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RELATIONSHIP AND TECHNIQUES IN COGNITIVE–BEHAVIORAL THERAPY – A MOTIVATIONAL APPROACH

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Motivational attunement is presented here as a set of guiding principles that can be used to foster the therapeutic alliance in cognitive–behavioral therapy (CBT). The overarching goal of motivational attunement is to provide the client with need-satisfying experiences. In order to do so, the therapist must attune his or her interventions to the client's motivational goals. The authors attempt to demonstrate how therapists can assess motivational goals and use this information to foster the central components of the alliance. The authors also outline how motivational attunement can be used to prevent and resolve alliance ruptures. Finally, empirical support for the effects of motivational attunement is briefly described.

Keywords: psychotherapy, relationship, techniques, motivation, CBT

Psychotherapy has undoubtedly established itself as an effective form of treatment for several psychological disorders (Lambert & Ogles, 2004). A considerable amount of research has led to a list of empirically supported treatments (EST) (Chambless & Ollendick, 2001), which have provided evidence for the efficacy of specific technical interventions. Based on the current list of ESTs, a number of technically oriented principles of change have in fact been delineated for depression (Follette & Greenberg, in press), anxiety disorders (Woody & Ollendick, in press), personality disorders (Linehan, Davison, Lynch, & Sanderson, in press), and substance use disorders (McCrady & Nathan, in press).

Research has also provided substantial support for the role of the therapeutic relationship in psychotherapy treatment effectiveness. The therapeutic alliance has been found to be one of the most robust predictors of psychotherapy outcome across client (presenting) problems, treatment approaches, outcome measures, and treatment lengths (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Wampold, 2001). In fact, empirical findings suggest that the "impact of the alliance across studies . . . is far in excess of the outcome variance that can be accounted for by techniques" (Horvath & Bedi, 2002, p. 61). Furthermore, several elements of the therapeutic relationship in addition to the alliance have been identified as effective or promising processes of change in psychotherapy (Castonguay & Beutler, in press; Norcross, 2002).

Because of the strong emphasis given to techniques in cognitive–behavioral therapy (CBT), some have questioned whether the therapeutic relationship is as important in this orientation as it is in other approaches (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Roth & Fonagy, 1996; Safran & Wallner, 1991). Feeley, DeRubeis, and Gelfand (1999), for example, suggested that the association of the alliance with outcome in cognitive therapy (CT) might be an epiphenomenon of symptom improvement. On the contrary, Waddington (2002), after reviewing the available empirical evidence with regard to CT, concluded that "an association between the

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therapy relationship and outcome has been observed more often than not, with the role of technical intervention as a possible mediator of this association greatly debated" (p. 184). Furthermore, the effect of the therapeutic alliance has been shown to be at least as robust in CBT as in other approaches (Raue, Castonguay, & Goldfried, 1993; Raue & Goldfried, 1994; Raue, Goldfried, & Barham, 1997; Salvio, Beutler, Wood, & Engle, 1992; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). These findings add to the results showing that clients in CBT consider the therapeutic relationship to be important (Morris & Magrath, 1983; Persons & Burns, 1985). Taken together, the findings support the claim that, in addition to specific techniques, the therapeutic relationship deserves a central position in CBT research, training, and practice.

For cognitive-behavioral therapists (as for therapists of any theoretical persuasion), a key question has thus become, "how does the therapeutic relationship interact with prescribed techniques to produce treatment outcome?" With regard to this issue, the predominant view among cognitive-behavioral therapists appears to be that the relationship provides the needed condition to implement specific techniques that are ultimately responsible for change. Thus, according to this view, a good alliance, or rapport, is necessary but not sufficient for change to take place in CBT (see Gelso & Fretz, 1992; Gelso & Hayes, 1998; Schulte & Eifert, 2002).

Other cognitive-behavioral therapists have ascribed a more direct curative role to the relationship in CBT. Goldfried and Padawer (1982), for instance, have argued that the relationship has a therapeutic value in and of itself due to the fact that many people do not frequently have the experience of being listened to in a sympathetic manner. As we have seen in our own clinical practice, the warmth, support, and acceptance of a nurturing other may, at different phases of therapy, go a long way toward reducing distress, a sense of demoralization and isolation, and feelings of depression and anxiety. In addition, some cognitive-behavioral therapists have argued that the therapeutic relationship provides a unique setting within which the client's distorted thoughts about others and maladaptive ways of relating can manifest and be altered (Arnkoff, 1981; Goldfried, 1985; Goldfried & Padawer, 1982; Safran & Segal, 1990). Working with what emerges in the therapeutic relationship therefore allows for emotionally immediate, in the here-and-now, corrective experiences. Within this context, the relationship is not only a condition that facilitates the implementation of techniques but also becomes the object of the therapist's techniques. Fostering the quality of the relationship can thus be viewed as a legitimate treatment goal, even in CBT.

