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Clinical Section

THE THERAPY RELATIONSHIP IN COGNITIVE THERAPY: A REVIEW

Louise Waddington

Institute of Psychiatry, London, UK

Abstract. Cognitive therapy has traditionally assumed that the therapy relationship provides a necessary context for intervention but is insufficient alone to produce therapeutic change. This assumption is reviewed in the light of up-to-date evidence from research studies of cognitive therapy and recommendations are made for further research. Mechanisms by which the therapy relationship may influence outcome and factors influencing the quality of the relationship are briefly discussed and the need for further research highlighted. Implications for the practice of cognitive therapy are suggested.

Keywords: Therapy relationship, cognitive alliance, review.

Introduction

The therapy relationship has been most simply defined as, ''the personal qualities of the patient, personal qualities of the therapist, and the interactions between them'' (Wright & Davies, 1994, p. 27). Although Aaron Beck has consistently stressed the necessity of a good therapy relationship, describing it in 1976 as ''an obvious primary component of effective psychotherapy'' (p. 220), cognitive therapy has traditionally assumed that the therapy relationship alone is insufficient to produce change (Beck, Shaw, Rush, & Emery, 1979). Cognitive therapy's commitment to empirical evidence leaves it well placed to review this assumption in the light of new evidence (Gelso & Hayes, 1998).

A literature search reveals that cognitive therapy has paid greater attention to the therapy relationship in the last decade (e.g. Bachelor & Horvarth, 1999; Newman 1998; Safran & Segal 1990; Wright & Davis, 1994). Research findings prompting increased attention to the therapy relationship include equivalent outcomes to diverse therapies which drew attention to factors common to all therapies (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliott, 1986), and social psychology research suggesting the therapy relationship may be a potent source of social influence. Developments in attachment theory have stimulated interest in consistencies between the concept of inner working models of relationships (IWMs: Bowlby, 1988), and interpersonal cognitions (Safran &

Reprint requests to Louise Waddington, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK. E-mail: spjtlow@iop.kcl.ac.uk

Segal, 1990). Extending cognitive therapy to clients with chronic interpersonal difficulties, with whom helpful relationships are not easily established, has also prompted cognitive therapists to pay more attention to the therapy relationship (Newman, 1998).

Developments in operationalizing and measuring the therapy relationship have rendered it more open to research and hence more interesting to cognitive therapists. Therapist empathy, genuineness and unconditional positive regard (Rogers, 1957) are now regarded as only one side of the relationship (Horvarth & Luborsky, 1993) and as subject to interpretation by the client (Bachelor & Horvarth, 1999). Measures based on conceptualizations of the therapy relationship as supportive or collaborative (Barrett-Lennard, 1962; Horvarth & Greenberg, 1989) have been found to access a common factor (Salvio, Beutler, Wood, & Engle, 1992). Horvarth and Luborsky (1993) conclude that the numerous measures of the therapy relationship show good reliability and validity. The main difference between measures appears to be not their conceptualization of the therapy relationship but whether it is assessed by the client, therapist or an observer. Evidence suggests that client and observer ratings show the greatest reliability and predictive validity (Burns & Auerbach, 1996; Orlinsky, Grawe, & Parks, 1994; Persons & Burns, 1985; Mallingkrodt, 1996).

In summary, cognitive therapists have shown greater interest in the therapy relationship in response to research findings, theoretical developments and practical necessities. Their interest has been encouraged by research supporting the reliability and validity of measures of the therapy relationship.

The therapy relationship and outcome: research evidence

Despite the recent increase in studies exploring the therapy relationship in cognitive therapy, these are still vastly outnumbered by studies from the wider therapy field. Roth and Fonagy (1996) discovered 100 research reports on the therapeutic alliance between 1976 and 1996 and claim these provide evidence of a ''robust relationship between alliance and outcome'' (p. 352). Similarly, in their review in 1993, Horvarth and Luborsky concluded that the therapy alliance has been shown to predict outcome across diverse therapies (including cognitive therapy, psychodynamic therapy, gestalt therapy), outcome measures (including drug use, social adjustment, global improvement, remission of depression) and treatment lengths (from 4 to over 50 sessions). However, there has been some speculation that cognitive therapy may be less influenced by the quality of the therapy relationship (Roth & Fonagy, 1996). Recent studies from the cognitive therapy field are now reviewed to explore the role of the therapy relationship in cognitive therapy. These are not intended to provide an exhaustive list but to present some of the most useful research in the area (see Table 1).

