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Processing the Therapeutic Relationship

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Abstract: *The authors propose that if therapists and clients process their therapeutic relationship (i.e., directly address in the here and now feelings about each other and about the inevitable problems that emerge in the therapy relationship), feelings will be expressed and accepted, problems will be resolved, the relationship will be enhanced, and clients will transfer their learning to other relationships outside of therapy. The authors review theories supporting the idea of processing the therapeutic relationship, discuss the relevant empirical literature in this area, and provide their conceptualization of the construct of processing the therapeutic relationship based on the theory and empirical findings. Finally, they discuss methodological concerns and suggest implications for clinical practice, training, and further research.*

Research has established that the psychotherapy alliance is the most robust predictor of psychotherapy outcome (Norcross, 2002), that poor alliances are associated with unilateral termination (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990, 1993, 1995), that therapists often respond to client hostility with counterhostility in the context of a weak alliance (Coady, 1991; Henry, Schacht, & Strupp, 1986, 1990; Kiesler & Watkins, 1989; Tasca & McMullen, 1992), and that it is difficult to train therapists to avoid

negative relational processes in therapy (Henry, Schacht, Strupp, Butler, & Binder, 1993; Piper et al., 1999). Thus, the alliance seems to be crucial for good process and outcome in therapy. But what in the alliance is healing, and how is the alliance developed or enhanced? These questions have not received as much attention as the quality of the alliance in the empirical literature, but they are crucial if we are to understand how the alliance functions.

One clue about how the alliance operates comes from Bordin's (1979, 1994) proposal that it is the tear and repair of the relationship that actually makes it stronger and leads to client change. He asserted as well that this tear-and-repair phenomenon is an essential and expected part of the therapeutic process. Likewise, we propose that one of the mechanisms of building and repairing the therapeutic relationship is processing the relationship, which we define as direct communication about the relationship. In other words, we speculate that if therapists and clients directly address in the here and now their feelings about each other and about the inevitable problems that emerge in the therapy relationship (also called metacommunication or relational work), feelings will be expressed and accepted, problems will be resolved, the relationship will be enhanced, and clients will transfer their learning to other relationships outside of therapy. Although there are other mechanisms of change in psychotherapy (e.g., insight, behavioral activation), we argue that relational work is one mechanism of change that is important for some clients and thus deserves attention.

To examine this proposition more deeply, we first provide a theoretical foundation for the importance of working directly with the therapy relationship. We then review the empirical work on processing the relationship. Finally, we describe methodological concerns and provide recommendations for research, practice, and training. In this article, we use the term ''relationship'' to refer to the totality of the interpersonal field between the therapist and client and include in this term the concepts of the real relationship, the working or therapeutic alliance, and transference and countertransference. Finally, we interchangeably use the phrases ''processing the therapeutic relationship'' and ''relational work.''

Theory

We now review some of the major theoretical perspectives regarding processing the therapeutic relationship. This review is not exhaustive but rather presents a representative theory from each of several traditions that advocate working with the therapeutic relationship as a mechanism of change in psychotherapy.

Classic Psychoanalytic Theory

In classic psychoanalytic theory, the therapy relationship, specifically the analysis of the client's transference to the therapist, is central to the work (Freud, 1920/1963, 1940/1970). According to Greenson (1967), "Psychoanalysis is distinguished from all other therapies by the way it promotes the development of the transference reactions and how it attempts systematically to analyze transference phenomena" (p. 151). Via transference, clients experience feelings, drives, attitudes, fantasies, and defenses about the therapist that rightly belong not to the therapist but instead to others in clients' lives (e.g., parents, siblings); furthermore, clients remain largely unaware of these distortions. By remaining anonymous, nongratifying, and neutral, the therapist seeks to establish an environment that heightens the client's transference reactions, because such reactions provide access to otherwise inaccessible pathogenic material.

Greenson (1967) identified four steps for analyzing transference. The therapist must first help the client recognize that her or his reactions to the therapist are the core material of the analysis. Some clients may already be aware of such reactions, whereas the therapist may need to confront others more directly so that they see how they are displacing onto the therapist patterns actually reflective of others in their lives. Second, the therapist seeks to have the client "sharpen, illuminate, deepen, and fill out the transference picture" (Greenson, 1967, p. 301), often via pursuit of intimate details or uncovering the transference trigger. Third, therapists interpret the transference, a lengthy process in which they make conscious what previously was unconscious so that clients can begin to understand their psychic phenomena. Interpretations must also extend beyond clients' initial level of cognitive understanding and pursue emotional

understanding. Finally, because no single transference interpretation holds its effect for an extended period of time, nor does one interpretation completely explain a client's whole transference reaction, therapists must use many individual interpretations to help clients acquire full understanding and achieve more enduring change. This working through involves the repetition and elaboration of insights that clients gain from interpretation.

Therapists must also vigilantly monitor their inevitable countertransference reactions, defined by Greenson (1967) as transference reactions of therapists to clients. According to Greenson (1967), "Countertransference reactions have to be detected and restrained" (p. 222) so as not to inhibit clients' transference or lead to inappropriate behavior toward clients.

Recent modifications to classic psychoanalytic models (e.g., Luborsky, 1984; Pollack, Fleigenheimer, Kaufman, & Sadow, 1992; Strupp & Binder, 1984) have focused on time-limited dynamic approaches. Typically, the therapist develops a case formulation of the client's major maladaptive interpersonal cycle and then works to help the client gain insight into this maladaptive interpersonal cycle through repeated interpretations of the transference.

Object Relations Theory

In object relations theory (e.g., J. R. Greenberg & Mitchell, 1983; Klein & Tribich, 1981), relationships are considered the most fundamental and necessary aspect of life. Furthermore, the most important relationship is with the early caretaker, usually the mother. Such early key relationships are internalized to form a sense of self and thus act as a template for subsequent interactions with others. If early relationships are inadequate, relational difficulties develop.

In therapy, clients replay pathological scenarios of early years with their therapists because they do not know other ways to interact and they yearn to repair those relational deficiencies. Cashdan (1988) referred to this process as projective identification and delineated four stages for working with it in psychotherapy. First, the therapist engages with the client and establishes an emotional bond. Second,

the therapist allows him- or herself to be drawn into the projective identification (i.e., to feel the feelings involved when the client attempts to manipulate the therapist with bids for dependency, power, sexuality, or ingratiation). The therapist uses her or his emotional reactions to understand the impact of the client's habitual and self-defeating way of relating to others. Once the projective identification has emerged, the therapist confronts it, in Stage 3, by refusing to go along with the client's metacommunicative demand (i.e., to be taken care of) while concurrently affirming the therapy relationship. The therapist avoids interpretations not only because such interventions defuse the emotional impact of the projective identification but also because the client typically can neither understand nor use interpretations at this stage. After considerable working through (often characterized by an intensification of demands and the development of new projective identifications), the client starts to realize that his or her maladaptive ways of relating to the therapist are no longer viable. In Stage 4, the therapist uses feedback and interpretations to help the client gain insight into repetitive ways of interacting with others. The client internalizes the therapist as a good object, and thus the therapist becomes a healthy figure in the client's inner world.

In object relations theory, the projective identifications arise from the client and then are projected onto the therapist, who must confront them. The therapist uses his or her internal reactions to help the client, but this countertransference is viewed as stimulated by the client. Therapists, of course, as in classic psychoanalysis, are expected to manage these potentially problematic reactions elsewhere rather than acting them out with clients.

Interpersonal Theory

Kiesler (1988, 1996) followed the tradition of interpersonal theory as first formulated by Sullivan (1953) and later elaborated by Leary (1957) and Carson (1969). In this model, interpersonal behavior is conceptualized along the dimensions of control (dominance-submission) and affiliation (friendly- hostile), such that the nature of an individual's behavior on the control dimension elicits opposite behaviors from others (dominance elicits submission), whereas one's behavior on the affiliation dimension elicits similar behaviors from

others (friendly elicits friendly). People who are disturbed tend to have rigid interpersonal patterns in which they use the same behaviors no matter with whom they interact (including the therapist), a pattern Kiesler called the maladaptive transaction cycle.