A number of recent recommendations have been made for how to foster and/or work with the therapeutic relationship within the context of CT (Burns, 1999; Burns & Auerbach, 1996; Newman, 1998; Safran & Segal, 1990; Waddington, 2002), brief forms of therapy (Safran & Muran, 1998), and psychotherapy in general (Crits-Christoph et al.,in press). While these recommendations certainly provide valuable contributions to the improvement of the therapeutic process, they are rather generic, in the sense that they do not individualize interventions according to specific client characteristics. In line with Paul's (1966) famous statement about where the field of psychotherapy should go, we believe that the applicability and effectiveness of therapeutic interventions are likely to be maximized if the interventions are specifically relevant to particular individuals. We also believe that efforts toward the individualization of therapeutic processes should have a theoretical as well as an empirical foundation. To address this need, this paper presents a motivational model of the interaction of techniques and the therapeutic relationship, as well as how this interaction influences therapeutic outcome. *Motivational attunement* will be presented as a "metatechnique" designed to individualize therapeutic interventions to foster and work with the therapeutic relationship. The motivational approach—and thus motivational attunement—is based on *Consistency Theory* (Grawe, 2004a/b), a general model of psychological functioning that is derived from research in psychotherapy, basic disciplines in psychology (e.g., general and social psychology), and the neurosciences. Consistency Theory is described in more detail below.

Need Satisfaction as a Dual Mediator of Successful Psychotherapy

Consistency Theory

The most fundamental assumption of Consistency Theory (Grawe, 2004a/b) is that human

beings strive for the satisfaction of their psychological needs. Based on Epstein's (1990) cognitive-experiential self-theory, four basic psychological needs are proposed: orientation and control, pleasure, attachment, and self-enhancement. To satisfy their psychological needs and prevent their needs from being frustrated, individuals develop *motivational goals*. Motivational goals consist of *approach goals* and *avoidance goals.* Approach goals are geared toward the satisfaction of needs. In contrast, avoidance goals are assumed to develop in response to strong and/or prolonged aversive experiences and are geared toward protecting the individual from reexperiencing the frustration of his or her needs. To pursue approach and avoidance goals the individual also develops more concrete plans and behaviors. According to Consistency Theory, insufficient need satisfaction (*incongruence*) contributes to the development and maintenance of psychopathology. Consequently, improved need satisfaction is proposed as a central mechanism to foster symptom reduction and improved well-being.

Similar to other mechanisms of change in psychotherapy, improved need satisfaction is proposed to operate via both direct and mediated pathways. Specifically, it is assumed that if need incongruence actively contributes to the current maintenance of the disorder, a reduction of such incongruence—that is, an increase in need satisfaction—can directly lead to symptom reduction and increased well-being. Need satisfaction can also contribute indirectly to change in therapy. Consistency Theory assumes that the fulfillment of some needs during therapy (e.g., by experiencing a good relationship with the therapist or by developing a stronger sense of control) triggers the client's *approach system* (behavioral activation system, BAS; Gray, 1981). As argued by Grawe (in press), the approach system is associated with approach-oriented behaviors (e.g., active engagement in pleasant and/or anxiety provoking activities) and the experience of positive emotions. In the context of psychotherapy, it is hypothesized that activation of the approach system will lead to a greater openness on the part of the client, which, as demonstrated by Orlinsky, Grawe, and Parks (1994), is one of the most important predictors of change in psychotherapy. Accordingly, activation of the approach system is assumed to facilitate the reception of and collaboration with disorder-specific interventions. Applied in such optimal context, disorder-specific interventions can have their impact maximized, both in terms of disrupting maladaptive behavioral patterns (e.g., avoidance, seclusion) and establishing new and more need-satisfying behavioral patterns.

Need-Satisfying Experiences

In the above model, need satisfaction is the link between the therapeutic relationship and therapeutic techniques: A good therapeutic relationship provides the client with need-satisfying experiences. These need-satisfying experiences can then facilitate the successful application of techniques. However, a positive influence might also work in the opposite direction: Disorder-specific techniques might provide the client with need-satisfying experiences, which in turn improve the therapeutic relationship. Considering both potential causal pathways, a client may benefit most if the therapist provides the client with as many need-satisfying experiences as possible. This would likely further improve the relationship and contribute to outcome via direct symptom reduction and/or facilitated application of techniques. In addition to the role of the therapeutic relationship as a resource, however, the relationship can also contribute to the change process by activating and correcting the client's interactional problems and maladaptive interpersonal schemata (Constantino, Castonguay, & Schut, 2000). In the following sections we will focus on motivational attunement as an attempt to provide need-satisfying experiences. We will show how to apply this theoretical account in therapy practice in order to foster the alliance and provide corrective interpersonal experience (especially via strategies to deal with alliance ruptures).

