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Review Article

The Impact of the Therapeutic Relationship and Contextual Issues on the Therapeutic Outcome

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Abstract

Previous research has looked at the therapeutic outcome as a function of the client's expectations about the value of treatment and as a function of the match between clients and therapist on characteristics like race, social class, sex, general personal constructs, personality characteristics. This essay will specifically focus on how 2 elements i.e. the therapeutic relationship and the contextual issues of cultural sensitivity in the initial treatment phase impact the therapeutic outcome at the end of the therapeutic process. A critical evaluation related to how well they impact the outcome when tested within the controlled conditions in which they were designed will be offered.

Keywords: Therapeutic Relationship; Therapeutic Outcome

The therapeutic relationship

If the therapeutic outcome is to be understood by the positive outcome of the therapy on the client, the latter correlates more with empathy, warmth and the therapeutic relationship than specialised treatment interventions, as reported by a meta-analysis of more than 100 studies which statistically analysed the predictors of therapeutic outcome [39]. Facilitative conditions of warmth, empathy and congruence, the personal attributes of the therapist together with the contribution of the client make the therapeutic alliance, the most vital aspect being that the client feels understood, accepted and prized in a meaningful way [6]. It was found that therapists who provided high levels of empathy, warmth, and genuineness produced a 90% improvement rate in their patients [66].

As early as 1913, the importance of a positive relationship shared between a therapist and client was highlighted by Sigmund Freud, who also pointed out how it was different from unconscious transference, which was emphasised by later researchers [70]. Later work focused more on the here and now of the encounter between the patient and the therapist and the latter's flexibility and spontaneity as classifying the quality of the relationship which ultimately decides the outcome of the therapy [48]. It is important to note that the term therapeutic relationship does not imply that the relationship is therapeutic in itself, but one which ensures that the patient accepts and follows the treatment faithfully [12].

Role in the initial phase of treatment

The development and maintenance of the therapeutic relationship is imperative at the beginning of therapy as it provides a context before specialised treatment interventions come into the picture, as the former correlates with client outcome more than the latter [14]. It has been noted that the client is able to share negative emotional responses at a later stage only if the development of the same is paid attention to earlier in the treatment [27]. Further, it has been proven that alliance is particularly predictive of the outcome when it is measured early in treatment as poor early alliance has predicted client dropout [17].This points to the importance of paying attention to the alliance as soon as the therapy begins, again stressing on its importance in particular during this time.

Critiquing on the emphasis into collaboration at an earlier stage of therapy, Safran and Muran (2000) [52] further point out that the alliance is, in fact, an ongoing, constantly shifting and emerging negotiation rather than a necessary collaboration.

Critical analysis of methodologies used in research and efficacy of the therapeutic relationship

Although the instruments which are used to assess the therapeutic relationship are chiefly based in the psychodynamic tradition, some inventories like the Working Alliance Inventory [28] stem back to the transtheoretical perspective. However, due to the lack of a uniformly accepted clear conceptual definition of the therapeutic alliance, each time it is researched, different assessment devices are used which have various differences among them making standardisation even more challenging [27]. This ambiguity also guides the directions of research away from elements which cannot be reliably observed or studied in the alliance, rendering possible only a statistical analysis of some elements like confrontation and withdrawal. However, using statistical techniques to study the interaction between the quality of the alliance and techniques to assess the impact of the same on the outcome, ignores the uniqueness in clients to be predisposed to different goals and tasks due to their own unique developmental histories and relational schemas [53]. Further, it is not always necessary that the effectiveness of the intervention is dependent upon the quality of the therapeutic relationship and hence future research should aim to focus on these two separately without fear of losing a conceptual grounding about the same.

It is important to note that the client's perspective of the alliance is more predictive of the outcome than that of the therapist hence suggesting a re-look into the methodologies which focus on the ones only been spoken about by the therapist [31]. However, while assessing the efficacy through client reports, it has been noted that the very nature of what is considered to be empathic across clients is not uniform, hence rendering the empirical evidence either ignorant or bias towards some attributes [6]. It has been suggested that it is the construal of the relationship through the eyes of the client rather than the observable evidence offered for empathy, congruence and/or positive regard displayed by the therapist which would be most related to the definitive outcome of the therapy [43]. Further, consistently positive results have been obtained about the impact of the therapeutic relationship, if the relationship is assessed from the point of view of the client rather than objective ratings [18], suggesting a close examination into the differences between assessments by observers and clients. Lastly, the research on the efficacy of the therapeutic relationships has taken into account the interdependent and overlapping nature of various factors like interpersonal style, attributes of the therapist, empathy, warmth and congruence which offer facilitative conditions, hence making it challenging to study the influence of one factor independently as they are not mutually exclusive.

