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Relationship Factors in Treating Dysphoric Disorders

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A substantial number of interpersonal factors have been associated with depression. These factors include parental separation, neglect, rejection and abuse, family discord during childhood, marital discord, lack of social support, and lack of intimate relationships (Klerman & Weissman, 1986). Since evidence suggests that interpersonal factors play a determinant role in depression, it should come as no surprise that variables associated with the interaction between clients and their therapists might have an impact in the *treatment* of depression, as well. The goal of this chapter is to summarize our existing empirical knowledge concerning the role of relationship variables in psychotherapy involving depressed individuals.

In accordance to the guidelines of the Task Force within which this chapter is being written (see Beutler & Castonguay, this volume), our summary is primarily based on the conclusions of the recent Division 29 APA Task Force (Norcross, 2002). When appropriate, these conclusions have been complemented by the findings of other reviews of the empirical literature. Examination of studies involving depressed individuals led us to determine whether the preponderance of evidence justifies adopting these conclusions for this specific clinical population.[1] Based on such evidence, principles of change were then delineated to guide psychotherapy for depression.

It should be mentioned that, when conducting our review, we divided relevant studies into two categories: (1) studies based on purely or predominantly depressed clients, and (2) studies based on mixed samples, in which a substantial number of clients (and at times all of them) were described as suffering from various forms of dysphoric or depressive disorders (e.g., dysthymic disorder, reactive depression, "anxious-depressed" clients). Included in this second category, are studies in which client samples were described as "neurotic" or "psychoneurotic." As argued by Bohart, Elliott, Greenberg, and Watson (2002), within our current nomenclature, these samples would primarily include affective and anxiety disorders.

Numerous relationship variables have been investigated by Division 29's Task Force. In this

chapter, these variables have been organized into three clusters: quality of the therapeutic interaction, therapist interpersonal skills, and therapist clinical skills.

QUALITY OF THE THERAPEUTIC INTERACTION

Three relationship variables covered by Division 29's Task Force refer to the quality of the interaction between the therapist and client: therapeutic alliance, group cohesion, and goal consensus and collaboration.

Therapeutic Alliance

No other ingredient of the process of psychotherapy appears to have received as much empirical attention as the therapeutic alliance. Although many definitions have been provided, two crucial aspects seem to cut across many of them. As pointed out by Constantino, Castonguay, and Schut (2002), it "is generally agreed that the alliance represents interactive, collaborative elements of the relationship (i.e., therapist and client abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment" (page 86).

The review of research on therapeutic alliance conducted for Division 29's Task Force (Horvath & Bedi, 2002) led to an effect size (ES) of .21 between alliance and outcome; this ES was close to what was found in previous reviews: .22 (Martin, Garske, & Davis, 2000), and .26 (Horvath & Symonds, 1991). Although Horvath and Bedi (2002) recognized that the magnitude of the relationship between alliance and outcome is not excessively high, they nevertheless concluded that "the quality of the alliance is an important element in successful, effective therapy" (p. 61). This conclusion is consistent with Orlinsky, Grawe, & Parks's (1994) authoritative review of process-outcome literature: "The strongest evidence linking process to outcome concerns the *therapeutic bond* or alliance, reflecting more than 1,000 process-outcome findings" (p. 360). Examining Horvath and Bedi's (2002) review of the empirical literature, we were able to find 10 studies involving samples of predominantly or purely depressed individuals (Andreoli et al., 1993; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Feeley, 1993; Gaston, Marmar, Thompson, & Gallager, 1991; Gaston, Thompson, Gallager, Cournoyer, & Gagnon, 1998; Krupnick et al., 1994; Krupnick et al., 1996; Marmar, Gaston, Gallager, & Thompson, 1989; Rounsaville et al., 1987; Zuroff et al., 2000). All of them reported at least one significant finding supporting the relationship between good alliance and positive outcome, and none of them reported a significant negative relationship between the quality of the alliance and client improvement. It should be noted, however, that: four of these studies were based on data from the Treatment for Depression Collaborative Research Program (i.e., Krupnick et al., 1994; Krupnick et al., 1996; Rounsaville et al., 1987; Zuroff et al., 2000); three others were based on the same sample of older depressed patients (Gaston et al., 1991, 1998; Marmar et al., 1989); and, finally, two others were based on a data set collected by Hollon et al. (1992) (i.e., Castonguay et al., 1996; Feeley, 1993).

Because of the overlap between these studies with "pure" or predominantly depressed samples, we also considered all of the studies (15) conducted with mixed depressed samples that we could find based on Horvath and Bedi (2002) review (i.e., Clarkin & Crilly, 1987; Crits-Cristoph, Cooper, & Luborsky, 1988; Gomes-Schwartz, 1978; Hatcher & Barends, 1996; Lieberman, von Rehn, Dickie, Elliot, & Egerter, 1992; Marmar, Weiss, & Gaston, 1989; Marziali, 1984; Muran et al., 1995; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; O'Malley, Suh, & Strupp, 1983; Paivio & Bahr, 1998; Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991; Piper, Boroto, Joyce, McCallum, & Azim, 1995; Safran & Wallner, 1991; Windholz & Silberschatz, 1988). All of these investigations found at least one significant positive relationship between alliance and improvement, and none of them reported a significant negative association.