Motivational Attunement

In line with Newman's (1998) assertion that "the therapist's approach has to be tailored to fit the specific needs of a given patient" (p.101), we propose that alliance fostering in CBT should be customized to the client's motivational goals in order to provide the client with need-satisfying experiences. Need-satisfying experiences are hypothesized to improve the therapeutic alliance as well as outcome. More specifically, the central hypothesis is that a better therapeutic relationship and a better outcome can be promoted if the

therapist supports the realization of approach goals and does not contribute to the activation of avoidance goals more than necessary. This motivational attunement can be considered a "meta-technique," that is, a technique to individualize other therapeutic techniques. Caspar and colleagues (Caspar, 1995; Caspar, Grossmann, Unmüssig, & Schramm, 2005) as well as Grawe (2004a) use the term "Complementary Therapeutic Relationship" (CTR) for custom tailoring the therapist's behavior to the client's motivation. To avoid any confusion with the complementarity concept in interpersonal theory and research (Carson, 1969) we use the synonymous term "motivational attunement." It is important to note that motivational attunement is not intended to replace the more general recommendations for alliance fostering mentioned above. Rather, motivational attunement is intended to be an addition to existing techniques. Before outlining motivational attunement in CBT, we will first describe two methods for assessing plans and motivational goals.

Assessment of Plans and Motivational Goals

Two methods can be used to assess the client's motivational goals: Plan Analysis (Caspar, 1995), and the *Inventory of Approach and Avoidance Motivation* (*IAAM*[1], Grosse Holtforth, & Grawe, 2000). Plan Analysis is an ideographic method for inferring the client's plan structure from various sources of information (e.g., anamnestic information, behavioral observations, the client's impact on others). "A person's plan structure is the total of conscious and unconscious strategies this person has developed to satisfy his or her needs" (Caspar et al., 2005, p. 92). The main question guiding the assessment process is: "What is the explicit or implicit purpose of this client's behavior?" The result is a graphic display of the structure of the client's most important approach and avoidance goals, as well as his or her individual means (plans and behaviors) toward pursuing these goals.

The Plan Analysis approach requires training, can be labor-intensive, is focused on the observer's perspective, and results in nonstandardized goal formulations. To overcome these limitations, Grosse Holtforth and Grawe (2000) identified the most prevalent approach and avoidance goals in case formulations that had been devised according to plan-analytical principles, and factor-analytically developed the IAAM as a standardized questionnaire for self-report and observer report. Approach-goal scales in the IAAM are *intimacy, affiliation, altruism, help, recognition, status, autonomy, performance, control, education, spirituality, variety, self-confidence,* and *self-reward*. Avoidance-goal scales are *separation, deprecation, humiliation, accusations, dependency, hostility, vulnerability, helplessness,* and *failure*. Plan Analysis and the IAAM, which have both been found to be psychometrically sound (Caspar et al., 2005; Grosse Holtforth & Grawe, 2000), can be used alone or in conjunction. As will be shown below, the approach and avoidance goals inferred by these methods can be used as targets for therapist interventions in the service of fostering and working with the alliance. As such, these methods provide tools for what has been described as a foundation of effective treatment: case formulation (Eells, Kendjelic, & Lucas, 1998). However, we need to stress that the type of motivational assessment proposed here is not intended to be an alternative to well-established methods of case formulation in CBT (e.g., Persons & Tompkins, 1997) or other approaches (Eells, 1997). It should rather be viewed as a system of analysis to complement other assessment methods that can be used for the fine-tuning of therapists' interventions. In addition, motivational attunement based on a case formulation is not intended to proscribe therapists' spontaneity. However, we do not attribute superior value to spontaneous over intended interventions. In fact, because we believe that spontaneous reactions are unlikely to be totally random, we would argue that such spontaneous reactions can be, at least to a certain extent, motivationally attuned. Concretely, this means that rather than suggesting that therapists should restrict their spontaneity, we would suggest that they can use motivational attunement as a criterion for monitoring and potentially filtering their spontaneous reactions (see also Bacal & Herzog, 2003). Finally, a case formulation based on motivational assessment should not be viewed as fixed or static. Each case formulation is a set of preliminary hypotheses that might be revised whenever new information becomes available. Furthermore, because the client's goal system

[1] The questionnaire is available in German, English, French, Italian, and Turkish from Martin Grosse Holtforth.

(his or her motivational goals, plans, behaviors, as well as their interrelations) change in the course of therapy, the clinician is well advised to continually monitor these changes (ideally via repeated administration of the IAAM), revise his or her case formulation when necessary, and adapt his or her alliance-focused interventions accordingly.