Several studies have looked at the therapy relationship in single sessions. Persons and Burns (1985) analysed single sessions and found that (i) the therapy relationship and (ii) decreased beliefs in automatic thoughts had independent and additive impacts on end of session mood. However, as clients gave ratings of the therapy relationship at the end of the session it is possible that changes in automatic thoughts may have caused mood changes, which in turn led to high ratings of the relationship.

Raue, Goldfried and Barkham (1997) studied single sessions of cognitive therapy and psychodynamic-interpersonal therapy. High alliance scores were associated with therapist

Table 1. Research exploring the role of the therapy relationship in cognitive therapy

Author	Date	Client group	*N*	Therapy modalities	No. of sessions	Relationship measures	Sessions when measures given
Persons & Burns	1985	Depressed and anxious	17	CT	Not stated	10 items asking for clients' views of therapist empathy, warmth and trustworthiness	1 session where a DTR was used
De Rubeis & Feeley	1990	Depressed	25	CT	7–108 median 19 1st 12 studied	Observer ratings of facilitative conditions + Penn Helping Alliance (Morgan et al., 1982)	1 from 4–6 1 from 7–9 1 from 10–12
Muran, Gorman, Safran, & Twining	1995	Depressed + anxious	53	CT	20	Short form of the California Psychotherapy Alliance Scales (CALPAS: Marmar & Gaston, 1988)	Post every session. Averaged across 1st and 2nd half of treatment
Krupnick et al.	1996	Depressed	225	CT, Interpersonal therapy, Medication and Placebo	16–20 sessions/ meetings	Modified version of Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983)	3, 9, 15 for completed cases — far as poss otherwise
Castonguay, Goldfried, Wiser, Raue, & Hayes	1996	Depressed	30	CT or CT with medication	12 weeks	Working alliance inventory (WAI: Horvarth & Greenberg, 1989)	One from sessions 4–7
Burns & Nolen-Hoeksema	1992	Affective disorders, Axis II disorders	185	CT	Mean of 15 by 12 week study point	Empathy Scale (Persons & Burns, 1985)	12 week study point
Raue, Goldfried, & Barkham	1997	Depressed	57	CT or psycho-dynamic interpersonal	16	WAI	1 high impact, 1 low impact session
Stiles, Agnew-Davies. Hardy, Barkham, & Shapiro	1998	Depressed	79	CT and Psycho-dynamic-interpersonal	8 or 16	Agnew Relationship Measure (Agnew-Davies & Stiles, 1998)	Mean of all sessions
Gaston, Thompson, Gallagher, Cournoyer, & Gagnon	1998	Depressed	91	CT, behaviour therapy or brief dynamic therapy	16–20	CALPAS	Mean of measures at 5,10,15

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Table 1. *Continued*

Author	Date	Client group	*N*	Therapy modalities	No. of sessions	Relationship measures	Sessions when measures given
Feeley, DeRubeis, & Gelfand	1999	Depressed	25	CT	Mean 14.6 Max 20	Penn Helping Alliance	Session 2 1 from 7–9 1 from 10–12
Rector, Zuroff, & Segal	1999	Depressed and anxious	47	CT	20	WAI	Pre and post treatment
Tang & De Rubeis	1999	Depressed	61	CT	Up to 20	CBT version of Vanderbilt Therapeutic Alliance Scale + WAI + Penn Helping Alliance	Whenever a rapid response occurred (drop of 11 BDI points between sessions)
Hardy et al.	In press	Depressed	24	CT	12–20 BDI <9 for 3 wks	CALPAS	Mean of all sessions

ratings of session depth and smoothness, client ratings of improved mood, and the impact of sessions. Again, it is impossible to determine which of these variables was causal.

In a study of 61 clients Tang and DeRubeis (1999) studied sessions surrounding a rapid improvement in depression ratings. They observed high cognitive change in the session preceding the improvement and high ratings of the alliance in the session following the improvement. This suggests a causal role of cognitive change in relation to both alliance and outcome. However, the authors do not comment on the alliance ratings in the session preceding the improvement.