In interpersonal treatment, the therapist first becomes "hooked" and reacts to the client much as others do. The therapist must then become aware of the pattern and interrupt it by disengaging or choosing not to respond to the client in the expected manner. By reacting in a different way than expected, the therapist can help the client have a corrective emotional experience and begin to see alternatives to rigid interpersonal behaviors. Kiesler highlighted the use of metacommunication ("any instance in which the therapist provides to the client verbal feedback that targets the central, recurrent, and thematic relationship issues occurring between them in their therapy sessions," p. 29) for addressing the maladaptive transaction cycles.

Relational Theory

Relational theory (e.g., Aron, 1996; Levenson, 1995; Mitchell, 1988, 1993; Safran & Muran, 2000; Wachtel, 2008) integrates American interpersonal theory, British object relations theory, self psychology, existential theory, and feminist and postmodern thinking. Compared with classic psychoanalytic theories in which the client is the dysfunctional person and has transference toward the therapist as she or he would toward many people (a one-person theory), relational theory is called a two-person system because the therapist and client are coparticipants. Furthermore, this theory assumes that the relationship would differ with whichever two people were involved and that change occurs when the therapist and client develop and then resolve problems in their relationship. The classic analytic stance of neutrality, anonymity, and abstinence gives way to "interaction, enactment, spontaneity, mutuality, and authenticity" (Mitchell, 1997, p. ix).

Safran, Muran, Samstag, and Stevens (2002) asserted that the key to therapeutic change is negotiation of ruptures in the alliance.

The ability to negotiate the needs of both self and others is a developmental process that many clients have not learned and thus becomes the major task of therapy. Safran and Muran (2000) focused on metacommunication, or ''attempts to communicate about and make sense of what is being enacted in the therapeutic relationship'' (p. 108), as the primary method for negotiating the relationship and addressing the therapeutic impasses that inevitably occur. With metacommunication, the therapist grounds interventions in his or her immediate experience of the relationship with the client and makes implicit messages more explicit so that they can be examined. The therapist collaborates with the client to explore and develop awareness of the here-and-now relationship, with each person taking responsibility for her or his part. Similar to Cashdan's (1988) model, the therapist first becomes aware of a problem in the relationship, tries to disembed from the situation, and then explores the situation with the client in a noncontrolling and open manner in which both therapist and client disclose their feelings. Through this process, the client comes to express underlying thoughts and needs. If the therapist helps the client process the relational difficulties, the client learns how to interact more healthily with another person, and this learning, it is hoped, generalizes to other relationships.

Humanistic/Experiential Theory

In the process-experiential approach to therapy (Elliott, Watson, Goldman, & Greenberg, 2004; L. S. Greenberg, Rice, & Elliott, 1993), therapists' efforts to intensify clients' emotional arousal and thus deepen their inner experiencing (e.g., via empty-chair work) may lead to disruptions in the therapy alliance, which then need to be addressed. Elliott et al. described six markers indicating disruptions in the alliance: (1) Clients overtly refuse to engage in activities suggested by the therapist; (2) the trust and collaboration between therapist and client suffer because of power and control concerns; (3) clients sense that their therapist does not genuinely care for them or perhaps even dislikes them; (4) clients covertly recede from the therapy process (e.g., they question their therapists' intentions but do not express those doubts to the therapist); (5) clients limit their engagement in therapy because it will soon end; and (6) therapists'

inability to monitor and control their negative reactions to clients renders them unable to respond in an accepting manner to clients.

When such threats to the alliance arise, Elliott et al. urged therapists to address clients' feelings that led to the difficulty, more specifically through a six-step "relationship dialogue" (p. 158). First, therapists acknowledge and empathically respond to clients' concerns. Next, therapists and clients more fully explore the difficulty to understand what is going on and to illuminate what each person is contributing. Third, therapists acknowledge their own role in the problem, while also helping clients examine how the problem may be related to their emotion patterns, previous life events, or relational strategies. In the fourth step, therapists summarize the difficulty and check the summary with the client. Next, therapists and clients discuss how the disruption may be resolved, including potential changes in how the therapy is conducted. Finally, once the difficulty has been worked through and the interpersonal pattern between the therapist and client is better understood, the relationship is indeed strengthened, with both participants appreciating their heightened mutual respect and trust and clients feeling greater enthusiasm for both the therapy and the therapy relationship.

Cognitive Theory

When relationship disruptions occur in cognitive therapy, Beck, Rush, Shaw, and Emery (1979) advised therapists to confront negative therapeutic reactions directly. More specifically, therapists should identify and correct clients' cognitive distortions contributing to the disruption in the hope that doing so addresses the source of the rupture itself and likely also some of the concerns that led the clients to seek therapy in the first place. Consistent with the emphases of this theory, therapists are to use logic and the empirical method to correct clients' distorted thoughts.

Beck et al. (1979) also asserted that ruptures may occur if therapists begin to believe clients' consistently negative views of themselves, because doing so may lead therapists to consider clients "born losers" (p. 59) mired in irredeemable circumstances. When therapists find themselves in such a situation, they are to remember

that clients' negative self-views are but beliefs and thoughts that warrant testing.

Finally, ruptures may also arise when clients in the later stages of therapy encounter new troubling experiences that threaten their objectivity regarding their pattern of negative thoughts. Such clients may then feel that therapy is not working, that they are incurable, or that their therapist is ineffective. Given such a perspective, clients may no longer follow therapists' suggestions and may no longer engage in the tasks of therapy as a whole. Here again, then, therapists are to resist accepting such perceptions of the therapeutic process and relationship and are instead to discuss client cognitions that have impaired the therapy work.

Summary

All of these theories describe how to address problems as they arise in the therapeutic relationship. They vary, however, in terms of the centrality of such work, with those in the relational camp suggesting that relational work is the key to therapeutic change, whereas behaviorists are more likely to address relational issues only when they interfere with therapy. Another difference across theories is therapists' role in contributing to relationship dynamics. In psychoanalysis, the emphasis is placed on understanding clients' transference distortions, and therapists attempt to be neutral so that those distortions become more apparent and thus ripe for working through. Similarly, in cognitive theory, therapists challenge clients' distorted thinking that contributes to their areas of difficulty. In object relations, in contrast, therapists are encouraged to become aware of and use their reactions to clients, although the emphasis is still on the therapists unilaterally untangling and fixing clients' interpersonal problems. As we move toward interpersonal, relational, and humanistic theories, the emphasis shifts to therapists and clients as coparticipants in the relationship.

As an example illustrating these different theoretical approaches, let us consider Suzie, a 20-year-old client who has strong negative reactions to Dr. Z, a 60-year-old therapist. Suzie feels angry that Dr. Z is not disclosing enough and is too much of a blank screen.

In classic Freudian treatment, Dr. Z might interpret Suzie's anger as a transference reaction, in that she has similar responses to her father, feeling that he does not love her enough and withdraws from her, rendering Suzie even more desperate for his love and affection. Here Dr. Z would monitor his own behavior to make sure that he maintained a prudent therapeutic stance; he would then wait until the appropriate moment in therapy to offer this interpretation. In cognitive therapy, Dr. Z would identify and then challenge the distorted thoughts and feelings that lie behind Suzie's anger and her potential fears related to Dr. Z's remaining a blank screen.