Motivational Attunement in CBT

In what follows, we will present the application of motivational attunement in CBT. It is important to mention, however, that the application of motivational attunement is not limited to CBT. Our focus on CBT here is motivated by the facts that motivational attunement has grown out of the cognitive–behavioral tradition (Grawe & Dziewas, 1978), has a theoretical basis that was founded in empirical research (Grawe, 2004a), and uses assessment methods that are either behavioral or are derived from behavioral analyses. Additionally, it is tempting to show the application of this alliance-fostering method within an approach that historically did not pay particular attention to relational issues.

As indicated above, motivational attunement is proposed as a customization of other technical interventions to alliance fostering. Crits-Christoph and colleagues' (in press) alliance-fostering therapy appears as the most differentiated set of guidelines for fostering the alliance thus far. The guidelines for this therapy are structured by the three components of the alliance as proposed by Bordin (1979): bond, agreement on goals, and agreement on tasks. To ensure compatibility of our presentation of motivational attunement with alliance-fostering therapy—which in turn would ensure compatibility with the most common theoretical systematization for alliance concepts—we will structure our presentation of motivational attunement according to the three components of the alliance. This structural decision is also supported by Rector, Zuroff, and Segal's (1999) research-based suggestion that the three components of the therapeutic alliance (Bordin, 1979) have different roles in CT: "certain aspects of the therapeutic alliance (i.e., goals and tasks) may facilitate the implementation of the technical factors of cognitive therapy, while other aspects of the alliance (i.e., bond) act in concert with technical factors of cognitive therapy to produce direct effects on depressed symptoms" (p.320).

Of the three components of the alliance, the task component is affected most by the therapeutic orientation. Therefore our discussion of motivational attunement related to fostering the task component of the alliance will be most specific to CBT. In contrast, motivational attunement for fostering the therapeutic bond will be less dependent on particular techniques, so the proposed interventions can be easily applied to approaches other than CBT.

Fostering the Bond

Crits-Christoph and colleagues propose several strategies to foster the therapeutic bond. Apart from showing respect, caring, acceptance, warmth, and positive regard, the authors propagate enhancing the client's change motivation through more specific techniques, establishing a collaborative and empathic climate, and handling alliance ruptures in an accepting and nondefensive way. Motivational attunement can be applied as part of all of these strategies. (We will discuss alliance ruptures separately in a later section.) Consistency Theory assumes that excessively strong avoidance goals and/or excessively weak approach goals potentially contribute to a decrease in the client's motivation to participate in the therapeutic work. For example, a depressed client might fear to be humiliated by others when it becomes known that he or she is in therapy. The therapist can try to enhance the client's change motivation by cognitively restructuring this fear. In addition, the therapist can strengthen the client's approach motivation for change by discussing and supporting the wished-for consequences of change. As an example, if the client wishes to have an exciting life, the therapist can help the client to imagine how he or she would, for example, travel to foreign countries again when he or she has overcome the depression; inquire about the exciting details of the journey; and show his or her own excitement about the client's imagination.

Motivational attunement can also facilitate communicating empathy to the client. Empirically, communicated empathy is related to a good alliance in general and a good bond in particular (Horvath & Bedi, 2002). What a particular client finds empathetic differs from client to client, so that the therapist is well advised to individualize

the expression of this understanding and support. Newman (1998) distinguishes *simple* and *accurate* empathy in CT. While simple empathy in CT consists of "listening, reflecting, and offering words of kindness, concern, and encouragement" (p. 104; e.g., "That must have been very difficult for you. . ."), accurate empathy implies a deeper understanding of the potential reasons for the client's experience. A motivationally attuned expression of accurate empathy would be based on a previous assessment of the client's approach and avoidance goals. Using the above example, this could sound like: "It must have been very difficult for you to take care of your ill father given that it is also very important for you to preserve your own autonomy."

Accurate empathy that is based on the assessment of the client's most important approach and avoidance goals can be seen as a refinement of the two kinds of empathy that Burns and Auerbach (1996) target in their "empathy training program" for CBT, that is, thought and feeling empathy. While thought empathy is a mere repetition of the client's words, and feeling empathy is the formulation of likely feelings "behind" a client's utterance, motivationally attuned empathy adds the expression of likely wishes and fears associated to the utterance. Information about the client's motivational goals can also support the application of the *disarming* technique that has been developed by Burns (1999; Burns & Auerbach, 1996) to deal with problems in the therapeutic relationship. A central intervention within the disarming technique is that the therapist finds "truth in what the patient is saying" (p.153). Having understood the client's wishes and fears is likely to help the therapist better capture the subjective background of the client's responses. Furthermore, we assume that showing motivationally attuned empathy will prevent the therapist from appearing insincere by simply paraphrasing the client's statements or labeling likely emotions in a general way (Gelso & Hayes, 1998).