We also found three studies (based on a purely depressed sample) not included in Horvath and Bedi's (2002) review. While one of them (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998) reported significant positive relationships between alliance and outcome, the other two failed to find a significant correlation between alliance and outcome (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand 1999). Despite these inconsistent findings, as well as the overlap between some of the previous studies, it appears that the decision by the Division 29 Task Force to consider the alliance as a "demonstrably effective" element of the therapeutic relationship (Norcross, 2002) is an acceptable conclusion with respect to psychotherapy for depression. This leads us to recommend the following principle of change:

1. When working with clients with dysphoric disorders, therapists should strive to develop and maintain a positive working alliance with their clients.

Cohesion in Group Psychotherapy

In their contribution to the Division 29 Task force, Burlingame, Fuhriman, and Johnson (2002) have argued that the concept of cohesion represents the "essence" of the therapeutic relationship in group psychotherapy. While it involves different categories of interaction than what is found in individual treatment (e.g., member to member, member to leader), cohesion explicitly refers, in the eyes of these authors, to the dimensions of bonding and collaboration. As such, cohesion could be perceived as the group equivalent of the therapeutic alliance in individual psychotherapy. Consistent with this line of reasoning, Orlinsky et al.'s (1994) review of the therapeutic bond or alliance includes studies on group cohesion.

Burlingame et al.'s (2002) consideration of the empirical literature led them to conclude that cohesion is a predictor of outcome. Of the specific studies reported in their chapter, two of them were based on mixed samples involving depressive disorders (e.g., "disturbed neurotic" or "depressed and/or anxious"; Budman et al., 1989; Tschuschke & Dies, 1994). In each of the studies, a significant positive relationship was found between cohesion and improvement, while a significant negative relationship was not found. Similar results were also found in a study that was not included in Burlingame et al.'s (2002) review, but that was conducted with a sample of purely depressed patients (Hoberman, Lewinsohn, & Tilson, 1988). Even though the number of studies is small, the findings of these three studies are consistent with the general conclusion arrived at by Burlingame et al. (2002), as well as the decision of the Division 29 Task Force to consider cohesion as a "demonstrably effective" element of the therapeutic relationship (Norcross, 2002). As such, it seems appropriate to state the following principle of change:

1. When conducting group therapy with depressed individuals, therapists should foster a strong level of cohesiveness within the group.

Goal Consensus and Collaboration

The Division 29 Task Force drew specific conclusions for goal consensus (i.e., therapist and client agreement on treatment goals) and collaborative involvement (i.e., therapist and client mutual involvement in therapy), even though both elements, and especially goal consensus, seem to be components of the working alliance. In fact, as noted in the Division 29 report, "goal consensus is one aspect of the *working alliance*" (Tryon and Winograd, 2002, p. 109).

Tryon and Winograd (2002) concluded that current research evidence provides a general support for a positive relationship between both goal consensus and collaboration and treatment outcome. This, of course, is hardly surprising considering the findings on alliance presented above. With respect to depressed clients, we found only two studies in Tryon and Winograd's chapter that investigated goal consensus (Gaston et al., 1991; Marmar et al., 1989). Because both of them are already included in our review of alliance studies, we have decided not to derive a conclusion (nor a principle of change) specific to this variable.

With regard to collaborative involvement, five published studies reviewed by Tryon and Winograd (2002) involved predominantly or purely depressive samples. Three of these studies found that involvement (as measured by homework compliance) significantly predicted improvement (Burns & Nolen-Hoeksema, 1991; Burns & Spangler, 2000; Persons, Burns, & Perloff, 1988), whereas the remaining two studies did not find that homework compliance or attendance significantly predicted improvement (Hoberman et al., 1988; Rounsaville, Weissman, & Prusoff, 1981). Five other studies conducted with mixed samples involving depressive or dysphoric disorders (e.g., ad-

justment disorder with depressed mood, anxiety and affective disorders) found different facets of involvement (e.g., high level of participation, low level of defensiveness or resistance) to be related to outcome (Buckley, Conte, Plutchik, Wild, & Karasu, 1984; Jones, Parke & Pulos, 1992; Kolb, Beutler, Davis, Crago, & Shanfield, 1985; Piper, de Carufel, & Szkrumelak, 1985; Soldz, Budman & Demby, 1992).[2] None of the 10 studies above reported a significant negative relationship between collaborative involvement and client improvement.[3] Taken together, these findings suggest that Tryon and Winograd's (2002) conclusion applies to the treatment of depressive disorders. Accordingly, we endorse the decision of the Division 29 Task Force to identify collaboration as a "demonstrably effective" element of the therapeutic relationship (Norcross, 2002), and recommend the following principle of change:

1. Therapists working with depressed individuals should attempt to facilitate their engagement during and between sessions.