In object relations therapy, Dr. Z would wait until he felt a strong pull from the client, representing her desire for him to love and take care of her. He would not gratify her dependency needs but would affirm his commitment to their therapy relationship. Later, after they had worked through Suzie's feelings about not getting what she wanted, Dr. Z might try to help Suzie understand her underlying dependency wishes. In interpersonal therapy, Dr. Z would wait until he felt ''hooked'' by Suzie's submissiveness and his corresponding urge to dominate. He would then try not to respond in a dominant way that recapitulates Suzie's unhealthy submissiveness but would talk about his reactions, explore her reactions, and help Suzie develop other ways of interacting. In relational and humanistic therapies, Dr. Z would ask Suzie to talk about her experiences of the therapy relationship in the moment and would likewise share his in-the-moment experiences. Both Suzie and Dr. Z would be assumed to contribute to the dynamics of the relationship, and they would together negotiate how to act with each other so that what was previously implicit becomes explicit and fodder for the therapy work.

Empirical Literature about Processing the Therapeutic Relationship

A number of studies have documented that difficulties do arise in therapeutic relationships, difficulties that then require attention. For example, Dalenberg (2004) interviewed 132 trauma clients and found that 72% had been angry at their therapists at least once during therapy, and 64% reported that the therapist had been unjustly angry with them at least once during therapy. Similarly, Castonguay,

Goldfried, Wiser, Raue, and Hayes (1996) found clear evidence of strains in the alliance (e.g., clients were negative, unresponsive, avoidant) in several cases of cognitive therapy; they noted that therapists addressed the strain by increasing their adherence to the cognitive therapy protocol and emphasizing the impact of the clients' distorted thoughts, which unfortunately then led to therapist-client power struggles. Likewise, for clients who prematurely terminated from interpretive individual psychotherapy, Piper et al. (1999) found a consistent pattern in the final session: The client communicated thoughts about dropping out early in the session and expressed frustration about unmet expectations and the therapist's repeated focus on painful feelings. The therapist responded by focusing on the client- therapist relationship and transference. Although the client resisted the focus on transference, the therapist persisted, resulting in a power struggle, with the therapist sometimes being sharp, blunt, sarcastic, insistent, inpatient, or condescending. The therapist ended the session by trying to force the client to return, but the client did not return.

Given the evidence that rather dramatic ruptures can arise in therapeutic relationships that then require therapist attention, we review the literature about what does and does not work to resolve such problems. We divide this literature into studies that focus on the overt relationship problems (e.g., ruptures, misunderstandings) and those that focus on specific therapist interventions (interpretation, immediacy) for processing the relationship.

The Overt Relational Problem

Repairing Ruptures in the Relationship

Safran et al. (see review in Safran et al., 2002) used task analyses in a number of studies to investigate rupture resolution. Their research pointed to a four-stage model of resolution: (1) The therapist notices that there is a rupture (e.g., either the client withdraws from or confronts the therapist), (2) an exploration of the rupture experience (e.g., exploring the client's feelings) occurs, (3) the therapist helps the client examine any avoidance to discussing the rupture as a result of anxieties or fears of being too vulnerable or

aggressive and expecting retaliation from the therapist, and (4) the client begins to understand, and then clearly states, the underlying wishes or needs that precipitated the rupture.

Within this general model, Safran et al. also found evidence that the process operates somewhat differently with withdrawal and confrontation ruptures. For withdrawal ruptures, the client progressively becomes more able to talk about feelings of discontent and to assert her or his wishes or needs, which are in turn validated by the therapist. In resolving ruptures involving client confrontation, the client begins with expressions of anger, then moves to disappointment and hurt in being let down by the therapist, and finally to being able to feel vulnerable and allow him-or herself to express the need to be taken care of.

Based on their empirical work on resolving alliance ruptures, Safran and Muran (2000) developed brief relational therapy (BRT), a model that treats ruptures by integrating relational psychoanalysis and humanistic psychotherapy. In one study, Muran, Safran, Samstag, and Winston (2005) found no significant outcome differences for clients who were randomly assigned to either short-term dynamic psychotherapy (STDP), cognitive-behavioral therapy (CBT), or BRT, although the dropout rate was lower for BRT (20%) than for STDP (46%) and CBT (37%). In an innovative twist, Safran et al. then identified 18 clients who were potential treatment failures (based on a diagnosis of personality disorders, low ratings on working alliance measures, therapist indications of client hostility or interpersonal tension with the client, or missing data) from the larger sample who had been in either the STDP or CBT conditions and who were willing to be reassigned. The 10 clients who agreed were reassigned randomly to either BRT or control (either STDP or CBT). Although the sample sizes were very small (5 vs. 5), BRT appeared to be effective in helping clients who had difficulty establishing a therapeutic alliance in the previous therapy. It seems, then, that attention to the therapy relationship was indeed beneficial, especially for those clients who previously experienced difficulties forming a bond with their therapist.

Two additional task analyses have been conducted in this area as well. In their study of alliance-threatening enactments in four

successful cases of cognitive-analytic psychotherapy with patients with borderline personality disorders, Bennett, Parry, and Ryle (2006) found seven stages of rupture repair: acknowledgment, exploration, linking and explanation, negotiation, consensus, getting in touch with "role positions," and further exploration and development of "exits" or aims and closure. Similarly, Aspland et al. (2008) found evidence for four stages of rupture repair in two successful cases of CBT: recognition of an emerging pattern/problem preventing progress; addressing the empathic failure through summarizing, exploring, validating; restoring the collaborative relationship by encouraging the client's active participation; and affirming the client's contributions, seeking client feedback about tasks, and negotiating a new or revised task.

Qualitative Studies of Relationship Negotiations Misunderstandings.

Rhodes, Hill, Thompson, and Elliott (1994) qualitatively examined instances in which clients (all of whom were therapists or therapists-in-training) felt misunderstood by their therapists. In the resolved cases, clients typically reported that they had a good relationship with their therapists before the misunderstanding event. The precipitant of the misunderstanding event for all cases was that therapists either did something that clients did not like (e.g., were critical of something the client did) or did not do something that clients wanted or expected (e.g., did not remember important facts). Following the initial feeling of being misunderstood, clients in the resolved cases asserted their dissatisfaction (e.g., told their therapists they felt criticized) either immediately or after some delay. In response to the clients' assertions, therapists sometimes accommodated clients by apologizing, accepting appropriate responsibility for the problem, and changing the offensive behavior (e.g., not being late or falling asleep). Likewise, clients sometimes accommodated the therapist by accepting the therapist's perspective or by deciding that the therapist's behavior was not all that egregious. After the immediate resolution of the event, most clients in the resolved cases reported that they continued to work with their therapists to make sense of the misunderstanding and thus were able to grow from the experience and integrate it into their learning. Clients

indicated that the therapeutic relationship was enhanced as a result of working through the misunderstanding. Thus, in these resolved cases there was a mutual repair process, with both participants trying to understand what led to and what occurred in the breach.

In contrast, clients in the unresolved cases did not report good relationships. As with the resolved cases, the precipitant was something the therapists either did that clients did not like or did not do that clients wanted or expected. Only a few clients in the unresolved cases asserted their dissatisfaction to their therapists. Unfortunately, when they did so, their therapists were not responsive, maintained their original stance without considering the client's viewpoint, and did not explore the clients' feelings. In a few other cases, the clients did not say anything to the therapists about their dissatisfaction; not surprisingly, these therapists never knew about the clients' dissatisfaction and thus were likewise unresponsive. Clients in the unresolved cases terminated soon after the misunderstanding events.

Based on the results of the Rhodes et al., it appears that it is important for both client and therapist to negotiate and repair the relationship. The client needs to assert her or his dissatisfaction and let the therapist know that there is a problem. The therapist needs to listen, respect, and be responsive to the client's assertion and make accommodations (e.g., apologize, take appropriate responsibility, change problematic behaviors). As a result of this mutual repair process, misunderstanding events can be resolved and the therapy relationship strengthened.

Impasses. Hill, Nutt Williams, Heaton, Thompson, and Rhodes (1996) qualitatively investigated the experiences of 11 seasoned therapists about a therapeutic impasse (i.e., a deadlock or stalemate) that resulted in the termination of therapy with a client. In these impasses, there was general disagreement between the therapist and client about the goals and tasks of therapy, and often there were power struggles over how therapy should be conducted. Therapists reported that they and the clients were angry, frustrated, hurt, disappointed, and upset about the lack of progress.