Because human communication involves both issues of content and process (Watzlawick, Beavin, & Jackson, 1969), motivational attunement for fostering the therapeutic bond also includes the nonverbal and paraverbal aspects of the communication. For example, if close relationships are important for a client, he or she is likely to prefer warm, close, and caring nonverbal behavior from the therapist. If, on the other hand, a client is irritated by seeing emotion in others, a more distanced, rational, "technical" therapeutic stance might be indicated. If it is very important for the client to be autonomous, the therapist should leave as many decisions as possible (e.g., about scheduling, location of an exposition, agenda-setting homework, etc.) in the client's hands. If the client values education and broad interests, the therapist might put in extra effort toward providing explanations or theoretical models for the client's problems. Finally, if the client finds religion very important, the therapist might allow the client to frame the therapy in spiritual terms (see Beutler et al., in press).

It is important to note that according to Consistency Theory, psychological needs (for attachment, control, self-enhancement, and pleasure) are by definition adaptive. However, a client's goal system (motivational goals, plans, and behaviors) might be maladaptive, that is, it might be too extensively geared toward the satisfaction of one need, or might involve maladaptive strategies and behaviors aimed at fulfilling adaptive needs. As a consequence, while a person's goal system may enable him or her to satisfy some of his or her needs in the short run, it may compromise other needs in the long run. For example, a narcissistic client who frequently brags about grandiose achievements may well foster his self-esteem by perceiving himself to be better than the others. The same behavior, however, is likely to compromise his need for attachment by alienating and distancing others. From a motivational attunement perspective, the presence of such maladaptive goals, plans and behaviors has important implications with regard to the therapeutic bond and, as such, requires different types of interventions at different phases of treatment. In order to foster an initial bond, an early task of a therapist working with such a client will be to understand the function of his arrogant behavior. It might be that the client has learned that being better than others was the most reliable way to gain his father's approval. Consequentially, bragging about grandiose achievements may have become a reinforced (at least early on in his development) means for connecting to others, that is, to fulfill his (profoundly and intrinsically) adaptive need for attachment. In therapy, it might be necessary for the therapist to initially conform to the client's wish to have his grandiosity confirmed by expressing admiration for the client's achievements. Once an initial bond is formed, however,

the therapist is likely to facilitate therapeutic (albeit difficult) change by shifting his or her focus to satisfying the underlying need (attachment) as opposed to immediately and directly responding to (reinforcing) the client's maladaptive motivational goals, strategies, and behaviors. The therapist might, for example, express accurate empathy by emphasizing with the client's legitimate wish for approval or the frustration he experiences when other people distance themselves from him. Attuning to what is assumed to be an underlying need is not only likely to stabilize the bond but also might additionally provide a corrective emotional experiences (Alexander & French, 1946), that is, allowing the client the opportunity of interacting with another person in an adaptive way without having to experience a feared outcome (e.g., being dismissed, attacked, or ignored). As can be seen from the example, the more complex a client's motivation appears, the more helpful a detailed analysis of the client's goal system by Plan Analysis, in addition to a standardized assessment of motivational goals, will be.

Fostering Goal Agreement

In general, the formulation of treatment goals has been shown to have beneficial effects on treatment process and outcome (Tryon & Winograd, 2002). The fostering of goal agreement in Alliance Fostering Therapy (Crits-Christoph et al., in press) mainly consists of establishing explicit treatment goals and regularly reviewing them. Goal formulation should be a joint effort by client and therapist and the resulting treatment goals should be representative of what the client wants and what the therapist thinks he can help the client with (Grosse Holtforth & Grawe, 2002). We propose that the beneficial effect of goal agreement on the therapeutic relationship can be enhanced when the formulation of the treatment goals closely matches important approach goals of the client. Treatment goals that match the client's approach goals are more attractive for the client because they promise to satisfy the client's needs. As the match between treatment goals and approach goals increases, the therapist's "value" for the client will also increase because his or her role is to facilitate, support, or enable the attainment of these goals. A motivationally attuned treatment goal for an agoraphobic client who finds helping other people very important, for example, could be: "I will be able to drive to my disabled niece and help her with the groceries." Even the process of finding goals itself can be need-satisfying for the client because mental representations of approach goals will be activated.

