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The Therapeutic Relationship in Cognitive-Behavioral Therapy

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Abstract. Cognitive behavioral therapy has often been criticized for ignoring the role of the therapeutic relationship. In this article, I outline several dimensions for case formulation and intervention that suggest that the cognitive-behavioral approach can be a powerful theoretical model for understanding the causes of and the strategies for overcoming impasses in therapy. I review how the clinician and patient can collaborate in understanding the importance of case conceptualization, validation, emotional philosophies, victim resistance, schematic resistance, schematic mismatch, sunk-cost commitment, and self-handicapping. The relevance of these factors for both patient and therapist are discussed. During the last decade there has been increased interest in the nature of the therapeutic relationship in cognitive behavioral therapy (Gilbert, 1992; Safran, 1998; Safran and Muran, 2000; Greenberg, 2002; Leahy, 2001; Gilbert and Irons, 2005; Leahy, 2005; Bennett-Levy and Thwaites, 2007; Gilbert and Leahy, 2007). Cognitive behavioral therapists have proposed that the therapeutic relationship reflects interpersonal schemas, earlier attachment problems, emotional processing, failures in validation and compassion, and a variety of processes underlying non-compliance or resistance. Resolving "ruptures" in the therapeutic relationship provides an often essential opportunity for using the relationship as a means to modify cognitive and emotional problems (Safran, Muran, Samstag and Stevens, 2002; Katzow and Safran 2007). In light of the emphasis on "empirically supported treatments" (such as CBT) there is the risk that the alliance in therapy may be foreshadowed by the techniques and protocols used in CBT, perhaps giving credibility to Mahoney's (1991) earlier claim that therapy can become "technolatry".

Keywords: Therapeutic relationship, psychotherapy, cognitive behavioral therapy, resistance.

Introduction

There is empirical support for the importance of the therapeutic relationship in CBT. The patient's perception of the quality of the relationship is related to outcome (Martin, Gorske and Davis, 2000; Orlinsky, Ronnestad and Willutzki, 2004), with early alliance predictive of later outcome (Gaston, Marmar, Gallagher and Thompson, 1991). In contrast to the view that alliance leads to better outcome, DeRubeis, Brotman and Gibbons (2005) propose that better outcomes lead to perception of better alliance (DeRubeis and Feeley, 1990; Feeley, DeRubeis and Gelfand, 1999). However, there is some evidence that better alliance does precede better outcomes in CBT in certain cases (Klein et al., 2003). In one study, both therapeutic alliance

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and cognitive therapy "skill" were predictive of outcome (Trepka, Rees, Shapiro, Hardy and Barkham, 2004). One conclusion that one may tentatively draw is that assuring the use of cognitive therapy techniques and improving the therapeutic alliance may provide the optimal treatment.

What affects the alliance?

There has been some attempt to identify the "microskills" underlying better therapeutic relationships, including active listening, regulating, and differentiating and attending (van der Molen, Hommes, Smit and Lang, 1995; Rollnick, Mason and Butler, 1999; Ivey and Ivey, 2003; Gillespie, Smith, Meaden, Jones and Wane, 2004). These skills, considered to be important regardless of therapeutic modality, may often be overlooked in training cognitive behavioral therapists, since emphasis is often placed on techniques and processes thought to be sufficient for change.

The therapeutic tasks and the relationship in cognitive behavioral therapy differ from those in psychodynamic therapy. In CBT, the emphasis is primarily on the here-and-now, problem-solving, and utilizing rationality and behavioral activation. Sessions often have an agenda, which includes a follow-up on prior self-help homework. As such, these "demand characteristics" in CBT may conflict with other assumptions and strategies that the patient has been employing (such as avoidance, procrastination, reassurance seeking, ruminating, focusing on emotion, blaming, safety behaviors, and "interpreting") rather than taking action. It is important to think of the therapeutic relationship or alliance as an on-going process, rather than an achievement that is fixed at one point in time, since the relationship is interactive and iterative, reflecting the patient's response to the therapist's response to the patient. Furthermore, the current therapeutic relationship may be a window into prior or current other relationships, thereby providing an opportunity for the therapist and patient to have first-hand experience of how past relationships permeate current functioning. Consequently, I will outline here a number of factors that can affect the alliance and suggest how these potential impasses may be overcome.