Therapists used two different strategies to address the problems in the therapeutic relationship. All but one tried to discuss the impasse with the clients, seeking to explore what had happened, help the client understand the impasse in light of past and present relationships, and help the client reconceptualize the problem. In addition, a few became more active and directive and told clients what to do. Despite these efforts, therapists reported that the relationships deteriorated and that the clients ultimately unilaterally terminated from therapy. In trying to understand what went wrong in these cases, therapists speculated that clients had considerable interpersonal pathology and transference; there was a continuing lack of agreement about the goals and tasks of therapy; therapists had made mistakes (e.g., were too pushy or unsupportive, too cautious or nondirective, or unclear; changed strategies too much; misdiagnosed the client); some clients had divided loyalty (i.e., felt conflicted between listening to the therapist and another person); and therapists' personal issues (e.g., strong negative reactions to client, concurrent life stressors) interfered with the therapy.

A comparison of this study on impasses with the Safran et al. (2002) resolution model and the Rhodes et al. (1994) misunderstanding data is striking. There was no mention in the Hill et al. (1996) study of the clients asserting their dissatisfaction or their feelings, a central element of both the Safran et al. and Rhodes et al. studies. And although therapists did try to discuss the impasse with the client, it was often too little and too late. Furthermore, therapists did not apologize, accept responsibility, or change; rather, they became more active and directive or tried to use more insight-oriented techniques, all of which might have further distanced them from their clients. Differences between studies may be related to the different perspectives being studied (e.g., clients in Rhodes et al., therapists in Hill et al., and external judges in Safran et al.).

Working with angry clients. Hill et al. (2003) examined the resolution of hostile versus unasserted client anger events (which conceptually parallel Safran et al.'s, 2002, confrontation and withdrawal ruptures) from the perspective of the therapist. Therapists indicated that they had more difficulty working with clients who expressed hostile anger than with those who did not assert their

anger. Hostile anger events had mixed outcomes and were characterized by a poor therapeutic relationship, clients expressing rage because of not liking some therapist action or inaction, negative therapist reactions (feeling anxious, incompetent, annoyed, frustrated), therapists wanting to decrease or manage the client anger, and therapists intervening by acknowledging the client feelings. In contrast, unasserted anger events had positive outcomes and were characterized by good therapeutic relationships, clients not liking some therapist action or inaction but not directly expressing anger, and therapists feeling concerned for the clients and trying to help clients express their anger. Thus, therapists felt compassion toward withdrawn clients and wanted to help them learn to express themselves, whereas therapists' negative feelings toward hostile clients made them struggle just to manage the client anger, let alone help the client express and work through the anger.

Furthermore, hostile events were more often resolved when therapists (1) did not challenge problematic client behaviors (e.g., did not confront a client in alcohol treatment about not going for a required urine screening); (2) were able to feel annoyed or frustrated at the client rather than feeling anxious or incompetent; (3) sought to connect with the client, made a major effort to talk about the anger with the client, and provided an explanation for their behaviors; and (4) attributed the event to problems in the therapeutic relationship rather than to personality problems within the client. In contrast, unasserted anger events were more often resolved when (1) there was a good therapeutic relationship and (2) therapists raised the topic of anger and tried to help the client explore the anger and gain insight, particularly in relating the current anger to other situations.

Providing Therapists with Feedback about Ruptures

When Lambert (2007) found negative outcomes (as determined by weekly outcome ratings) indicating that clients were at risk, they asked clients to complete measures of alliance, readiness for change, and social support. Therapists were then provided feedback about these scores and were also given Lambert et al.'s (2008) *Clinical Support Tools Manual*, with suggestions for how they might intervene to help clients with the problems identified on the measures (Harmon et al., 2007; Whipple et al., 2003). The advice given in the *Clinical*

Support Tools Manual for how therapists might intervene when there were poor alliances was derived from the work of Safran et al. (2002), reviewed previously. Thus, therapists were instructed to elicit negative affect from the client, listen to the affect carefully, and encourage elaboration of the affect. Above all, therapists were instructed not to respond by explaining, justifying, or disagreeing (being defensive) when the client expressed negative affect; rather, they were to empathize and apologize. The results of using the *Clinical Support Tools Manual* indicated reduced deterioration and improved outcome across clients, especially those predicted to be treatment failures (Harmon et al., 2007).

Focus on Specific Therapist Intervention

Working with the Relationship via Transference or Relational Interpretations

Transference interpretations are those in which therapists interpret to clients how their behavior toward the therapist is based on distortions from the past; these interpretations are used most often by classic psychoanalytic therapists. More recently, psychodynamic therapists from relational perspectives have called these relational interpretations (defined as therapist explanations that add to the client's knowledge of his or her thoughts, feelings, and behaviors in interpersonal relationships; Lowenstein, 1951).

In their review, Crits-Christoph and Gibbons (2002) reported that roughly 5% of all therapist statements across a variety of theoretical orientations were interpretations broadly defined. Of all interpretations, between 5% and 45% were transference/relational interpretations. Their review suggested that high rates of transference/relational interpretations can lead to poor outcome (a finding confirmed by Piper, Azim, Joyce, & McCallum, 1991), particularly with clients with low quality of object relations (i.e., poor interpersonal relationships). Furthermore, they found in their review that the quality rather than the frequency of interpretations was associated with positive treatment outcome (high-quality interpretations were those that fit the client's presenting complaints). Relatedly, Foreman and Marmar (1985) found that interpretations that

directly addressed tenuous therapy alliances were related to good outcome, whereas interpretations not addressing alliance difficulties neither improved the alliance nor led to good outcome.

In more recent work, Safran et al. (2005) found that, in the context of a poor therapy alliance, interpretations that focused on parallels between the therapy relationship and other relationships in clients' lives were often experienced by clients as criticizing, because these interpretations suggested that the source of such difficulties lay primarily within the client rather than in the therapeutic relationship. Instead, a more collaborative examination of the contribution of both partners to the difficulty felt less blaming to clients and was thus advantageous.

Working with the Relationship via Immediacy

Immediacy has been defined as working with the therapeutic relationship in the here and now (Hill, 2004). Immediacy thus involves such therapist actions as inquiring about reactions to the therapy relationship, drawing parallels between other relationships and the therapy relationship, processing ruptures or boundary crossings, and disclosing feelings of closeness to or lack of closeness from others.

Analogue research (i.e., using written or taped stimuli rather than actual therapy interactions) has found that interventions in which therapists describe their feelings about the client and the therapy relationship were perceived by nonclients as helpful (see Hill & Knox's, 2002, review). In addition (and as described previously), in actual therapy immediacy has been found to be useful for resolving misunderstandings or ruptures (e.g., Rhodes et al., 1994; Safran et al., 2002).

Hill et al. (2008) and Kasper, Hill, and Kivlighan, (2008) conducted case studies on the use and effects of therapist immediacy in brief therapy. In the earlier of these two investigations, Kasper et al. (2008) completed a case study of a 12-session time-limited psychotherapy with an interpersonally oriented male therapist and an articulate, volunteer female client whose primary goal for therapy was to work on interpersonal relationships. Results from quantitative and

qualitative analyses suggested that the client felt validated and cared for when the therapist expressed his positive feelings toward her. In addition, immediacy facilitated negotiation of the therapeutic relationship, provided a corrective relational experience, opened the client up to a new kind of relationship, and helped lower the client's defenses. Immediacy also had a few negative effects, though, in that the client sometimes felt puzzled by these interventions, felt pressured to respond, and felt awkward and confused by the possible implications of the therapist's caring for her beyond the professional relationship (which was not his conscious intention). In terms of outcome, the client valued the therapist and the therapy, increased her level of self-understanding, but worsened in terms of symptomatology and interpersonal functioning (although evidence suggests that she was initially highly defended and became more reality based in her self-estimates). Kasper et al. concluded that immediacy was an intense and mostly positive experience for this client.