Generally, it is preferable if the treatment goal is formulated in terms of approach instead of avoidance. Naturally the removal of symptoms is one of the main motivations to seek treatment (e.g., "get rid of my anxiety"), but treatment goals will be even more attractive for the client if the removal of a problem is paired with an individually attractive approach goal (e.g., "be able to help my niece again"). Additionally, an approach formulation of treatment goals might contribute to the activation of the approach-oriented mode of functioning (see above), which is thought to have a beneficial effect on therapy process and outcome. Furthermore, by regularly reviewing treatment goals, the therapist can keep refreshing the beneficial effects of motivational attunement. If client and therapist have to revise their treatment goals, the therapist should make sure that the new goals match the client's approach goals.

Fostering Task Agreement

Task agreement has a special relevance to our discussion about the interaction of relationships and techniques in CBT. If we equate tasks with therapeutic techniques, task agreement translates into agreement on the techniques to be applied to reach the treatment goals. Consistency Theory assumes that interventions have beneficial effects in psychotherapy if they help to better satisfy psychological needs. As with goal agreement, we assume that the beneficial effects of task agreement vary with the attractiveness of the techniques for the client. Part of the attractiveness of the techniques is their promise to help reach the therapeutic goals. Therefore, when presenting the treatment rationale, the therapist has to plausibly explain that the techniques will lead to goal attainment.

Consistency Theory also assumes, however, that in addition to this cognitive plausibility, there is a motivational component to the subjective attractiveness of techniques. The techniques can be more or less attuned to the client's motivational goals, and thereby have a stronger or weaker potential to satisfy the client's psychological needs. The subjective prospect to satisfy

needs, on the one hand increases the client's motivation to engage in the application of techniques, and, on the other hand increases the therapist's "stimulus value" as the "provider" of these techniques. This means that the therapeutic relationship will be better if the techniques are attuned to the client's motivational goals. Additionally, if a technique activates an avoidance goal, the likelihood of task disagreement, alliance ruptures, noncompliance, and/or resistance increases.

To motivationally attune the choice of techniques, the therapist can compare a list of empirically supported techniques for a given problem with the list of the most important approach and avoidance goals of the client and try to match approach goals with techniques. For example, a client who especially values close relationships might particularly enjoy direct reassurance, self-disclosures, or modeling of behavior by the therapist. Clients who find it particularly important to be independent might particularly favor exploring new activities, exploring new meanings of thought, examining available evidence, testing beliefs, or searching for alternative explanations. Clients who favor being in control of their situations might particularly enjoy explanations of the treatment rationale, agenda setting, frequent summarizing, recording behaviors and cognitions, or training skills. (We will discuss the relationship of avoidance goals and techniques in a later section on alliance ruptures).

We are not arguing that motivational attunement should be the only criterion for selection of techniques. Instead we argue that the therapist should be aware of the attractiveness of the applicable techniques for his or her client. If comparably effective techniques are available, the therapist can choose the one that is more attuned to the client's goals. If the therapist has to choose a technique that is motivationally "unattractive" for the client, however, the therapist will have to put in extra effort toward activating the client's approach goals by means other than techniques.

Alliance Ruptures

The recommendations for fostering the therapeutic relationship cited above (Crits-Christoph et al., in press; Safran & Muran, 1998; Waddington, 2002) all agree that the therapist should attend, and respond appropriately, to alliance ruptures. However, an interesting question for CBT is whether, or to what extent, a therapist should prevent alliance ruptures. If the alliance is viewed as a facilitator of techniques, alliance ruptures should be avoided as much as possible because such ruptures can only hinder the application of techniques. If the alliance is viewed as a curative factor in its own right, however, alliance ruptures may have contrasting types of impacts on the process of change. On the one hand, alliance ruptures might (temporarily) hinder need satisfaction in the therapeutic interaction. On the other hand, if one assumes that alliance ruptures occur because the therapist activates and engages in maladaptive interpersonal cycles that resemble the client's relationships outside of therapy, they can also be considered an opportunity to facilitate corrective interpersonal experiences (Constantino, et al., 2000). We neither demonize nor naïvely favor triggering alliance ruptures. Following the assumption of Consistency Theory that satisfaction of psychological needs is crucial for a good therapeutic relationship, we propose that the CBT therapist should try to foster the alliance and try to prevent alliance ruptures as much as he or she can. However, if alliance ruptures occur, they should be addressed with the appropriate techniques. In the following, we will show how alliance ruptures can be understood in motivational terms, which alliance ruptures are typical for CBT, which approach and avoidance goals are likely involved, and how motivational attunement can support the resolution of alliance ruptures.

Based on empirical studies, Ackerman and Hilsenroth (2001) categorized potential precipitants of alliance ruptures either in terms of the "therapist does something that the patient does not want or need" or "the therapist fails to do something that the patient wants or needs" (p. 183). These two categories of precipitants suggest a motivational basis of alliance ruptures. Failing to do something that the patient wants or needs can be translated as "failing to satisfy the patient's approach goals," and doing something that the client does not want as "activating the patient's avoidance goals."