THERAPIST'S SKILLS: ATTUNING TO THE CLIENT

Reflecting the major impact of the client-centered approach on the field, three interpersonal skills have been the focus of considerable amount of research attention: empathy, positive regard, and congruence.

Empathy

Empathy, or the therapist's ability to understand the client's inner experience from the client's frame of reference, has been described in most therapeutic orientations as an essential element of therapy. The Division 29 Task Force has provided empirical support for this theoretical and clinical assumption on the basis of a meta-analysis involving 47 studies (which included, all together, more than 3,000 clients; Bohart et al., 2002). Reflecting a medium effect size, an *r* of .32 was reported as the best summary value of the relationship between empathy and outcome.

The findings of this meta-analysis are consistent with Orlinsky et al.'s (1994) box score review, in which 54% of the reported findings showed a positive significant correlation, and in which no negative correlations were observed.

Forty-seven percent of the study included in Bohart et al.'s (2002) review involved "mixed neurotic" clients. As mentioned above, these authors have argued that such a client population would, in most recent studies, include primarily affective and anxiety disorders. Of the studies reviewed by Bohart et al. (2002) that we examined, however, only one appeared to be either exclusively or predominantly based on a sample of depressed individuals (Burns & Nolen-Hoeksema, 1992). On the basis of a sophisticated structural modeling equation, the finding of this study suggested a causal relationship between the experience of the therapist as being empathic and the client's improvement. We also surveyed 15 studies cited by Bohart and his colleagues (2002) involving less homogeneous samples (e.g., mixed depressed and anxious clients; Bergin & Jasper, 1969; Beutler, Johnson, Neville, & Workman, 1972; Bugge, Hendel, & Moene, 1985; Cooley & Lajoy, 1980; Dormaar, Dijkman, & de Vries, 1989; Kurtz & Grummon, 1972; Lafferty, Beutler, & Crago, 1989; Lorr, 1965; Peake, 1979; Saltzman, Leutgert, Roth, Creaser, & Howard, 1976; Saunders, 2000; Staples, Sloane, Whipple, Cristol, & Yorkston, 1976; Strupp, Fox, & Lessler, 1969; Truax et al., 1966; Truax & Wittmer, 1971). We found that 12 of them reported at least one significant finding supporting a positive relationship between empathy and outcome.[4] We also found three relevant studies with mixed samples (including clients with depressive disorders or described as neurotics) that were not included in Bohart et al.'s (2002) review. While two of them found that empathy correlated significantly with outcome (Conte, Ratto, Clutz, & Karasu, 1995; Truax, 1971), the other did not (Staples & Sloane, 1976). Thus, as a whole 79% of the studies reviewed here reported at least one significant relationship with client's improvement (because two of the studies [Truax et al., 1966, and Truax & Wittmer, 1971] appear to have used the same data set, however, a more conservative ratio of 78% [14 out of 18] might be more appropriate). Furthermore, none of these 19 studies revealed a significant negative link between empathy and improvement. Taken together, these findings suggest that the conclusion of the Division 29 Task Force with regard to the positive role of empathy (as a "demonstrably effective" element of the therapeutic relationship) is likely to be accurate for the treatment of depression. As such, these findings lead us to state the following principle of change:

1. When working with depressed individuals, therapists should relate to their clients in an empathic way.

Positive Regard

In their contribution to the Division 29 Task Force, Farber and Lane (2002) refer to positive regard as a "general constellation of attitudes" that encompasses nonpossessive warmth, acceptance, prizing, and caring. Based on a summary of six previous reviews of the empirical literature, as well as their own review of 16 recent studies, these authors cautioned that it is difficult to draw firm conclusions about positive regard. Nevertheless, they argue that the research suggests there is a positive (although modest) relationship between this component and outcome.

With respect to the magnitude of the relationship between positive regard and improvement, a number of issues appear salient. As observed in Orlinsky et al.'s (1994) review (the most comprehensive one summarized by Farber and Lane [2002]), the effect size varies considerably, which suggests that the relationship may be impacted by different factors. Farber and Lane's (2002) own review showed that the effect sizes appear to be larger with length of stay than with outcome, which, as they cogently note, may indicate that the main helpful impact of positive regard may be to facilitate the client's staying in therapy for a longer period of time. While the authors emphasized that the effect size with regard to outcome appears to be modest, they conclude that it is strongly indicated for the therapist to provide positive regard and that, "at minimum, it sets the stage for other mutative interventions and that, at least in some cases, it may be sufficient itself to effect positive change" (p. 191). Even with these caveats in mind, the authors clearly indicate that there is no evidence to suggest that therapists should avoid being warm, accepting, and caring toward their clients.