Hill et al. (2008) examined immediacy in a second case study of 17 sessions of brief therapy with a bright, articulate, inner-city, African American female client seeing an interpersonally oriented White male therapist. A qualitative examination of seven immediacy events revealed that immediacy enabled the therapist and client to negotiate the relationship, helped the client express her feelings to the therapist and thus learn how to interact with other people, and provided the client with a corrective relational experience. There were no reported negative effects of immediacy. In terms of outcome, the client changed dramatically in terms of decreased symptomatology, increased interpersonal functioning, and increased self-understanding. In addition, she made several important behavioral changes (e.g., moved to a better living situation, got a better job).

A comparison of the two cases reveals that the Kasper et al. therapist more often used challenging forms of immediacy that helped break down the client's defenses, whereas the Hill et al. therapist more often used supportive forms of immediacy that helped build the client's fragile ego. Thus, the types of immediacy used varied across cases.

In a rejoinder to comments about these two cases (Anchin, 2008; Muran & Samstag, 2008), Hill (2008) suggested that these therapists used immediacy in three general ways: (1) to negotiate the tasks and goals of therapy (e.g., inquired about the client's reactions to different therapeutic strategies, asked about what was and was not working); (2) to illuminate unexpressed feelings in the room or make the covert overt so that the communication would be more direct, here and now, and honest (e.g., inquired about immediate feelings, expressed immediate feelings, or drew parallels between what the client was saying about outside relationships and what might be going on in the therapeutic relationship); and (3) to repair relationship ruptures by talking about what was going on between the therapist and client.

Trauma Clients' Perceptions of Effective and Ineffective Therapist Interventions

As noted, Dalenberg (2004) interviewed 132 clients who had received therapy for trauma. The results provide evidence for effective and ineffective therapist interventions for addressing relationship problems resulting from client or therapist anger. According to these clients, the most ineffective therapist responses to client anger were a lack of response (which was interpreted as a lack of caring), angry responses, switching stances from encouraging closeness and dependency to pushing the client away for being too demanding, and hostile disclosures. The most effective therapists' responses were taking at least partial responsibility for the angry exchanges and teaching clients that anger is possible within the context of a good relationship and need not mean either abandonment or imminent physical danger. In contrast, clients reported that the most ineffective therapist strategy for managing therapist anger at clients was an insincere apology, whereas the most effective strategy was a ''true'' apology and an explanation that the anger arose from the therapist's caring and attachment for the client.

Summary

Table I summarizes the findings presented in this section related to the precursors, client contributions, therapist interventions, and

consequences of relational work. Recall that two of the citations in the table refer to reviews of the literature (Crits-Christoph & Gibbons, 2002; Safran et al., 2002), whereas the rest refer to individual studies.

Summarizing across studies, it appears that a good therapeutic relationship before the relational event makes it easier to resolve the difficulty. Furthermore, several client actions seem to facilitate successful resolution, most notably exploring feelings about the relationship. In contrast, client hostility, pathology, and defensiveness hinder resolution. In terms of therapist contributions, acknowledging that there is a problem in the relationship and encouraging client exploration of feelings seem particularly effective, whereas blaming the client for the difficulty seems particularly ineffective. Furthermore, some consistent positive consequences of processing the therapeutic relationship were clients' enhanced interpersonal functioning and greater ability to express their feelings as well as an enhanced therapeutic relationship. We note, however, that these findings are preliminary given the small number of studies in the area and the lack of explanation of some of the descriptive qualitative methods used in some of the studies (e.g., Castonguay et al., 1996; Dalenberg, 2004).

Implications for Research

Although admittedly preliminary, these findings offer intriguing ideas regarding the influence of the initial therapeutic relationship, possible therapist and client contributors, and consequences on relational work. Before more research can be done, however, we need some agreement about definitions. Furthermore, we need to think about the advantages and disadvantages of various methods. Once these issues are described, we discuss several areas that are ripe for further investigation.

Definition

First, it is clear that we need a better definition of what is meant by ''processing the relationship'' or ''relational work.'' Similarly, Wachtel (2008) noted a problem in the way that psychoanalysts currently talk about interpretations. He asserted that the definition of interpretation within psychoanalytic thinking has become so broad that almost everything the therapist says counts as an interpretation.

Clearly, when a construct becomes so broad, it loses its meaning, and we cannot then determine the effects of such interventions in comparison with other interventions.

The definition chosen for "processing the relationship" or "relational work" needs to be sufficiently clear and pantheoretical so that researchers from different perspectives can be sure they are examining the same phenomenon. We assert that at its most basic level processing the relationship requires that both therapist and client talk overtly about the therapeutic relationship. In an effort to operationalize this basic level more specifically, we propose that (1) both therapist and client have to be mentioned, or at least implied, in the communication ("I" and "you"); (2) the communication must directly address their relationship (i.e., the communication should be more than feedback from one person to the other, such as "I think this about you," because such a comment does not address the relationship); a comment such as "I feel that we're not really understanding each other today, and I'm wondering what may be going on between us" would qualify; (3) the communication must be overt so that other people can observe that the therapist and client are indeed talking about their relationship; (4) the communication must go beyond social pleasantries, such as "It's great [for me] to see you today"; and (5) both therapist and client must be involved in the discussion (e.g., one person might make a bid for processing the relationship, but unless the other person also enters into the discussion, it would not fit our definition). The exchange between the therapist and client might be as short as one interchange (with each person speaking) or as long as the entire session.

Methods Used for Studying Relational Work

Several different methods have been used for investigating relational events. We review these approaches briefly and then make recommendations for future research.

Analogue research. In this method, nonclients are shown transcripts or tapes of relational events versus other events and asked to indicate their preferences or reactions to the interventions. Although initially appealing because it appears to allow for rigor and internal

validity (e.g., interventions can be carefully scripted and extraneous variables controlled), the lack of external validity (applicability to clinical settings) is a major limitation. People who are not clients likely react very differently to clinical material than clients within a relationship in a therapy setting.

Coding verbal response modes. In this method, which has a rich history going back to the 1940s (see historical review in Hill & Corbett, 1993), each unit (sentence) of therapist behavior is coded by trained judges using transcripts of therapy sessions to identify interventions associated with processing the relationship (e.g., relational interpretations, immediacy) versus other interventions (e.g., direct guidance, open questions). The therapist behavior is typically coded in terms of quantity (e.g., number of immediacy statements) but also is sometimes rated in terms of quality (e.g., accuracy of immediacy statements). The resulting coding or rating is then correlated with outcome (e.g., immediate client behavior, session outcome, or treatment outcome; see review in Crits-Christoph & Gibbons, 2002; Hill et al., 2008; Kasper et al., 2008). Although this method is intuitively appealing because it allows researchers to track exact instances of relational work, it is also fraught with problems. There is no evidence to suggest that frequency of occurrence of relational interventions should be related to session or treatment outcome, because the outcome of specific interventions depends on the needs of the client at the moment. Furthermore, this method fails to take into account the context of the intervention (e.g., the dyad, the stage of therapy, the alliance) and also does not account for moderating variables (e.g., client defensiveness). Finally, the effects of interventions are rarely uniform across time (e.g., sometimes there is an immediate impact, whereas other times the impact is delayed), making it difficult to investigate this area. Sophisticated quantitative models may be able to be developed to address these issues, but our personal experience having done this kind of research for many years is that the method often misses the clinical richness of the phenomenon.

Session-level ratings of relational work. Another method is to have trained judges code relational behavior on a session-level basis (e.g., listen to a tape of a session and rate the extent to which

relational work occurred in the session). Although less time consuming than the method of coding response modes, this method is also limited in that it provides only a rough estimate of whether or not relational work occurred. Furthermore, researchers do not know exactly what the relational work was nor exactly how clients responded to those interventions.