Newman (1998) and Safran and Muran (1998) give examples of typical alliance ruptures in CBT: clients might feel overwhelmed with activity and optimism by the therapist, feel rushed into tasks before they are ready, perceive a competition with the therapist for control, perceive the therapist as patronizing, and react to the antici-

pation of abandonment. From this list, we can infer motivational goals that might be activated in these situations. For example, both overwhelming the client with activity and urging the client to engage in a task for which he or she does not feel ready might trigger fears of failure, criticism (by the therapist), or helplessness in the client if he or she does not live up to the therapist's expectations. The client might also fear disappointing the therapist if the therapist expresses a lot of optimism. Expression of optimism might further disappoint the client's wish for understanding and care because the therapist does not acknowledge the client's suffering or the difficulty of the current task. The aforementioned therapist behaviors might also be particularly aversive for clients who strongly value autonomy and being in control. These clients might engage in power struggles with the therapist when they feel that they cannot influence the therapy process enough. Power struggles can also occur with clients who have motivational goals other than autonomy and control. Clients who strongly value status and respect, for example, may see it as an expression of disrespect when the therapist assumes a dominant or directive role. Similarly, directive behavior on the therapist's part might be perceived as being patronizing for clients who value status and/or autonomy. Finally, clients who react with disruptive behaviors to the therapist's suggestion to reduce the session frequency obviously fear being abandoned by the therapist.

Constantino et al. (2000) noted that "some technical interventions, at least when applied in specific contexts, may play a role in maintaining and potentially increasing alliance ruptures" (p.115). The "specific context" could be therapy relationships in which strong motivational goals exist in the client. Clients who fear criticism, for example, might be particularly reluctant when asked to recognize their cognitive errors. Similarly, clients who are very fearful of failure might perceive the trying out of new behaviors as threatening. Clients who, on the other hand, strongly value autonomy might experience tight self-observation as a violation of personal space. Finally, clients who either fear deprecation or strongly value status might be especially averse to psychoeducational interventions.

Continually providing the client with need-satisfying experiences via motivational attunement to approach goals (see above) is the primary strategy to prevent alliance ruptures. By motivationally attuning interventions to the client's approach goals, the therapist ends up decreasing the client's motivation to use disruptive behaviors because his or her needs get satisfied without the use of maladaptive strategies. In addition to motivational attunement to approach goals, the therapist can prepare to avoid possible triggers of alliance ruptures by assessing the client's avoidance goals and noting in the case formulation which potential therapist behaviors might be particularly aversive for the client. If these behaviors are not part of necessary interventions, the therapist should try to avoid them. If necessary interventions will likely trigger avoidance goals, ". . . therapists must tune into the patient's fears . . ." (Newman, 1998, p. 114). In addition, the therapist should activate as many of the client's resources as possible (e.g., praising client strengths and previous successes, engaging a supportive partner, etc.) in order to bolster the implementation of these aversive tasks (Gassmann & Grawe, 2002; Grawe, 2004a/b).

Techniques to resolve alliance ruptures have been described in detail by Safran and Muran (2000), as well as by Burns (1999; Burns & Auerbach, 1996). According to Safran and Muran (2000), the therapeutic alliance is the result of an ongoing process of negotiation between client and therapist. These authors outline a taxonomy of interventions for addressing (directly or indirectly) alliance ruptures that is based on the three-component model by Bordin (1979). Alliance ruptures are conceptualized as either problems in the therapeutic bond or as disagreements on task and goals. In addition to these specific interventions, the authors also outline general heuristics for renegotiating the alliance after a rupture has occurred depending on how the rupture is expressed in the client's behavior (confrontation or withdrawal markers). In an experimental study, an innovative treatment that focused on the application of these rupture resolution principles (*Brief Relational Therapy, BRT*) was shown to be equally effective as CBT but yielded a lower frequency of dropouts (Safran, Muran, Samstag, & Stevens, 2002). We believe that the therapist's attunement with the client's motivational goals could be complementary to Safran and Muran's interventions. Knowing the client's motivational goals might prevent, or alert the therapist to, potential alliance ruptures. Furthermore, resolution of such ruptures may lead to a better understanding and thus attunement to the client's mo-

tivational goals. In fact, as noted by Safran and Muran (1998), one of the outcomes of a successful resolution of alliance ruptures is that the client becomes able to express his or her wishes that were not met by the therapist and/or identify the fears that the therapist confirmed. It remains to be shown, however, whether the combination of motivational attunement with the principles of rupture resolution outlined by Safran and Muran (2000) leads to better outcomes and fewer dropouts.