Examining the studies reviewed by Farber and Lane (2002), we found seven that involved samples with depressed adults (Bachelor, 1991; Coady, 1991; Conte et al., 1995; Gaston et al., 1991; Hayes & Strauss, 1998; Hynan, 1990; Quintana & Meara, 1990). We also found three other relevant studies not included in this review (Lafferty et al., 1989; Staples & Sloane, 1976; Truax, 1971). Of these 10 studies, six (60%) found at least one significant finding between positive regard and outcome.

It is important to mention, however, that neither of the two studies involving a purely depressed sample found a significant positive relationship between positive regard and outcome (Gaston et al., 1991; Hayes & Strauss, 1998). Such discrepancies in the results obtained with the two types of samples (mixed and pure) should raise caution in our conclusion. Nonetheless, the predominance of the positive findings found in the studies as a whole, and the absence of any negative relationship in all of them, suggest that positive regard can be considered, at least tentatively, as a therapeutic factor in the treatment for depressive or dysphoric disorders. At the minimum, the evidence provides support for the Division 29 Task Force decision to consider positive regard as a "promising and probably effective" element of the therapeutic relationship (Norcross, 2002). This, in turn, leads us to cautiously suggest the following principle of change:

1. When adopted by therapists, an attitude of caring, warmth, and acceptance is likely to be helpful in facilitating therapeutic change in depressed clients.

Congruence

Congruence, the third Rogerian attitude, has been defined in the Division 29 Task Force as "a self-awareness on the part of the therapist, and a willingness to share this awareness in the moment" (Klein, Kolden, Michels, & Chisholm-Stockard, 2002, p. 196). After noting that the consensus emerging from previous reviews (11, completed between 1970 and 1994) pointed to a mixed support for the role of congruence on client's improvement, Klein et al. (2002) conducted their own review of 20 studies. They found that 34% of the reported results were positive, a number similar to the comprehensive reviews of Orlinsky and

his colleagues (Orlinsky & Howard, 1986; Orlinsky et al., 1994).

Taking into consideration many of the methodological limitations (e.g., small *N*, restricted variance) that have characterized studies on congruence, the authors concluded that despite the mixed empirical evidence this construct "should be recognized as a key psychotherapy treatment parameter and a potent change process with both interpersonal and intrapersonal dimensions" (p. 210).

We reviewed six studies cited by Klein et al. (2002) that involve clients with depressive disorders (e.g., all of them based on mixed samples; Jones & Zoppel, 1982; Lafferty et al., 1989; Sloane, Staples, Cristol, Yorkson, & Whipple, 1975; Staples & Sloane, 1976; Truax, 1971; Truax et al., 1966). We found that three of these studies (50%) reported a significant positive relationship between congruence and outcome, while none of them reported a significant negative relationship. Because these results meet the criteria proposed and labeled by the current Task Force as "preponderance" of the evidence (i.e., 50% or more; Beutler & Castonguay, this volume), we accept the Division 29 Task Force's categorization of congruence as a promising and potentially effective element of the therapeutic relationship (Norcross, 2002) and recommend the following principle of change:

1. When working with individuals suffering from depressive symptoms, therapists are likely to facilitate change when adopting an attitude of congruence or authenticity.

THERAPIST'S SKILLS: WORKING WITH THE THERAPEUTIC RELATIONSHIP

In addition to investigating the skills involved in the therapist's attunement to the client's experience, researchers have also studied a number of strategies based on the therapist's focus on, attempt to manage, or reaction to aspects of the therapeutic relationship. These strategies include repairing alliance ruptures, feedback, self-disclosure, management of counter-transference, and relational interpretations.

Repairing Alliance

One of the obvious clinical implications of the robust link between the quality of the alliance and outcome is that, when alliance problems emerge (e.g., disagreement about tasks or goals, difficulty in maintaining a strong bond), they should be properly repaired. As noted in the Division 29 report (Safran, Muran, Samstag, & Stevens, 2002), preliminary and/or qualitative studies have begun to suggest that some strategies or processes (e.g., exploring client's negative feelings related to ruptures, therapist's nondefensiveness) are related to the improvement of alliance and outcome, and that the pattern of worsening and repairing of alliance during treatment is positively related to outcome.

None of the studies providing support for such positive relationships specifically involved depressed samples. Following the guideline proposed by the current Task Force (see Beutler & Castonguay, this volume), we thus accept by default (i.e., pending further research) the decision of the Division 29 Task Force to define the repair of alliance rupture as a "promising and probably effective element" of the therapeutic relationship (Norcross, 2002). On this basis, we also tentatively proposed the following principle of change:

1. Repairing alliance ruptures that emerge during treatment is likely to be helpful when working with depressed clients.

It should also be mentioned, however, that three studies conducted with depressed individuals (one based on a purely depressed sample and two based on mixed samples) involved qualitative analyses that suggest that the therapist's persistence in the use of specific interventions (e.g., focus on cognitive model in cognitive therapy, interpretation in psychodynamic therapy) when confronted with alliance problems may foster engagement in a negative interpersonal cycle as opposed to resolving the alliance rupture (Castonguay et al., 1996; Piper, Azim, Joyce, & McCallum, 1991; Piper et al., 1999). While the qualitative nature of these findings calls for caution, we nevertheless believe that they provide at least tentative support for the following principle of change:

2. Therapists working with depressed individuals may find it helpful to adopt an empathic and nondefensive (or nonrigid) attitude when attempting to repair alliance ruptures.