A meta-analysis of 24 studies reported that 26% of the difference in the rate of therapeutic success may be attributed to the quality of therapeutic outcome [30]. Multiple meta-analyses have reported the effect size for the alliance-outcome association to be between. 22 to. 26 [14]. The client-therapist relationship accounted for 30% of the variance in client outcome and was found to be most significant in contributing to client improvement [39]. However, the positive correlations between quality of the therapeutic relationship and client outcome in later research only amounted to about. 24, or up to 6% of the outcome variance indicating a more critical look into this construct [53].

As early as 1985, the alliance being transference versus conscious- based was discussed and debated about [22]. Subtle ignorance on part of the therapist by labelling certain unconscious motivated complaint behaviours from the client like withdrawing or confronting emotions as an alliance could be the reason for emphasising on this distinction strongly [52]. Whether the process is conscious or unconscious, the constant negotiation serves as the base through which the client acts out these negotiations in other relationships in their life in a constructive way, without compromising on the self [53]. This stresses again on the importance of the constantly developing therapeutic relationship as, through it, the client may develop a capacity for intimate and authentic relatedness embedded in intersubjectivity.

As suggested by Horvath(2006) [27], precise research can be carried out into the nature of therapeutic relationships by focusing on small -scale observable and recordable events which lead to short term goals, hence making it clear how these empirically supported processes, e.g., reduction in cancellation of sessions due to more ease with the therapist are linked to making an alliance more effective. Future research has the capacity to look beyond the distinctions between transference and relationships, develop

new forms of instruments or the interdependence of relational and technical aspects as this would not help in reducing the already deeply developed ambiguity in this pool of research. It can focus on transference and how it impacts the outcome of therapy and the impact that certain relational schemas of both the therapist and client have on particular forms of intervention [52]. To conclude, the alliance has been linked with the outcome but if it causes a positive outcome has not been clearly established and the research should hence be looked at with caution.

Ethical issues

For any therapeutic relationship to be effective, it is essential to be ethically considerate about factors like informed consent, right to information concerning purposes, processes and outcomes of the study, give the client the right to withdraw at any time, be aware of the potential power balance and be confidential in the practice. Ethical issues related to the therapist displaying disappointment, anger, hostility, communicating less approval, immediate self-disclosure, acting out their personal difficulties, making fewer interventions, not managing countertransference, acting in authoritarian and aggressive ways, being impatient and intrusive has led to a deterioration in the client outcomes. Further, the ethics code of the APA (1992) clearly prohibits sexual relationships between clients and therapists however research has hinted to the occurrence of the same, mostly with male psychologists [38]. Going beyond solely sexual encounters, even non-sexual boundary crossings like extreme self-disclosure, or emotional involvement has been shown to affect the outcome [21].

Cultural background as a contextual issue

Therapy does not take place in a vacuum but in a larger social, cultural and economic context. Since counselling started as a white middle-class activity and has been dominated by Western traditions, the focus in the current section will be on one of the many contextual issues of cultural sensitivity particularly towards the less represented ethnic and minority groups and its impact on the therapeutic outcomes. Some examples of an ethnically informed service may include factors like providing flexible hours, placing treatment facilities in ethnic communities, employing bilingual and bicultural staff to even modifying certain therapeutic practices so that the cultural customs, values and beliefs of the client are taken into consideration [61]. A psychotherapist would hence possess cultural competence if he/she is scientifically minded, is able to culturally categorise experiences before analysing them and is proficient in working with different cultural groups [61].

Role in the initial treatment phase

More than 50% of ethnic minority clients at 17 mental health facilities terminated treatment after one session compared to the 30% dropout rate for White Americans in an area emphasising on the relevance of cultural sensitivity in the very first session [59]. A 10 year follow up in the same area [46] reported a significant reduction in the dropout rates after ethnic-specific services were developed, which clearly depicts the relevance of the same at the beginning of therapy. It has shown to affect the validity of the assessment, development of client-therapist rapport and treatment effectiveness, hence it needs to be paid attention to in the very beginning [61].

Methodological issues in assessing efficacy of the impact of cultural consideration on outcome

Due to the linguistic dominance of research in western languages, not much is known about the needs of clients from ethnic backgrounds. The cultural and linguistic mismatches between clients and providers has been stated as one of the main problems in delivering mental health services. Studies which have assessed the treatment outcomes do not adapt rigorous methodologies which include pre and post-treatment outcomes for clients for one or more ethnic groups. In most of the studies, clients have not been randomly assigned to conditions and control groups which means that that a no treatment or a placebo group is missing. When comparisons of outcomes by treatment or ethnicity have been assessed, the type of ethnicity and treatment have not been crossed. Further, culturally cross valid assessment instruments. have not been used and this shows a major problem in taking the research in this area without a pinch of salt [61].

