (i.e.,

talking to the patient about how the therapist anticipates that he or she might react in that

situation), and (g) are adjusted flexibly regarding their complexity and emotional intensity in

response to the intensity of the patient’s emotional arousal (withdrawing when arousal and

attachment are strongly activated).

Fonagy, Luyten, & Strathearn, 2011, pp. 57-58

The key task of therapy is thus to promote curiosity about the way mental states motivate and

explain the actions of self and others. Therapists achieve this through the judicious use of “the

inquisitive stance,” highlighting their own interest in the mental states underpinning behavior,

qualifying their own understanding and inferences (i.e., showing respect for the opaqueness in

mental states), and demonstrating how such information can help the patient to make sense of

his or her experiences.

Fonagy, Luyten, & Strathearn, 2011, p. 58

The therapist’s mentalizing therapeutic stance should include (a) humility deriving from a sense

of “not knowing;” (b) whenever possible, taking time to identify differences in perspectives;

(c) legitimizing and accepting different perspectives; (d) active questioning of the patient in

relation to his or her experience—asking for detailed descriptions of experience (“what” questions)

rather than explanations (“why” questions); and (e) eschewing the need to understand

what makes no sense (i.e., saying explicitly that something is unclear). An important component

of this stance is monitoring one’s own mistakes as a therapist.

Fonagy, Luyten, & Strathearn, 2011, p. 58

**Alliance Research**

Extensive prior research has consistently found a significant relationship

between therapeutic alliance with therapy process and outcome [ 1– 4 ] . Moreover, alliance

has been found to be one of the most robust predictors of positive psychotherapy outcome regardless

of the type of therapy utilized or whether assessed by therapist, client, or independent observer [ 1 ] .

Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003, p. 361

**Table 22.2** Summary of therapist’s techniques and attributes found to contribute positively to the alliance

Techniques positively related to alliance Attributes positively related to alliance

*Supportive*

Support the patient’s struggle Helpful

Affirm the patient’s experience Affirming

Convey a sense of understanding and connection Understanding

Note past therapy success Accepting

Foster a collaborative treatment process Collaborative

Enhance motivation for change Enthusiasm

*Exploratory*

Utilize open-ended questions Open

Clarify areas of distress or discrepancy Empathic

Communicate clearly Warm

Foster depth Friendly

Provide appropriate, nonhostile, confrontation Egalitarian

Provide accurate interpretation

*Experiential and affect focused*

Attend to patient experience Honest

Reflect patient statements and experience Trustworthy

Facilitate the expression of affect Respectful

Explore different patient emotional states

*Engaged and active relationship* Interested

Active-engaged involvement Alert

Focus on the here and now of therapy relationship

Discuss therapist’s own contribution to process Flexible

Provide ongoing feedback to patient Relaxed

Confident

Experienced

Competent

Adapted from [ 51 ]

Hilsenroth, Cromer, & Ackerman, 2012, p. 368

**Table 22.3** Summary of therapist’s techniques and attributes found to contribute negatively to the alliance

Techniques negatively related to alliance Attributes negatively related to alliance

Managing the treatment in inflexible manner Rigid

Over structuring the therapy Tense

Failure to structure the therapy Defensive

Inappropriate self-disclosure Self-focused

Inappropriate use of silence Exploitive

Unyielding transference interpretations Distant/detached

Belittling or hostile communication Cold

Superficial interventions

Distracted

Uncertain

Critical

Aloof

I indifferent

Adapted from [ 50 ]

Hilsenroth, Cromer, & Ackerman, 2012, p. 371

**Rupture and Repair research**

In this article, we review the existing empirical research on the topic of therapeutic alliance ruptures in

psychotherapy. Ruptures in the therapeutic alliance are defined as episodes of tension or breakdown in

the collaborative relationship between patient and therapist. Two meta-analyses were conducted. The first

reviewed studies examining the relation between rupture-repair episodes and treatment outcome (*r*  = .24,

*z =* 3.06, 95% CI [.09, .39], *p <* .002, k *=* 3, *N =* 148). The second meta-analysis reviewed the research

examining the impact on treatment outcome of training therapists in the use of alliance rupture

intervention principles (prepost *r*  = .65, *z*  = 5.56, 95% CI [.46, .78], *p<* .001, *k* = 8, *N* = 376). Both

meta-analyses provided promising evidence regarding the relevance of alliance rupture-repair processes

to therapeutic outcome. The limitations of the research reviewed are discussed as well as practice implications

for repairing the inevitable alliance ruptures in psychotherapy.

Safran, Muran, & Eubanks-Carter, 2011, p. 80.

**Table 22.6** Strategies for the repair of alliance ruptures

Therapist intervention Technique

1. Focus on immediate experience

(a) Inquiry

(b) Empathic reflection

(c) Subjective feedback

2. Facilitate patient self-assertion

(a) Inquiry

(b) Empathic reflection

(c) Subjective feedback

(d) Awareness experiment with direct expression

(e) Acceptance of own responsibility for rupture

(f) Focus on the therapeutic relationship

3. Explore patient’s negative feelings

(a) Explore the meaning underlying the feelings

(b) Facilitate patient awareness of feelings

4. Validate patient assertion

(a) Support and empathize with patient’s assertion

Adapted from [ 98 ]

Hilsenroth, Cromer, & Ackerman, 2012, p. 373

**Qualifications & limitations:**

1. The data are too white (see Watkins, 2012): there’s a need for much more work on culture and collaboration.
2. Other techniques or approaches may be needed/indicated, more effective, or more efficient, for certain clients or certain types of clients. There is conflicting data in some cases, but examples include research indicating that ERP is best for phobias and panic disorder, CBT and meds for OCD, Systemic Family Therapy for troubled youth, etc. A little humility is a good thing, no?

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