Feedback

Feedback can be considered an essential component of human interactions. In psychology, the term "feedback" has been used to describe "(1) information provided to a person (2) from an external source (3) about the person's behavior or the effects of that behavior" (Claiborn, Goodyear, & Horner, 2002, p. 217). In psychotherapy, two types of feedback seem particularly relevant, that is, feedback in the therapeutic process and feedback about testing results. According to Jacobs (1974; cited in Claiborn et al., 2002), feedback can consist of (1) observation/description of the client's behavior, (2) emotional reaction to the client's behavior, (3) inference about something that is not directly observable in the client, or (4) mirroring (e.g., showing video recordings).

Based on Claiborn et al.'s (2002) review of evidence, feedback was designated as a "promising and probably effective" element of the therapeutic relationship by the Division 29 Task Force (Norcross, 2002). Of the studies reviewed by Claiborn et al. (2002) that investigated the relationship of feedback and outcome, however, none were based on a sample that explicitly included clients with depressive or dysphoric disorders. Thus, in accordance to the guidelines of the present Task Force (see Beutler & Castonguay, this volume), we accept the Division 29 conclusion by default (i.e., pending further research), and tentatively propose the following principle:

1. Depressed clients are likely to benefit from receiving feedback from their therapists.

Therapist Self-Disclosure

Self-disclosure is defined in psychotherapy process research as the therapist act of revealing personal information about oneself to the client. Therapist self-disclosure can be further categorized along dimensions such as its content of disclosure (i.e., simple personal facts, therapist's own life experience, response to the client), type (reassuring or challenging self-disclosures), and level of reciprocity with client or not.

Traditionally therapists were trained to remain neutral, anonymous, and non-self-disclosing. Humanistic and feminist theories of psychotherapy brought this stance into question and encouraged therapist authenticity and mutuality in the therapeutic encounter. Current interest in relational aspects of psychoanalytically and psychodynamically oriented therapies, as well as cognitive-behavioral, experiential, and integrative approaches, may foster further interest in studying the function of therapist self-disclosure in treatment.

In Orlinsky et al.'s (1994) review of process research, the majority of the studies on self-disclosure did not show a significant association with outcome, and where there was a significant relationship, it was negative as often as positive. In the Division 29 Task Force's review, however, self-disclosure appears to receive more credibility as a useful therapeutic intervention. While the studies reviewed by Hill and Knox (2002) revealed mixed findings with regard to post-treatment outcome, they also point to the helpfulness of self-disclosure when the effect of therapy is measured in terms of immediate outcome. As a result, self-disclosure was retained as a "promising and probably effective" element of the therapeutic relationship (Norcross, 2002).

Based on Hill and Knox's (2002) review, we found a relatively small number of studies involving depressed individuals (all of them conducted with mixed samples). In a study comparing the conditions of increased disclosure and limited disclosure, Barrett and Berman (2001) found that heightened therapist disclosure was significantly related to client reports of lower levels of symptom distress and a client's liking of his or her therapist. In another study, self-disclosure was folded into a multivariable therapist dimension (including being more personal, self-disclosing, active, and emphasizing current feelings in their relationship with clients) that correlated positively with good treatment outcome (Beutler & Mitchell, 1981). Using the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), however, Coady (1991) failed to find that the therapist's behavior of disclosing/expressing significantly differentiated between cases of good and poor outcome.

In the first of two studies conducted with the same sample of anxious-depressed clients, Hill et al. (1988) failed to find a significant correlation between self-disclosure and treatment outcome. They did, however, find that self-disclosure received the highest client ratings of helpfulness and experiencing (both defined as immediate outcome) among therapist response modes. Interestingly, therapists tended not to rate self-disclosure as highly as clients, with some of the therapists rating it as the most helpful and others rating it as one of the least helpful response modes. In the second study, Hill, Mahalik, and Thompson (1989) found that reassuring disclosures were rated by clients and therapists as more helpful and related to higher levels of client experiencing than challenging disclosures. However, no support was found for the hypothesis that self-involving disclosures (therapist's personal response to the client) were more helpful than self-disclosing disclosures (past tense statements of therapist's personal experience).

A qualitative study worthy of mention for the light it sheds upon therapist self-disclosure (Knox, Hess, Petersen, & Hill, 1997) examined a predominantly depressed sample of clients' perceptions of the effects of therapist self-disclosure in long-term therapy. Therapists were of varied orientations (behavioral, cognitive-behavioral, psychoanalytic-psychodynamic, humanistic-experiential, and eclectic) and word descriptions were used to evaluate the event of therapist self-disclosure. Clients perceived therapist self-disclosures as important events resulting in positive consequences of insight, a new perspective from which to make changes, a more equalized or improved therapeutic relationship, normalization, and reassurance. Interestingly, all examples were of personal nonimmediate information, such as revelations about family, leisure activities, or past similar experiences with those of the client.