Ethical issues

Ethical issues regarding cultural adaptations have often been raised when these adaptations have been adopted in just about any case without paying attention to whether there was necessarily ineffective clinical engagement, unique risk or resilient factors, unique symptoms of a common disorder or if the intervention was not effective significantly for a particular subcultural group [40]. It has also been expressed that there has been no effort for developing outreach programs which would reach ethnic minority groups on a large scale. It is ethically essential for therapists to be non-judgemental, open and aware of dynamic issues, cultural complexities, orientations of clients to therapy, cultural beliefs, cultural differences in expression and communication and cultural issues

of salience while dealing with their clients [69]. Supervision and specification of personnel skills and training is essential to ensure that the therapist is culturally component [33], It has also been pointed out that some research in this area has stereotyped members of certain communities [25], and an uproar regarding creating evidence-based interventions for other social groups based on their gender, sexual orientation has also been brought to attention [68].

Impact on therapeutic outcome

At the very heart of psychotherapy is the well-being and normal functioning of the client, and this basic understanding differs from culture to culture. A meta-analysis of over 76 studies reported how cultural adaptations of interventions had a medium effect size of d =.45 [24], particularly noting how it worked most for non-English speaking and low acculturated individuals. For example, Calia (1996) suggested how therapists should use action-oriented and externally focused instead of intrapsychic approaches when they are dealing with Black American clients. It is important to note, however, that this knowledge alone could not guarantee better client outcomes and it needs to change into operational services which are culturally appropriate leading to better outcomes.

Research indicated that Asian Americans and Mexican Americans displayed lesser dropouts and better treatment outcomes when they saw a therapist who was matched ethnically or linguistically, basically showing a certain amount of similarity in culture [59]. This was not only the case for ethnical minorities as even White Americans showed lower rates of premature termination when they were ethnically matched, with a large effect size in the result of the study. Worth noting from the previous research is that culturally informed better outcomes is not related to ethnic match as such as it is to cognitive match [64], which means that more than an ethnic gap it is a lack of congruence and understanding. The difference in ethnicities further influences other aspects like the physical arrangement of the room, frequency of eye contact, conversation conventions etc which strongly influence the therapeutic relationship and eventually the therapeutic outcome. A lack of awareness and sensitivity about the different interpretations about physical distance [23], frequency of eye contact [37], physical expressions of greeting etc may act as a hindrance for a client from a different culture who may misinterpret some aspects of that behaviour.

A discussion about cultural sensitivity would be incomplete without including clients who belong to a certain class. Research has pointed out how clients from upper socio-economic backgrounds have more exploratory interviews while those with lower socioeconomic backgrounds have less intensive therapeutic relationships [50]. This indicates that apart from matching ethnically and beyond language barriers, other factors like class may also act as impediments to the therapeutic outcome.

However, research and discourse in this area have a long way to go. There is a need to undertake not only cross-cultural research but also ethnic minority research by focusing on the historical background, prejudices, stereotypes and discriminations faced by the ethnic groups [34]. It was also noted that most research on this tends to talk about cultural considerations whilst ignoring the heterogeneity in ethnic groups and across cultures. It is worth noting that the very understanding of culture will have to go beyond its understanding as only an ethnic, geographical or linguistic variable and extend to its psychological aspects like identity, attitudes, beliefs, personality which influence and impact the psychotherapeutic outcome even if language or ethnic background is the same. A major critique in the way the efficacy of cultural sensitivity on the therapeutic outcome is assessed is that some parts of the discourse equate culture with ethnicity or nationality whereas none of these are synonyms for one another [41]. Future research will have the scope to focus on the possibility of matching these aspects and whether consideration of the same will have a significant impact on the psychotherapeutic outcome. The way forward in culturally informed practice will certainly be to train service providers belonging to diverse ethnic backgrounds and more importantly, train them in a way which would enable them to understand different culturally informed worldviews. The movement towards cultural attunement [20] would help in assuring the engagement and retention of subcultural treatments when assessing the efficacy of psychotherapeutic interventions. Further, being a dynamic entity, culture cannot be considered to be a stable variable and hence research in this area constantly needs to be re-examined. Lastly, cultural sensitivity should be at the very core of psychotherapy as any treatment should be validated cross-culturally over time, considering ethnic minorities, for it to be deemed as reliable and credible.

Conclusion

To conclude, both elements i.e. therapeutic relationship and cultural sensitivity are interconnected as the establishment of a healthy relationship would help the client who may not necessarily align with the cultural and ideological views of the therapist to ultimately be able to share issues more easily with the therapist. It is possible that positive therapeutic outcomes which have been associated with culturally adapted mental health interventions were moderated by the quality of the therapeutic relationship as much as the adaptation, further emphasising on how these 2 constructs go together.

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