Task analyses of relational events. In this method (see L. S. Greenberg, 2007, for a description and Safran et al., 2002, for an example related to relational work), researchers first develop a theoretical model of steps for resolution of relational difficulties. They then observe several resolved events of relationship processing and revise their model. Then they develop criteria for how to assess the steps, select measures (e.g., Experiencing Scale; Klein, Mathieu-Coughlan, & Kiesler, 1986), and have trained judges code the client and therapist behaviors using these measures. Based on the results of the coding, the model is then modified. The results from this method have been impressive, although it is not always easy to find existing measures to assess the behaviors involved in each step, and the whole process is very time intensive.

Qualitative analyses of actual events. This method (see Hill et al., 2008; Kasper et al., 2008) involves a team of judges observing tapes of therapy sessions and consensually agreeing on the components of relationship processing events. Components across different processing events can then be compared to determine whether there is consistency in what transpires in these events. This method allows researchers to uncover the components of the events without placing a lot of restrictions on clinical judgment. Disadvantages involve the need for large teams and a number of auditors to ensure that multiple perspectives are heard and bias is reduced; the method is also very time intensive, so it is difficult to examine a large number of cases.

Qualitative analyses of recalled events. Researchers interview clients or therapists about their experiences during and after relationship processing events (e.g., Hill et al., 1996; Rhodes et al., 1994); data are then analyzed via qualitative methods (e.g., consensual qualitative research; Hill, Thompson, & Williams, 1997; Hill

et al., 2005). This method has the same advantages and disadvantages as qualitative analyses of actual events. Additionally, however, unlike the prior model, this method allows for assessment of inner experiences during relationship processing events, which are often not evident in the observable tapes of sessions. An added disadvantage, on the other hand, is not knowing exactly what took place overtly in the session (unless the two methods are combined).

Summary recommendations about methods. Perhaps not surprisingly, we are most excited about the qualitative methods for studying relational work because they allow us to use more of our clinical expertise to study what occurs within individual cases. In addition, task analysis is a promising approach that allows researchers to combine theory and discovery-oriented methods within a single approach. We are less sanguine about analogue methods because of their distance from the clinical phenomenon. We are also less positive about coding verbal response modes because it does not allow for the fluctuating context within and across cases. Furthermore, combining methods (e.g., examining the events as they occurred overtly during sessions and interviewing clients and therapists about events after the session) is ideal because it provides different perspectives on the events.

Areas for Further Investigation

Markers for processing the relationship. We need to investigate more thoroughly markers of opportunities to process the relationship. From the literature, it appears that one type of marker may be when ruptures develop, broadly defined as problems in the quality of relatedness or deteriorations in the communicative process (Safran & Muran, 2006). A second marker for processing the relationship may arise when the therapist is having strong feelings about the client. These feelings might be experienced during or between sessions (e.g., boredom, annoyance, attraction, overconcern, hostility) or may be revealed by therapist dreams about the client (Spangler & Hill, in press). As with ruptures, such feelings or dreams indicate to the therapist that something might be going on in the relationship (although it could also be due to therapist countertransference), and then the therapist needs to decide how to manage the situation (either

in her or his own therapy, in supervision, or directly with the client). In addition, many therapists seem to introduce relational work routinely as a preventive intervention, trying to catch problems before are observably apparent. In the two case studies of immediacy (Hill et al., 2008; Kasper et al., 2008), therapists routinely checked in with clients at the beginning or end of events or sessions to ask how the client was feeling. Asking about reactions may help address problems before they become ruptures, may educate clients about the importance of talking about the relationship, and may give clients permission to talk about feelings. It seems likely that the process would differ for each of these three types of relational events (ruptures, therapist strong affect, routine checking in), and thus each merits empirical examination.

Mechanism of change in relational work. Further work is also needed to assess the importance of various components of relational work. In the review of the empirical literature, we identified several such components, but it is not clear whether any of these are necessary for resolution. Furthermore, we need to be aware that a single relational discussion is probably not effective but rather that relational work develops across therapy; thus, we need to test the development of relational work across therapy, most likely through case studies. In addition, we need to test the impact of influences outside of therapy on the process of relational work, given that relationships with people outside of therapy could facilitate or impede the relational work within therapy.

Outcomes of relational work. Again, the empirical literature suggested several positive outcomes of relational work (enhanced interpersonal functioning, enhanced therapeutic relationships, greater client expression of feelings) that need further systematic testing with standardized measures. In addition, there well may be other consequences (e.g., instillation of hope, transfer to clients' other problems in living) that are worthy of investigation.

Moderating variables. In the empirical literature discussion, we noted that client hostility, psychopathology or personality problems, low quality of object relations, or high defensiveness influenced the outcome of relationship processing events. Again, more systematic work is needed to further understand these results. We also suspect

that attachment style influences the process and outcome of relational events. Clients with avoidant or insecure attachment styles will probably respond more negatively and less openly to processing the relationship than will clients with secure attachment styles, because the latter are better able to withstand the sometimes difficult interpersonal negotiations that such discussions demand. In addition, therapist reactions (i.e., countertransference) undoubtedly influence the delivery of immediacy interventions (see Gelso & Hayes, 2007). If therapists are unable to move beyond their own reactions, for instance, they may be unable to offer the openness and honesty required when processing their relationships with clients. Each of these potential moderators begs for additional research.

Clinical Implications

Research in this area suggests clinical applications as well. For instance, how relationships are processed probably varies over the course of therapy. Therapists may, for example, be more likely to inquire about clients' reactions to therapy early in therapy but wait to get into deep relational work until a solid relationship is established. If the bond is tenuous from the start, however, therapists may well need to talk about the relationship even in its early stages. Relatedly, there is probably a cumulative effect of processing the relationship: It may be that early relationship processing lays the groundwork for later, deeper processing, which also implies that effective processing may require multiple episodes before each participant feels wholly comfortable. We acknowledge as well that it is probably easier to process a relationship without major problems than one with ruptures, because the latter is likely imbued with tension and difficult feelings on both sides. Therapists may also need to educate clients about why they are talking about the relationship; such preparation may help clients understand why the therapist is even pursuing such a discussion. Furthermore, when termination of therapy approaches, therapists' and clients' ability to address the imminent ending of their relationship in a healing way may depend on how they addressed their bond earlier in the work together. Finally, it is very important that therapists be empathic when doing relational work (see also Wachtel, 2008).

Another clinical issue is determining with whom to do relational work. Some therapy dyads, for instance, neither need nor want to process their relationship. As an illustration, if the client prefers that the therapist work from a more cognitive or behavioral perspective, she or he may have no interest in exploring the therapy relationship. In addition, it may not be necessary or desirable to work on the therapeutic relationship if the client is already deeply immersed in exploring his or her concerns. The therapist in the Hill et al. (2008) case, for example, indicated that he used less immediacy than he typically would because the client was already exploring deep issues within the therapy. Similarly, the second case in Hill (1989) never seemed to have any difficulties in the therapeutic alliance, and they were able to work productively on other issues; thus, the therapist never processed the relationship with the client. Indeed, in Kasper et al. (2008), when the therapist brought up relationship issues early in therapy, the client was confused and had no referent for what the therapist was talking about. Hence, it may be that bringing up relationship issues feels annoying or irrelevant to some clients, who might wonder about the therapist's narcissism in connecting everything to the relationship rather than listening to the client talk about other more pressing problems.

Relatedly, a question arises about the use of relational work in brief psychotherapy or whether it is only appropriate for long-term psychotherapy. We have no empirical data to guide us here, but clinicians often report hesitancy about going too deep with relational work in brief psychotherapy (other than checking out clients' reactions to the work). A similar question arises about whether therapists could actually use too much immediacy in brief psychotherapy, with the outcome of distracting clients from working on key symptom reduction (e.g., suicidal ideation, panic attacks). Admittedly, we do not yet have the answers to these questions and thus hope that clinicians and researchers will begin to address them.