These studies suggest an association between the therapy relationship and improvement over single sessions. However, causality is unclear and studies of single sessions cannot give a clear indication of what happens over a course of therapy. Two large-scale studies have explored the role of the therapy relationship over a course of therapy. The Sheffield Psychotherapy Project examined the role of the therapy relationship in cognitive and psychodynamic-interpersonal therapy (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998) with 79 clients. The authors found an association between mean alliance ratings across all sessions and outcome. This association was stronger in cognitive therapy than in psychodynamic interpersonal therapy. The authors acknowledge the difficulty of determining whether results reflected a causal role of the therapy relationship or simply a correlation between improved depression and high ratings of the relationship. Similarly, Gaston, Thompson, Gallagher, Cournoyer and Gagnon (1998) studied 120 depressed elderly clients and found that pre-therapy depression level and alliance assessed across sessions 5, 10 and 15, predicted outcome. However, the temporal precedence of the therapy relationship and its possible causal role is again unclear.

DeRubeis and Feeley (1990) studied 25 clients receiving a highly structured 12-session cognitive therapy for depression. They found that the use of cognitive therapy techniques predicted outcome but the therapy relationship did not, suggesting that the therapy relation-

ship does not have a causal role in relation to outcome. However, several other studies support the idea that the therapy relationship has an impact on outcome beyond its association with technical interventions. For example, Burns and Nolen-Hoeksema (1992) studied 185 clients with affective disorders, and some with additional axis two disorders, using a three-stage least-squares estimation procedure to ameliorate some of the difficulties in determining direction of causality. Clients of therapists who were warmer and more emphatic had a better outcome when other factors, including level of depression and completion of homework, were controlled. Technical factors (completion of homework) and relational factors (strength of alliance) had independent and additive effects on outcome.

In a recent paper Feeley, DeRubeis and Gelfand (1999) argue that when temporal sequencing of process variables is taken into account the therapy relationship emerges as nothing more than a by-product of symptom change. They studied 25 clients receiving cognitive therapy for depression and found that the alliance measured at session two did not predict subsequent outcome. The value of using a temporal analysis was marred by the use of a poor measure of the therapy relationship. The Penn Helping Alliance (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) has a lower reliability than the Vanderbilt Therapeutic Alliance Scale and the Working Alliance Inventory (0.60, 0.70, 0.76 respectively: Tang & DeRubeis, 1999). This is unsurprising as observers are asked to rate clients' experiences and therapists' attributes from session transcripts and may, for example, be required to rate whether, ''the patient shares similar conceptions about the aetiology of his problems'' from transcripts where the client has made no comment on the matter. Measuring the relationship at a single session further compounds the problem and makes it unlikely that the overall early therapy relationship has been accurately assessed. These methodological issues may account for the discrepancy between the findings of this study and those of other studies that have incorporated the temporal sequencing of the therapy relationship as a process variable.

Castonguay, Goldfield, Wier, Raue and Hayes (1996) studied the relative impact of technical and relationship factors on cognitive therapy for depression and found that a good therapy relationship assessed between sessions four and seven was associated with a good outcome at 12 weeks (a mean of 15 sessions). This was clearly not an artefact of technical intervention as technical interventions (focus on distorted cognitions) were negatively related to outcome.

Muran, Gorman, Safran and Twining (1995) studied 20-session cognitive therapy for 53 depressed and anxious clients. They observed that both the quality of the therapy relationship and cognitive change were strong predictors of outcome. The relationship over the first half of therapy was more predictive of outcome than the relationship over the second half of therapy. Client ratings of the alliance were most predictive of therapist rated outcome measures. By contrast, client ratings of cognitive change were most predictive of client rated outcome measures.

Krupnick et al. (1996) explored the contribution of the therapy alliance to outcome in cognitive-behaviour therapy, interpersonal therapy, antidepressant medication with clinical management, and placebo medication with clinical management, for depressed clients. Clients' contributions to the therapy alliance assessed at session three were associated with outcome at session 16–20 in each condition. This raises the interesting possibility that the therapy relationship has an impact not only on the outcome of psychological therapies, including cognitive behaviour therapy, but also the outcome of pharmacotherapy. It also

suggests that the association between therapy alliance and outcome cannot be entirely attributed to technical features of therapy.