As a whole, the evidence reviewed seems to provide support for self-disclosure, at least as a promising and possibly effective relationship factor. However, it should be mentioned that some of the findings reported above were obtained with immediate outcome measures (i.e., clients' perceived helpfulness and level of experiencing), which are distinct from the post-treatment outcome measures that have been used as the primary basis of evaluation in this chapter and the current Task Force. Even when only considering treatment outcome measures, however, 50% of the studies that examined the link between self-disclosure alone or in combination with other variables and improvement found a significant positive relationship. While this meets the criteria proposed for the current Task Force (see Beutler & Castonguay, this volume), one should also keep in mind that the number of the quantitative studies is relatively small (i.e., four, if one counts the two investigations conducted by Hill and her colleagues with the same sample as one study). Taking all of these issues into consideration, it seems indicated to cautiously propose the following principle of change:

1. When working with depressed clients, therapists' use of self-disclosure is likely to be helpful. This may be especially the case for reassuring and supportive self-disclosures, as opposed to challenging self-disclosures.

Management of Countertransference

As Gelso and Hayes (2002) indicate in their review for Division 29's Task Force, the concept of countertransference is associated with a considerable "definitional ambiguity" (p. 267). Following Epstein and Feiner (1988), at least three conceptions of countertransference can be distinguished. In the "classical" view, which we owe to Freud, countertransference is described as "the therapist's unconscious, conflict-based reaction to the client's transference" (Gelso & Hayes, 2002, p. 268). A second perspective, termed "totalistic," defines countertransference as "all of the therapist's emotional reactions to the patient" (Gelso & Hayes, 2002, p. 268). In contrast, the "complementary" view sees countertransference as the "complement to the patient's transference or style of relating" (Gelso & Hayes, 2002, p. 268), that is, the therapist's internal and behavioral responses to the patient's interpersonal "pulls."

Based on Gelso and Hayes's (2002) review of the research evidence, countertransference was retained by the Division 29 Task Force as a "promising and probably effective element" of the therapeutic relationship (Norcross, 2002). However, none of the studies that investigated the link between outcome and the degree of countertransference or the management of countertransference explicitly described their samples as involving clients with depressive or dysphoric disorders. Following the guidelines of the present Task Force (see Beutler & Castonguay, this volume), we thus accept the Division 29 conclusion by default (i.e., pending further research) and tentatively suggest the following principle:

1. When working with depressed clients, therapists are likely to be more effective when they adequately manage their countertransference reactions toward their clients.

Relational Interpretations

As Crits-Christoph and Connolly Gibbons (2002) point out in their review for the Division 29 Task Force, the concept of relational interpretations stands midway between technical and relationship aspects of psychotherapy. Like all techniques, they occur in the context of (and are likely to influence) the therapeutic relationship. In contrast with most other technical procedures, however, they directly focus on client relationship, including the client–therapist interaction.

Crits-Christoph and Connolly Gibbons's (2002) review of the empirical evidence revealed differential findings depending on whether one considers the frequency or the quality of the interpretations. With regard to the relationship between the frequency of relational interpretations and outcome, these authors concluded that the findings have been generally mixed. This conclusion appears to be consistent with Orlinsky et al.'s (1994) review. While they found that interpretation, as an intervention mode, appears to be effective, they also found mixed results with regard to the therapist's direct focus on core personal relationships and transference issues (i.e., "2 of the 27 findings are significantly negative and fewer than 40% indicated significant positive association with outcome," p. 296). Interestingly, Crits-Christoph and Connolly Gibbons (2002) have argued that transference interpretations should be used with care, as recent studies suggest that high rates of this intervention are associated with poor outcome.

An examination of the studies relevant to the frequency of relational interpretation that have been reviewed by Crits-Christoph and Connolly Gibbons (2002) revealed that only one involved a sample of purely depressed individuals (Connolly et al., 1999). For the entire sample, the authors found that the proportion of transference interpretations to total interventions in supportive-expressive therapy did not significantly predict outcome. However, the proportion of transference interpretations predicted worse outcome for clients who specifically demonstrated low quality of interpersonal relations prior to treatment.

When examining Crits-Christoph and Connolly Gibbons's (2002) review, we also found seven studies with mixed samples (including depressed or dysphoric clients) that focused on frequency of relational interpretation (Hill et al., 1988; Høglend, 1993; Malan, 1976, Studies 1 & 2; Piper, Debbane, Bienvenu, de Carufel, & Garant, 1986; Piper, Debbane, de Carufel, & Bienvenu, 1987; Piper, Azim, Joyce, & McCallum, 1991). Four of these studies (Malan, 1976, Studies 1 & 2; Piper et al., 1986, 1987) reported at least one positive significant finding supporting a relationship between the frequency or proportion of relational interpretations and improvement. However, three of these studies (Høglend, 1993; Piper et al., 1986; Piper, Azim, Joyce, & McCallum, 1991) reported at least one negative significant relationship between frequency or proportion of transference interpretations and favorable outcome. In Høglend (1993), however, such negative effect was only significant for clients with a high quality of object relations. Furthermore, when Piper et al. (1986) conducted separate analyses for high versus low quality of object relations, the negative results were significant only for the group with a high quality of object relations.