Case conceptualization

Cognitive-behavioral therapists vary in their conceptualizations of patients and their problems. It can be quite helpful to develop a theoretical model, with the patient, of the origins of their problems, their fear of change, and their expectations in relationships (Kuyken et al., 2008; Persons 1993; Needleman 1999; Beck 2005). Problems arise in case conceptualization or case formulation, as it is alternately labelled. One problem is that there may be low reliability amongst therapists conceptualizing the same case, with therapists emphasizing different dimensions in their case formulations (Flitcroft, James, Freeston and Wood-Mitchell, 2007); for example, some therapists emphasize the "here and now", others "function and process", and others "traits". Second, case conceptualization may differ in terms of the theoretical model allegiance of the therapist. For example, a schema focused therapist will emphasize early attachment and relationship issues, the persistence of early maladaptive schemas, and maintenance, compensation and avoidance of schemas. In contrast, more behaviorally oriented therapists will emphasize a functional analysis of therapy interfering behaviors. Nonetheless, the value of a case conceptualization is that it may help the therapist anticipate impasses that

may arise, it can provide a way for patient and therapist to understand how the current impasse has been a recurrent problem and it may suggest strategies for negotiating the alliance. For example, if abandonment has been a recurrent issue in the patient's life, then the patient and therapist may anticipate how this might arise in the therapeutic relationship (e.g. the therapist is on vacation) and they may collaborate to develop strategies to off-set any dysfunctional interpretations or responses that the patient may have to "abandonment" (e.g. personalizing, catastrophizing, substance abuse, hopelessness, or deciding to discontinue treatment) (Persons and Tompkins 1997; Tompkins, 1999). Functional analysis (which is seldom labelled by its proponents as "case conceptualization") may be used to anticipate therapy interfering behaviors or emotional dysregulation and help develop skills and strategies to address these potential problems (Foertsch, Manning and Dimeff, 2003).

Validation

The perception that the therapist lacks empathy and does not validate the patient's feelings has often been identified as a predictor of outcome. Indeed, in one study "comprehensive validation" led to no dropouts in treatment and, on many outcome measures, was equivalent to dialectical behavior therapy for heroin addicts (Linehan et al., 2002). But people differ as to what they view as satisfactory validation. Validation resistance may occur if the patient is "stuck" and views change as invalidating and dismissive. For example, the patient says, "You don't understand how bad I feel. This is really *terrible.* You're just trying to get me to *ignore* how I really feel." Some patients have idiosyncratic rules for validation ("Unless you feel as bad as I do you don't care about me"), or problematic strategies to elicit validation (escalation of conflict, repetitive demands, recurrent crises) (Linehan, 1993; Leahy, 2001). Identifying these "rules" for validation, the history of invalidation, and acknowledging the dialectical nature of treatment (validation of suffering and change) can help overcome this powerful roadblock.

Emotional philosophies

Gottman, Katz and Hooven (1996) have proposed that people differ in their beliefs or philosophies about painful emotions. Some people are dismissive ("You'll get over it"), others are contemptuous ("You're being a baby") and others may use a more Rogerian style that Gottman refers to as "emotional coaching". Therapists and patients may have different "emotional schemas"; that is, beliefs and strategies about how to interpret and respond to emotions (Leahy, 2007a). For example, if the patient believes that painful emotions don't make sense, are shameful, can become overwhelming and persistent, then emotional avoidance will be the strategy that will be activated (Leahy, 2003, in press), a factor that may interfere with effective treatment (Hayes, Strosahl and Wilson, 1999). If the therapist believes that emotional expression is a waste of time, that validation interferes with accomplishing important goals, or that validation "reinforces" rumination, then the patient is likely to feel invalidated, and may decide to terminate treatment (Leahy, 2007b).