Rector, Zuroff and Segal (1999) studied the role of cognitive change and the therapy relationship in 20 session cognitive therapy for clients with depression or anxiety. They observed that pre-treatment cognitions were predictive of alliance formation and that the alliance was itself predictive of changes in these cognitions. High ratings of the ''bond'' component of the alliance combined with change in cognitions predicted the best improvement. An interaction between cognitive change and the quality of the therapy alliance seems evident but the nature of this interaction is unclear. The authors suggest that a good therapy relationship may facilitate technical interventions, which then cause cognitive change.

Another recent study provides evidence which, contrary to Feely et al. (1999), suggests the therapy relationship has a role in determining outcome. Hardy et al. (in press) found an association between avoidant personality disorder and poor outcome to cognitive therapy for depression that was mediated by the therapy relationship.

In summary, an association between the therapy relationship and outcome has been observed more often than not, with the role of technical intervention as a possible mediator of this association greatly debated. The black and white thinking inherent in seeing the relationship as either critical or irrelevant to outcome seems unhelpful. More helpful would be to explore it as a process variable within a complex process.

Recommendations for research

Further research exploring the temporal sequencing of technical interventions, symptom change and the quality of the therapy relationship is needed to unpack the individual contributions of these processes. A measure of the relationship taken from multiple sessions within e.g. early, middle, late phases of therapy is likely to be more meaningful than a measure taken at a single time point (Stiles et al., 1998). Attention to whether the alliance is rated by the client, therapist or an observer and whether it is their experience of it or contribution to it that is being assessed, would help to clarify the most useful measure. In the meantime a measure that is quick to administer and has good reliability (e.g. Agnew Relationship Measure (Agnew-Davis & Stiles, 1998) may be most clinically feasible. Finally, as Table 1 illustrates, studies to date have focused on depressed clients and occasionally included mixed anxiety diagnoses. We need to study a wider range of distinct client groups to understand the significance of the therapy relationship in treating different disorders.

By what mechanisms might a good therapy relationship affect outcome?

The following discussion draws together theoretical ideas to form hypotheses as to the possible mechanism of action of the therapy relationship. Social influence theory holds that positive therapist attributes increase a therapist's social influence, thereby maximizing clients' compliance with therapy. Consistent with this view Beck, Freeman and Associates (1990) suggested the therapy relationship is an important source of reinforcement with clients for whom technical interventions cannot provide rapid rewards. There is evidence from non cognitive therapies that when a client perceives their therapist to be expert, trustworthy and attractive they are less likely to drop out of therapy (McNeil, May, & Lee, 1987), and more likely to feel satisfied with therapy and make gains from therapy

(Chambers, 1986). These attributes may be particularly important in increasing compliance with potentially aversive treatments (Morris & Magrath, 1983).

By contrast with social influence theory, Beck and Young (1985) emphasize the importance of a collaborative therapy relationship in which clients are able to progress through exploration of empirical evidence rather than persuasion. This is consistent with the attachment theory view of a good therapy relationship providing a secure base from which a client is able to explore. The association between a positive therapy relationship and outcome may be mediated by the likelihood of clients engaging in shared exploration.

Snyder, Michael and Cheavens (1999) propose that a sense of hope is central to therapeutic change and describe the therapy relationship as one factor that can promote hope.

Attachment theory suggests that the therapy relationship can act to disconfirm dysfunctional beliefs about the self and others formed in early relationships with caregivers (Bowlby, 1988; Safran & Segal, 1990). Cognitive theory sheds light on the persistence of these beliefs in terms of confirmatory information processing and behaviour. Therapists can raise a client's awareness of their beliefs regarding relationships and encourage them to examine the evidence. Safran and Segal (1990) describe ruptures and repairs to the therapy relationship as a crucial part of this experience. Critical to the notion of experiential disconfirmation of beliefs is the extent of generalization from the therapy relationship to expectations and behaviour in other relationships. Knox, Goldberg, Woodhouse and Hill (1999) found that clients spontaneously formed internalized representations of their therapists, supporting the idea that the therapy relationship can provide an important internalized model. Mallingkrodt (1996) observed that a positive therapy relationship was associated with increased social support, which may reflect generalization of learning from the therapy relationship. More research is needed on generalization from the therapy relationship.

Safran and Segal (1990) suggest that the therapy relationship may serve to increase clients' awareness of their own disposition to act to change a situation. This awareness may have been held back by ''tacit rules'' formed in early relationships. For example, a client who has developed a tacit rule of not acknowledging emotions related to a desire for intimacy may be enabled through the therapy relationship to recognize their loneliness and disposition to seek company.