As a whole, we found that, whereas 50% of the studies with depressed or dysphoric clients reported at least one significant positive finding, 50% of the same group of studies reported at least one significant negative result. Taken together, the evidence lends support to Crits-Christoph and Connolly Gibbons's (2002) conclusion that direct correlations between frequencies of interpretations and outcome yield mixed results. The notable presence of negative results also gives credence to

their warning about the potential risk of high rates of relational interpretation and seems to justify the following principle:

1. When working with depressed clients, therapists should avoid high levels of relational interpretations.

With respect to the relationship between the quality of the interpretations and outcome, Crits-Christoph and Connolly Gibbons's (2002) consideration of the empirical literature led them to conclude that "studies of the quality of interpretations have yielded consistent findings suggesting that relatively more favorable treatment outcomes are produced when therapists accurately address central aspects of patients' interpersonal dynamics" (p. 295). All three studies cited by the authors (Crits-Christoph, Cooper, & Luborsky, 1988; Piper, Joyce, McCallum, & Azim, 1993; Norville, Sampson, & Weiss, 1996) were conducted with mixed samples involving clients with dysphoric disorders. All three studies found at least one positive correlation between the quality of interpretations and outcome, and none of them found a negative correlation.

Based on the evidence reviewed above, it appears that the decision of Division 29 to consider the *quality* of relational interpretation as a promising and probably effective element of the therapeutic relationship (see Norcross, 2002, p. 442) is acceptable with regard to psychotherapy for depression. This leads us to recommend the following principle of change:

2. When making relational interpretations, therapists should strive to accurately address client's central interpersonal themes, as a high level of accuracy (or quality) with regard to these interpretations is likely to be beneficial for the client.

CONCLUSION

Summary

From the current state of the literature, largely based on the evidence reviewed within the context of the Division 29 Task Force on therapeutic relationship factors, two sets of principles of change have been derived for psychotherapy with dysphoric clients. The first set is based on the acceptance of conclusions reached by the Division 29 Task Force, even though the evidence supporting these conclusions has not been obtained on samples of clients explicitly identified as having dysphoric or depressive disorders. As such, this first set of principles should be considered tentative.

1. Repairing alliance ruptures that emerge during treatment is likely to be helpful when working with depressed clients.
2. Depressed clients are likely to benefit from receiving feedback from their therapists.
3. When working with depressed clients, therapists are likely to be more effective when they adequately manage their countertransference reactions toward their clients.

The second set of principles is based on some amount of evidence obtained with the dysphoric clients. These principles concern the general quality of the therapeutic relationship, the therapist's interpersonal attitude (deeply anchored in the client-centered tradition), and a number of skills related to the management of the therapeutic relationship.

1. When working with clients with dysphoric disorders, therapists should strive to develop and maintain a positive working alliance with their clients.
2. When conducting group therapy with depressed individuals, therapists should foster a strong level of cohesiveness within the group.
3. Therapists working with depressed individuals should attempt to facilitate their engagement during and between sessions.
4. When working with depressed individuals, therapists should relate to their clients in an empathic way.
5. When adopted by therapists, an attitude of caring, warmth, and acceptance is likely to be helpful in facilitating therapeutic change in depressed clients.
6. When working with individuals suffering from depressive symptoms, therapists are likely to facilitate change when adopting an attitude of congruence or authenticity.
7. Therapists working with depressed individuals may find it helpful to adopt an empathic and nondefensive (or nonrigid) attitude when attempting to repair alliance ruptures.
8. When working with depressed clients, therapists' use of self-disclosure is likely to be helpful. This may be especially the case for reassuring and supportive self-disclosures, as opposed to challenging self-disclosures.
9. When working with depressed clients, therapists should avoid high levels of relational interpretations.
10. When making relational interpretations, therapists should strive to accurately address client's central interpersonal themes, as a high level of accuracy (or quality) with regard to these interpretations is likely to be beneficial for the client.

Future Directions

Although the majority of these principles have been derived from a considerable amount of process-outcome research, much more needs to be done. To begin with, it is important to recognize that, with the exception of alliance, few studies have been conducted with purely or predominantly depressed samples. This is surprising considering the fact that a substantial number of clinical trials have been conducted specifically on this disorder. Thus, more efforts should be directed toward making use of archival data in order to explore different aspects of the process of change and their links with outcome. Interestingly, more studies investigating alliance with purely depressive samples have recently appeared, providing further evidence for its role in client improvement (Hardy et al., 2001; Klein et al., 2003).