The therapist's underlying emotional philosophy will determine how the therapist responds to the patient's crying. The therapist who views intense emotion and its expression as interfering with the task-orientation of cognitive behavioral therapy may attempt to inhibit or dismiss the patient's crying. Problematic responses are "Do you *really* feel better if you cry?", "Is it worth

crying over?" or even "Don't cry". Ignoring the patient's crying entirely -and quickly returning to the agenda – sends the message that the painful feelings and the vulnerability expressed in crying are viewed as experiences not worthy of the therapist's respect. These may reinforce old emotional schemas from the family of origin that "my emotions are a burden" and "I don't have a right to feel this way". Rushing in with conversation, advice, and questions that interrupt the patient's crying can also suggest to the patient that hurt feelings are "to be gotten over", another dismissive message that may be consistent with the patient's own negative emotional schemas (Leahy, in press).

Victim resistance

Many people seeking help have been treated unfairly; indeed, they may have been abused and victimized. Victim resistance consists of the belief that the patient is stuck in the view that he is *nothing but a victim* and views change – or the ownership of responsibility for self-improvement – as morally self-condemning and as letting others "get away with it" (Leahy, 2001). The patient says, "You're telling me to just say that it's all right that this happened. Whose side are you on?" Indeed, the therapist may fall into the trap of challenging the legitimacy of the victim role, further adding to the patient's belief that the therapist is just "another oppressor". Acknowledging, validating, and using case conceptualization can all be helpful (Leahy, 2001). For example, the therapist can develop a collaborative set with the patient that recognizes that what had happened was unfair or even terrible. Here, one can consider the possibility that "awfulizing" may be a legitimate emotional response for people who have been victimized or abused – in contrast to a Rational Emotive approach that challenges "awfulizing"(Ellis, 1962). Indeed, challenging "awfulizing" may enhance resistance and impair the relationship, since the patient may view this as just another invalidation and victimization. Other "Third Wave" approaches may also address the victimization issue, including the use of radical acceptance strategies that are balanced with the dialectic of "change" (Linehan 1993; Hayes et al., 1999). Moreover, victim resistance may also be tied to schematic issues – especially "shattered assumptions" – that may need to be addressed through developing a new protective but empowering approach to life (Janoff-Bulman, 1992).

Schematic resistance

The patient's schema may be so impervious that he cannot see an alternative: "If I try to make a change it will never work – I'm a total loser". Schema therapy is useful in helping patients with long-standing personality disorders that are related to "protection" and maintenance of schemas (Young, Klosko and Weishaar, 2003). These personal schemas may have dramatic impact on the therapeutic relationship. For example, the patient with schemas about abandonment may interpret the therapist's vacation as another sign that he or she will be abandoned. Self-help homework may be interpreted as a sign that one will be evaluated for defectiveness. Utilizing case conceptualization, identifying schemas, examining their origins, using experiential techniques and utilizing the therapeutic relationship with "empathic confrontation" can help off-set these impasses (Leahy, Beck and Beck, 2005; Kellogg and Young, 2006).

Schematic mismatch

Therapists are just like their patients in that they also have their own potentially dysfunctional personal schemas, such as demanding standards (expecting to cure all their patients and

demanding conformity to their agenda), abandonment (that is, fear that their patients will leave them) or self-sacrifice (that is, the willingness to defer to the patient's demands even when they conflict with the rights or needs of the therapist). Safran and his colleagues have described how "interpersonal'' or "relational schemas" can elicit ruptures in the interpersonal alliance (Safran, 1998; Safran and Muran, 2000; Safran and Segal, 1990). These therapist schemas constitute the equivalent of a counter-transference model in cognitive therapy (Leahy, 2001). The Therapist Schema Questionnaire (Leahy, 2001) provides a measure of the therapist's biases and values in the therapeutic relationship. Haarhof (2006) found that the most common therapist schemas among trainees in CBT were "demanding standards", "special superior person", and "excessive self-sacrifice". Therapists with "demanding standards" may inadvertently communicate to patients that they are "not living up to their standards of being a good patient". These therapists may be more impatient with the slower and more complicated process of change for patients with complicated personality disorders and negative emotional schemas. Or, conversely, therapists who are excessively self-sacrificing may believe that encouraging patients to use anxiety-provoking exposure techniques may be "too much to ask", thereby communicating that exposure may be "beyond your capability".