In sum, the issue of alliance ruptures shows how techniques and the relationship inseparably interact with each other. Techniques might trigger alliance ruptures because they fail to satisfy approach goals or confirm avoidance goals. Additionally, the therapist uses specific techniques to not only prevent alliance ruptures, but also to try to resolve them. Having a clear picture of the client's approach and avoidance goals early in the therapeutic process can support both of these therapeutic tasks.

Empirical Support for Beneficial Effect of Motivational Attunement

There is initial evidence that motivational attunement has a beneficial impact on CBT and other forms of psychotherapy. The Berne Comparative Treatment Study (BCTS, Grawe, Caspar, & Ambühl, 1990) compared broad-spectrum behavior therapy (BSBT), interactional behavior therapy (IBT), and client-centered therapy for outpatients with heterogeneous diagnoses. Both BSBT and IBT are based on Lazarus' (1973) multimodal therapy. In IBT, however, the choice of interventions used by the therapist is guided by principles of Plan Analysis (see assessment section) and a Complementary Therapy Relationship (CTR; motivational attunement). Results indicated that IBT was superior in some outcome measures, especially from the client's perspective. Additionally, in IBT, success depended less on client characteristics, and there were also fewer dropouts. Further empirical support for the beneficial effect of motivational attunement can be found in a study conducted by Caspar et al. (2005) analyzing the impact of spontaneous CTR on outcome with respect to Interpersonal Therapy for 22 depressed inpatients. In this study, spontaneous relationship behavior (displayed by the therapist) that matched the client's most important goals was associated with better outcome, from the clients' perspective. Further support can be found in research conducted by Stucki (2004), in which the relationship behavior of therapists during the first three sessions of psychotherapy was analyzed using a sample of 30 outpatients with heterogeneous diagnoses. The therapists practiced an integrative form of psychotherapy, in which the therapists differentially combined cognitive–behavioral, process-experiential, and interpersonal interventions following a case formulation based on Consistency Theory and applied motivational attunement as defined by Grawe (2004a). Results indicated that the therapists in dyads with a better client-rated relationship are more attuned to the clients' motivational goals as assessed by the IAAM. These results support the notion that motivationally attuned therapist behavior is associated with a better relationship and a more favorable outcome.

Discussion

Empirical research has shown that both technical interventions and the therapeutic relationship are important contributors to the outcome of psychotherapy, both in general and specifically in CBT. Based on the theoretical work of leading figures in CBT (as well as in other orientations), it can also be argued that the therapeutic relationship is in continuous interaction with technique, either as a facilitator of the application of techniques or as the object of techniques when it comes to fostering the alliance or dealing with alliance ruptures. We presented Consistency Theory as a model that explains the interaction of relationship and techniques and its impact on outcome via the mediational influence of need satisfaction. Motivational attunement is presented as a method that can be used to tailor therapeutic interventions to the clients' motivations in order to provide clients with need-satisfying experiences. We have attempted to demonstrate how motivational attunement can be used to foster the bond, goal, and task components of the alliance and to handle alliance ruptures. We have also described studies that begin to provide evidence to support the effectiveness of this model in psychotherapy. However, much more empirical work needs to be done.

Future research should further test the associations between motivationally attuned therapist behaviors, the therapeutic relationship, and therapy outcome. Given the small number of clients

in Caspar and colleagues' (2005) study, naturalistic studies should try to replicate these findings on spontaneous motivational attunement and outcome in CBT. Future studies should also involve experimental designs to assess the causal impact of motivational attunement on therapeutic change. For example, a CBT condition without specific alliance-fostering efforts could be compared to a CBT condition with alliance-fostering interventions according to Crits-Christoph et al. (in press), and to a CBT condition with alliance fostering via motivational attunement. Our hypothesis is that alliance fostering via motivational attunement will be associated with the best alliance ratings from the client perspective, fewer dropouts, and better outcomes.

Finally, it should be noted that this article addresses the task of fostering the therapeutic alliance by focusing mainly on client individual differences. However, the therapeutic alliance should be understood as the product of an ongoing negotiation between client and therapist, in which the needs of both participants are at play. It is therefore important to recognize the role of the therapist (as a unique person) in the successful application of the therapeutic guidelines described in this paper. Research findings have indeed revealed that therapists' individual differences account for a substantial part of the variance in the alliance (Horvath & Bedi, 2002) and in outcome (Wampold, 2001). At the minimum, these findings suggest that empirical studies examining the effects of motivational attunement on the process and outcome of psychotherapy should attempt to control for therapist effects. More important, perhaps, these results indicate that in order to fully understand how to best attend to our client's needs, our theories and research should examine therapists' characteristics that may foster and/or interfere with the satisfaction of specific needs experienced by particular clients.

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