It is interesting as well to ponder the role of insight in relationship processing. Cashdan (1988) suggested only working on insight later in the therapy once problems in the relationship have been resolved. In contrast, other theorists, such as Strupp and Binder (1984), took a more insight-oriented approach to looking at clients'

maladaptive interpersonal patterns. We wonder whether there is an ideal time to help clients attain insight into the relationship. Finally, at least two entire treatments have been developed that include elements of relational work as integral to the approach. As mentioned earlier, Safran and Muran (2000) developed BRT. In addition, Castonguay, Schut, Aikins, and Constantino (2004) developed an integrative cognitive therapy approach that incorporates several methods for repairing alliance ruptures (using listening skills, inquiry, and disarming techniques). Both approaches have been shown to be promising and deserve further empirical attention.

Training Implications

Processing the relationship has implications for therapist training as well. A few studies have examined training therapists to implement manualized therapies focused on building and repairing the therapeutic alliance (Crits-Christoph et al., 1998; Henry, Schacht et al., 1993; Henry, Strupp et al., 1993; Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Piper et al., 1999). Although promising in terms of training, these broad training studies are minimally informative about the specific effective components of training. Hess, Knox, and Hill (2006) investigated the effects of three components of training (supervisor-facilitated training, self-training, biblio-training) on graduate students' anxiety and self-efficacy for managing client anger as well as their use of immediacy in response to videotaped vignettes of angry clients. Each type of training was rated as helpful, and each also increased self-efficacy for working with angry clients, although supervisor-facilitated training (in which participants experienced modeling of immediacy and then received direct feedback on their own use of the intervention) was rated most helpful.

Given the importance of processing the relationship, we believe it crucial that therapists be trained regarding how best to establish and maintain a strong relationship with clients. Such training should certainly address ensuring that an appropriate therapeutic context is created (e.g., safe environment, respect for the client, empathic listening, responding to the client's concerns) but should also attend to specific skills (immediacy, therapist self-disclosure, relational interpretations) likely to enhance the relationship. Furthermore,

trainers should attend to helping trainees become aware of their strong emotional reactions (i.e., countertransference) to clients, given that these seem to play a pivotal role in the outcome of relational events.

In our experience training novice therapists, learning relational skills often induces great anxiety in trainees. Our students worry that because here-and-now relational conversations are not the social norm, they and their clients will feel uncomfortable engaging in such a discussion. Furthermore, they fear that they will not know how to handle any negative reactions clients may express. As with therapist self-disclosure, new trainees often fear that such interventions are inherently ill-advised because they cross a therapeutic boundary. Thus, trainers need both to educate their students regarding the benefits of appropriate use of relational interventions and provide opportunities for students to read and talk about, observe, and then practice their effective use.

One venue for such training may be supervision. Just as therapists hope that by addressing their relationship with clients, clients' other relationships and interactions will improve, supervisors have an opportunity for equally important modeling. When supervisors and trainees examine their own interpersonal processes, trainees are engaged in an important cognitive and experiential learning opportunity: They intellectually come to understand the benefits of such conversations, but perhaps more importantly, they can experience for themselves favorable repercussions. Trainees can take that learning, both intellectual and affective, into their work with clients and facilitate effective discussions of the therapy relationship.

Finally, training in targeting specific circumstances in which addressing the therapy relationship may be especially difficult should be included as well. For example, it may be difficult for therapists to use relational work with clients who shut down, retreat, or are highly defended. The latter may, for instance, interpret any such discussion as a criticism of themselves, and thus it is important that therapists be able to mitigate such concerns. Clients who evince sexual attraction to therapists are likely also quite challenging. As noted, a combination of reading/discussing how to approach such situations, followed by

observing (either live modeling or videotape) and then supervised practice, may be a wise course of action for such training.

Conclusions

We provide here, then, both theoretical and empirical evidence about the need for and effectiveness of processing the relationship. Much empirical work remains to be done, of course, to understand more about the process and outcome of relational work for different types of clients and therapists. In particular, we need to learn more about the specific components of our proposition that if therapists and clients process their therapeutic relationship (i.e., directly address in the here and now feelings about each other and about the inevitable problems that emerge in the therapy relationship), feelings will be expressed and accepted, problems will be resolved, the relationship will be enhanced, and clients will transfer their learning to other relationships outside of therapy. We also need to learn more about the timing of relational events (e.g., whether some processing is more appropriate early in therapy or in brief therapy and other processing more appropriate later in therapy or in long-term therapy) and to develop innovative methods for studying this phenomenon, because it is a complicated process that takes place over time and varies from dyad to dyad. Given that working on the therapeutic relationship is unique to interpersonal interventions (i.e., it is not applicable to self-help interventions and not often viewed as relevant to behavioral or medical interventions), and that the therapeutic relationship is the most robust predictor of psychotherapy outcome, investigating what makes these relationships work is indeed important.

References

Anchin, J. C. (2008). Integrating methodologies in the scientific study of interpersonal psychotherapy: A reaction to ''Therapist immediacy in brief psychotherapy: Case study I and case study II.'' *Psychotherapy: Theory, Research, Practice, Training, 45*, 316-319.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: Analytic Press.

Aspland, H., Llewelyn, S. P., Hardy, G. E., Barkham, M., & Stiles, W. (2008). Alliance ruptures and rupture resolution in cognitive-behavior therapy: A preliminary task analysis. *Psychotherapy Research, 18*, 699-710.

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy. *Psychology and Psychotherapy, 79*, 395-418.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). New York: Wiley.

Carson, R. C. (1969). *Interaction concepts of personality*. Oxford, England: Aldine.

Cashdan, S. (1988). *Object relations therapy: Using the relationship*. New York: Norton.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*, 497-504.

Castonguay, L. G., Schut, A. J., Aikins, D. E., & Constantino, M. J. (2004). Integrative cognitive therapy for depression: A preliminary investigation. *Journal of Psychotherapy Integration, 14*, 4-20.

Coady, N. (1991). The association between client and therapist interpersonal processes and outcomes in psychodynamic psychotherapy. *Research on Social Work Practice, 1*, 122-138.

Crits-Christoph, P., & Gibbons, M. B. C. (2002). Relational interpretations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 285-300). New York: Oxford University Press.

Crits-Christoph, P., Siqueland, L., Chittams, J., Barber, J., Beck, A. T., Frank, A., Liese, B., Luborsky, L., Mark, D., Mercer, D., Onken, L. S., Najavits, L. M., Thase, M. E., & Woody, G. (1998). Training in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of Consulting and Clinical Psychology, 66*, 484-492.

Dalenberg, C. J. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy: Theory, Research, Practice, Training, 41*, 438-447.

Elliott, R., Watson, J. C., Goldman, R. H., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

Foreman, S. A., & Marmar, C. R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry, 142*, 922-926.

Freud, S. (1963). *Introductory lectures on psychoanalysis* (J. Strachey, Trans.). New York: W.W. Norton. (Original work published 1920)

Freud, S. (1970). *An outline of psychoanalysis* (J. Strachey, Trans.). New York: W. W. Norton. (Original work published 1940)

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Erlbaum.

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. New York: Basic Books.

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research, 17*, 15-30. Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change*. New York: Guilford Press.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis (Volume 1)*. Madison, CT: International Universities Press.

Harmon, S. C., Lambert, M. J., Smart, D. W., Hawkins, E. J., Nielson, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*, 379-392.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology, 54*, 27-31.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology, 58*, 768-774.

Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses to training. *Journal of Consulting and Clinical Psychology, 61*, 441-447.

Henry, W. P., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 434-440.

Hess, S. A., Knox, S., & Hill, C. E. (2006). Teaching graduate trainees how to manage client anger: A comparison of three types of training. *Psychotherapy Research, 16*, 282-292.