Schematic mismatch refers to the condition in which the therapist's schemas about therapy and relationships confirm the patient's negative personal schemas. Thus, the therapist with schemas about demanding standards may become impatient with the patient who is showing slower progress. The therapist may communicate his or her own frustration, thereby confirming for the patient that he cannot trust the therapist with his vulnerability. Or the therapist with a schema of self-sacrifice may fail to set limits or boundaries, thereby confirming for the patient that he cannot take care of himself and must be continually rescued by the therapist. Examining one's own schemas as a therapist can assist in avoiding the risk of being caught up in a schematic mismatch. For example, a therapist who recognized her own self-sacrificing tendencies was able to set limits on a patient and learn that the patient could tolerate limit-setting. Moreover, this could then be used as evidence that the patient was capable of using the cognitive therapy techniques on her own, thereby challenging the belief in her own helplessness and need for dependency.

Patients and therapists can also have similar schemas that can create their own problems. This "over-match" can be seen when the therapist is overly dependent on the patient and the patient fears abandonment by the therapist – an example of "over-match" (Leahy, 2007, in press). The therapist may use an avoidant strategy – she does not bring up difficult topics, avoids discussing patient's dependent behavior, and does not set limits on the patient. As a consequence, the patient may conclude: "My emotions must be overwhelming to other people"; "Doing new things will be risky and terrifying"; "My therapist must think I am incapable of doing things on my own".

Sunk-cost commitment

Impasses in the therapeutic relationship may occur when the patient is committed to self-verification and self-justification of past commitments, choices and behaviors, for example, "the sunk-cost effect" (Leahy, 2000). The patient cannot walk away from a losing commitment and says, "If I walk away now, it means that everything was a total waste." In these cases the patient and therapist appear to be committed to different goals – the patient to justifying the past, the therapist to a better future. The patient may believe that giving up on a losing

cause means that he or she is a bigger loser, that the past was a waste of time, and that only by redeeming a sunk cost can self-esteem be re-established. The therapist may find that "challenging" the patient's "resistance" to a sunk cost only escalates the commitment to it. However, developing a conceptualization of "sunk cost", examining other instances in which sunk costs have been abandoned, weighing the cost-benefit ratios over the long-term and short-term, and asking what advice would one give a friend can help "de-couple" the patient to a commitment to past decisions.

Self-handicapping

In self-handicapping the patient attempts to avoid finding out how well he can do under the best of conditions and develops excuses to lower expectations. The patient sets up obstacles for himself: "I was out late the night before the exam and I hadn't studied, so I probably won't do well." Because there are obstacles that can account for not doing well, the patient's true potential cannot be determined. If he fails, it's because he was out late and didn't study. If he does well, then he's a genius. Again, the patient and therapist may be at cross-purposes. The patient wishes to come up with handicaps and hedging to avoid any direct evaluation of "how well I can do if I try my best". Thus, the patient attempts to sabotage self-help and may escalate pathologizing himself in order to hide from direct evaluation. Helping patients identify their shame about failing at their best and their guilt about past unwillingness to change may help the patient experiment in gradual improvement. We have found it helpful to anticipate with the patient further attempts to self-sabotage, such as devaluing alternatives, discounting positives, attacking the therapist, and withdrawing from treatment (Leahy, 1999).

Conclusions

Ironically, it may be that cognitive behavioral therapy is uniquely qualified to help in case conceptualization and in strategies to effectively utilize, intervene and assist in resolving impasses in the therapeutic relationship. For many years, psychodynamic therapy has prided itself on its understanding of the therapeutic relationship. However, the conceptualizations offered are often obtuse and difficult to use as a guide to effective action. In the current article, I have outlined a number of dimensions of resistance, impasses, conflicts and confusions in the therapeutic relationship that are amenable to cognitive behavioral therapy.

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