It should also be pointed out that much of the research on relationship variables have been plagued by problems. This could be explained, at least in part, by the fact that, for a number of the relationship constructs, the buck of the empirical investigation was conducted several decades ago—when process-outcome research was still at its infancy. To take the concept of congruence as an example, Klein et al. (2002) have noted that most of the process-outcome results came from studies conducted in the 1960s and 1970s, without any such studies conducted after 1989. The authors also concluded that many of the methodological limitations (e.g., small *N*, low levels of conditions) may have failed to do justice to the relationship between congruence and outcome. It might therefore be appropriate to revisit the status of many relationship variables by conducting new research with better and more powerful designs.

Although the principles listed above recognize the role or potential influence of several relationship variables in the psychological treatment of dysphoric clients, they do not begin to reflect the complexity of the process of change within which these relationship factors are likely to be involved. Not addressed in this chapter are fascinating and, ultimately, crucial questions such as these: Is the contribution of any of the specific relationship variables to client improvement independent of other factors, e.g., does the alliance predict outcome above and beyond the client's pretreatment symptoms and/or the therapist's empathy? Does the quality of relationship factors precede or follow client change, for example, are therapists more effective when they adequately manage their countertransference, or are they less likely to act out their maladaptive internal reactions when clients are experiencing less distress and life difficulties? How are these variables influencing each other, for example, what kind of impact does the therapist's self-disclosure or quality of relational interpretations have on the alliance? Do some of these variables interact among themselves to produce change, for example, is a highly authentic (congruent) therapist more or less effective when clients pull for countertransferential reactions? Can a high level of congruence, low level of countertransference, and moderate level of self-disclosure be an optimal combination of therapeutic components? Is the effect of some relationship variables moderated by client and therapist pretreatment characteristics, for example, are high rates of relational interpretations particularly counter-indicated for some types of clients? Should therapists with relatively poor attachment style refrain from frequent self-disclosure? Do some of these relationship variables serve as mediators of change?

Although some of these specific questions have

begun to receive empirical attention, we believe that researchers should make more use of current sophisticated statistical and qualitative methods to provide contextual, multidimensional, and sequential analyses of the process of change. Rather than restricting ourselves, as we often do, to investigate simple relationships between two variables (e.g., a measure of alliance and a measure of outcome), we should devote more energy to complex effects that are perhaps best expressed by modifications of Paul's (1966) famous question, such as: Under what condition, in combination of which skills and techniques, and with what kind of participants, is a specific relationship component likely to be more beneficial?

Investigation of such complex relationships is likely to provide support for what we believe is a basic principle of change operating in the treatment of depression, as well as all other forms of psychological disorders:

1. Relationship variables are effective when provided in appropriate contexts and in interaction with several other therapeutic factors.

Although the evidence reviewed in this chapter suggests that many relationship variables contribute to client improvement, we do not believe that a few factors (e.g., empathy or alliance) in and of themselves directly lead to good outcome. Accordingly, we hope that future research will attempt to contextualize relationship factors by investigating the interaction of multiple influences operating in the process of change.

Furthermore, while research has made a considerable contribution to our understanding of relationship factors in psychotherapy, it is important to recognize that it has been difficult to operationalize, and therefore formally study, several aspects of the therapeutic relationship that clinicians have long believed to be important. These involve issues such as: the containment function of the relationship; identifications that the client makes concerning the therapist; and the shifts in the therapeutic relationship over time. Future empirical efforts, hopefully conducted in close collaboration between clinicians and researchers, should address these complex issues.

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Notes

1. Although we made an effort to conduct a comprehensive review of the relevant studies cited by the Division 29 Task Force, we were not able to find all of them (e.g., conference presentations, unpublished dissertations).

2. In Buckley et al. (1984), the negative relationship between client lack of involvement (i.e., degree of resistance) and outcome was marginally significant ($p < .1$).

3. It should be noted, however, that in one of these studies, the therapeutic participation ("extent and quality of the patient's involvement in the group") interacted with the overall level of activity (as measured by the number of times the patient was the main actor in group therapy) in predicting therapeutic benefit (Soldz et al., 1992). As noted by the authors, "more resistant behavior was connected with better outcome for patients who were the main actor only a few times, whereas the direction of the relationship was reversed for patients who were the main actor more frequently" (p. 60). It should also be mentioned that Soldz et al. (1992) found that the patient's ease of self-expression ("the main actor's spontaneous openness in expressing his/her feelings") negatively correlated with self-esteem improvement. Consistent with Tryon and Winograd's (2002) review, however, we did not consider this process variable to reflect collaborative involvement. Some patients can have difficulty expressing their emotion and still be very much involved in the group, while others may find it difficult to take initiative and work collaboratively and yet be able to easily express their feelings when they talk in the group.

4. In Bugge et al.'s (1985) study, no significance level was provided for "understand your feelings." However, this item was included in the group of process variables that accounted for more than one-third of the variance in either or both of the outcome measures used (i.e., satisfaction with therapy and therapist helpfulness).

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