Hill, C. E. (1989). *Therapist techniques and client outcomes: Eight cases of brief psychotherapy*. Newbury Park, CA: Sage.

Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology, 40*, 3-24.

Hill, C. E., Kellems, I. S., Kolchakian, M. R., Wonnell, T. L., Davis, T. L., & Nakayama, E. Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research*, 13, 475-491.

Hill, C. E., & Knox, S. (2002). Self-disclosure. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs* (pp. 249-259). Oxford, UK: Oxford University Press.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205.

Hill, C. E., Nutt Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207-217.

Hill, C. E., Sim, W., Spangler, P., Stahl, J., Sullivan, C., & Teyber, E. (2008). Therapist immediacy in brief psychotherapy therapy: Case study II. *Psychotherapy: Theory, Research, Practice, Training, 45*, 298-315.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517-572.

Hilsenroth, M. J., Ackerman, S. J., Clemence, A. J., Strassle, C. G., & Handler, L. (2002). Effects of structured clinician training on patient and therapist perspectives of alliance early in psychotherapy. Psychotherapy*: Theory, Research, Practice, Training, 39*, 309-323.

Kasper, L., Hill, C. E., & Kivlighan, D. (2008). Therapist immediacy in brief psychotherapy therapy: Case study I. *Psychotherapy: Theory, Research, Practice, Training, 45*, 281-287.

Kiesler, D. J. (1988). *Therapeutic metacommunication: Therapist impact disclosure as feedback in psychotherapy*. Palo Alto, CA: Consulting Psychologist Press.

Kiesler, D. J. (1996). *Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy*. New York: Wiley.

Kiesler, D. J., & Watkins, K. (1989). Interpersonal complementarity and the therapeutic alliance: A study of relationship in psychotherapy. *Psychotherapy: Theory, Research, and Practice, 26*, 183-194.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 21-72). New York: Guilford Press.

Klein, M., & Tribich, D. (1981). Kernberg's object-relations theory: A critical evaluation. *International Journal of Psychoanalysis, 62,* 27-43.

Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research, 17*, 1-14.

Lambert, M. J., Bailey, R. J., Kimball, K., Shimokawa, K., Harmon, S. C., & Slade, K. (2008). *Clinical support tools manual-brief version-40*. Provo, UT: Department of Psychology, Brigham Young University.

Leary, T. (1957). *Interpersonal diagnosis of personality*. New York: Ronald Press.

Levenson, H. (1995). *Time-limited dynamic psychotherapy: A guide to clinical practice*. New York: Basic Books.

Lowenstein, R. M. (1951). The problem of interpretation. *Psychoanalytic Quarterly, 20*, 1-14.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S. A. (1993*). Hope and dread in psychoanalysis*. New York: Basic Books.

Mitchell, S. A. (1997). *Influence and autonomy in psychoanalysis*. Hillsdale, NJ: Analytic Press.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 42*, 532-545.

Muran, J. C., & Samstag, L. W. (2008). Can some interpersonalists be more different than alike? Implications for method in practice and research. *Psychotherapy: Theory, Research, Practice, Training, 45*, 320-323.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Piper, W. E., Azim, H., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48*, 946-953.

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCallum, M., Rosie, J. S., O'Kelly, J. H., & Steinberg, P. I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy, 36*, 114-122.

Pollack, J., Fleigenheimer, W., Kaufman, J., & Sadow, J. (1992). *Brief adaptive psychotherapy for personality disorders: A treatment manual*. San Diego, CA: Social & Behavioral Documents.

Rhodes, R., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41*, 473-483.

Safran, J. D., & Muran, J. C. (2000). Negotiating *the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training, 43*, 286-291.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 235-255). New York: Oxford University Press.

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training, 42*, 512-531.

Samstag, L. W., Batchelder, S., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice and Research, 7*, 126-143.

Spangler, P., & Hill, C. E. (in press). Therapist perspectives on their dreams about clients: A qualitative investigation. *Psychotherapy Research*.

Strupp, H. H., & Binder, J. L (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York: Basic Books.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.

Tasca, G. A., & McMullen, L. M. (1992). Interpersonal complementarity and antithesis with a stage model of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 29*, 515-523.

Tryon, G. S., & Kane, A. S. (1990). The helping alliance and premature termination. *Counselling Psychology Quarterly, 3*, 233-238.

Tryon, G. S., & Kane, A. S. (1993). Relationship of working alliance to mutual and unilateral termination. *Journal of Counseling Psychology, 40*, 33-36.

Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research, 5*, 189-198.

Wachtel, P. L. (2008). *Relational theory and the practice of psychotherapy*. New York: Guilford Press.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielson, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment failure and problem-solving

strategies in routine practice. *Journal of Counseling Psychology, 50*, 59-68.

Notes

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Appendix

Table 1. Contributors to Processing of the Therapeutic Relationship

Variable	Description	Study
Positive precursor	Strong alliance or therapeutic relationship (client must feel safe and trust therapist)	Hill et al. (1996, 2003), Rhodes et al. (1994)
Positive client contributions	Assert negative reactions	Rhodes et al. (1994)
	Thoroughly explore feelings about relationship	Hill et al. (2003), Rhodes et al. (1994), Safran et al. (2002)
	Accept therapist apologies and understand the therapist perspective	Rhodes et al. (1994)
	Understand underlying wishes and needs and how feelings toward therapist echo feelings toward others	Hill et al. (2003)
Negative client contributions	Hostility	Hill et al. (2003), Safran et al. (2002)
	Substantial psychopathology or personality disorders	Hill et al. (1996, 2003)
	Low quality of object-relations	Crits-Christoph & Gibbons (2002)
	Defensiveness	Kasper et al. (2008)
Positive therapist interventions	Be aware of reactions to client	Hill et al. (2003)
	Acknowledge problem in the relationship	Aspland et al. (in press), Bennett et al. (2006), Safran et al (2002)
	Empathize and connect with client	Hill et al. (2003)
	Encourage client exploration of feelings	Aspland et al (in press), Bennett et al. (2006), Hill et al. (2003, 2008), Kasper et al. (2008), Safran et al. (2002)
	Apologize and accept appropriate responsibility	Dalenberg (2004), Rhodes et al. (1994)
	Change offending behaviors	Rhodes et al. (1994)
	Use transference or relational interpretations with clients who have high quality of object relations	Crits-Cristoph & Gibbons (2002)
	Use immediacy	Hill et al. (2008), Kasper et al. (2008)
	Teach that anger is possible within the context of a caring relationship	Dalenberg (2004)
Negative therapist interventions	Dogmatically maintain one's position and not respond to client feelings	Castonguay et al. (1996), Rhodes et al. (1994)
	Blame client	Dalenberg (2004), Hill et al. (2003), Safran et al. (2005)
	Pressure client to respond	Kasper et al. (2008)
	Change strategies	Dalenberg (2004), Hill et al. (1996)
	No response, insincere apology, angry response, hostile disclosure	Dalenberg (2004)
	Push for insight too early, tell clients	Hill et al. (1996)

	what to do, do not conceptualize the client accurately, too directive, to unsupportive, too cautious	
Positive consequences	Clients more able to express feelings	Hill et al. (2008): Kasper et al. (2008), Safran et al. (2002)
	Clients experience personal growth	Rhodes et al. (1994)
	Enhanced therapeutic relationship	Hill et al. (2008), Kasper et al. (2008), Rhodes et al. (1994)
	Corrective relational experiences for clients	Hill et al. (2008), Kasper et al. (2008)
	Enhanced interpersonal functioning for clients (other than with the therapist)	Hill et al. (2003, 2008), Kasper et al. (2008), Rhodes et al. (1994), Safran et al. (2002)
Negative consequences	Impasses, worsened therapeutic relationships, premature termination	Hill et al. (1996)

Note. Crits-Christoph & Gibbons (2002) and Safran et al. (2002) are reviews of the literature, whereas all other citations refer to individual studies.