In summary, various mechanisms by which the therapy relationship may affect therapeutic outcome have been proposed but there is little evidence available from cognitive therapy research with which to evaluate them. Further cognitive therapy research incorporating time sequencing is needed before we can conclude that the relationship has any effect beyond increasing client compliance or collaboration. The notion of the therapy relationship as a source of evidence to disconfirm dysfunctional interpersonal cognitions is compatible with cognitive therapy and deserves further investigation.

What factors influence the quality of the therapy relationship?

There are as yet no well-established differences between therapies in their ability to foster a positive therapy relationship. Salvio et al. (1992) found no differences in alliance between cognitive therapy, focused expressive psychotherapy and supportive/self-directed therapy involving only brief telephone contact with non-expert counsellors. Could the apparently equivalent impact of diverse therapies also hold true for their ability to foster a positive therapy relationship? Some evidence against equivalence comes from Raue, Castonguay and

Goldfried (1993) and Raue et al. (1997) who each found cognitive behaviour therapy was associated with a stronger therapy alliance than psychodynamic-interpersonal therapy. Similarly, Stiles et al. (1998) found that client ratings of their sense of partnership with their therapist, and their confidence in their therapist, were higher in cognitive behaviour therapy than in psychodynamic-interpersonal therapy. Further research to explore and possibly confirm this finding would be valuable.

Research has found, perhaps not surprisingly, that the better a client's intrapersonal resources (e.g. ''psychological mindedness'' and motivation: Roth & Fonagy, 1996) and interpersonal facility (e.g. positive marital and social relationships: Horvarth, 1991; Mallingkrodt & Nelson, 1991) the better able they are to form a good therapy relationship. Could the apparent association between the therapy relationship and outcome be accounted for by the impact of client factors on each? Studies finding no strong association between severity of distress and ratings of the relationship make this seem unlikely (e.g. Beckham, 1989; DeRubeis & Feeley, 1990). Burns and Nolen-Hoeksema (1996) observed that clients' ratings of the therapy relationship were unaffected by their experience of depression and co-morbid Axis II disorders, and that initial level of depression and therapy relationship had independent impacts on outcome.

Lambert (1989) points out that even in large-scale studies, where efforts are made to prevent differences in delivery of therapy, therapists obtain widely different results (e.g. Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985; Shapiro, Firth-Cozens, & Stiles, 1989). Therapist maturity, motivation (Strupp, 1980), personal adjustment, interest in helping patients (Luborsky et al., 1985) have all been observed to influence therapy outcome, possibly via their impact on the therapy relationship. Roth and Fonagy (1996) recommend further research into the impact of therapist factors on the therapy relationship and outcome.

Research into therapist-client matching (e.g. Talley, Strupp, & Morey, 1990) could be extended to consider potentially beneficial differences between therapist and client e.g. a male therapist may provide disconfirmatory evidence for a female client with the belief, ''all men are threatening''. Matching or complementing individual characteristics is unlikely to be feasible within service constraints but may give insights into relationship difficulties.

Cognitive therapy research is needed to clarify the role of client factors and therapist factors, and the interaction between these, on the therapy relationship and to investigate indications that cognitive therapy may generate a more helpful therapy relationship than psychodynamic-interpersonal therapy.

Implications for the practice of cognitive therapy

Cognitive therapists agree that a good relationship is necessary for collaborative empiricism, the hallmark of cognitive therapy (e.g. Beck, 1976; Beck et al., 1979; J. Beck, 1996, Persons, 1989). Ilardi and Craighead (1994) purpose a model that integrates technical and relational aspects of therapy based on Howard, Lueger, Maling and Martinovich's (1993) three-phase model of psychotherapy. This suggests (i) increased hopefulness is brought about by a good therapy relationship (ii) this creates a reduction in symptoms and (iii) improvement across further areas of functioning is then achieved using specific cognitive skills.

Safran and Segal (1990) recommend specifying the skills involved in developing a good therapy relationship (p. 29) but Gelso and Hayes (1998) argue that applying techniques to the therapy relationship will appear ingenuine to clients. Specifying skills seems an essential

first step and cognitive therapists can aspire to learn these skills to a level where they can be flexibly and creatively applied (CTS-R: Newcastle CBT Centre & University of Newcastle Upon Tyne, 1999). Some pointers follow as to how cognitive therapists may be able to maximize the therapeutic potential of the therapy relationship. These are based on research available so far and could no doubt be improved as further evidence from cognitive therapy studies becomes available.

Elicit the client's view of the therapy relationship

Research suggests client and therapist views of the therapy relationship are often divergent and that the client's perspective is most predictive of outcome (Burns & Auerbach, 1996). Therapists should keep this in mind and seek client feedback throughout therapy (Newman, 1998), possibly using client ratings of the relationship (Burns & Auerbach, 1996). Mallingkrodt and Nelson (1991) noticed that experienced therapists had a better understanding of the client's view. This could be used to generate recommendations for less experienced therapists.

Aim to generate hope using the therapy relationship

The therapy relationship, as well as the treatment rationale, can generate hope (Snyder et al., 1999). The CTS-R (Newcastle Cognitive and Behavioural Therapies Centre & University of Newcastle Upon Tyne, 1999) uses the term ''charisma'' to assess a therapist's ability to inspire their clients. Therapists would benefit from concrete details of this concept.

Use cognitive skills to establish a good therapy relationship

Foreman and Marmar (1985) recommend direct attention to the therapy relationship. Strategies for attending to the relationship range from specific techniques such as the disarming technique (Burns & Auerbach, 1996) to overriding skills such as use of the clinical formulation (Persons, 1989). Many writers advocate applying key cognitive techniques, such as guided discovery, thought records and eliciting feedback, to the therapy relationship (Blackburn & Twaddle, 1996; Newman, 1998; Overholser & Silverman, 1998). In an interesting reversal of the position that a good therapy relationship supports technical interventions, some have also recommended good therapeutic practice (e.g. collaborative agenda setting) in order to promote a positive therapy relationship.

Attend to ruptures in the therapy relationship

Safran and Segal (1990) suggest that attending to ruptures in the therapy relationship is critical to outcome. Newman (1998) and Reandau and Wampold (1991) describe factors that may precipitate alliance ruptures and cognitive methods for repairing these.

Aim for positive therapist characteristics

Evidence suggests that therapists' personal characteristics, such as personal adjustment, relate to therapy outcome (e.g. Strupp, 1980). Therapists can helpfully attend to their own

issues, possibly making use of chapters on therapist issues within cognitive therapy texts (Beck, J., 1996; Persons, 1989; Padesky & Greenberger, 1995).

Attend to generalization from the therapy relationship

Generalization from the therapy relationship to other relationships can be addressed carefully and explicitly. Beck, J. (1996) and Blackburn and Twaddle (1996) recommend using cognitive techniques to address the therapy relationship as a precursor to modifying cognitions about relationships in general.

Consider individual client issues in the therapy relationship

The most helpful approach to the therapy relationship will depend on the client's personal issues and individual conceptualization is critically important (Persons, 1989). Other individual considerations include the client's perception of helpful therapist' responses and the session number (Bachelor & Horvarth, 1999).

Use supervision to monitor therapists' relationship skills

Wright and Davis (1994) investigated factors influencing client's satisfaction with therapy and suggest ''training programs for cognitive-behavioural therapists should include intense supervision on relationship issues'' (p. 42). By specifying factors associated with good therapeutic relationships, these can be explicitly monitored in supervision, perhaps with further modification of the CTS-R (Blackburn & Twaddle, 1996).

In summary, there are many pointers from the literature as to how best to maximize the therapeutic potential of the therapy relationship but these need further research.

Conclusions

Research from other therapeutic approaches suggesting the therapy relationship has an impact on outcome, independent of technical interventions, has stimulated cognitive therapists to explore the therapy relationship. Although more has been written about optimizing the therapy relationship over the last decade (e.g. Newman, 1998) there is still a need for research to clarify the role of the therapy relationship as a process variable in cognitive therapy. As Beck et al. (1979) recognized, technical and relational aspects of therapy are necessary for an optimum therapeutic outcome and the interaction between these appears a productive focus for research. Research incorporating the significance of temporal sequencing and including a wider range of distinct client groups is needed. Meanwhile, cognitive therapists can draw on existing research to develop skills in establishing and using a good therapy relationship.

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