CLINICAL EFFECTIVENESS INSTITUTE

Position Paper

When the Relationship Became the Treatment

Alliance Research, Clinical Accountability, and the Limits of Relationship as an Explanation for Change

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Position: The therapeutic relationship is an essential condition of psychotherapy, but it is not itself a sufficient account of what makes treatment effective. When the therapeutic relationship is treated as the treatment itself, rather than as the relational context in which clinical work occurs, formulation and intervention can become obscured. Effective clinical work also requires an account of what is maintaining the client's difficulty and how the therapist intends to intervene.

Clinician-facing educational content from a major continuing education provider currently describes the therapeutic relationship itself, apart from any technique or protocol, as the most powerful intervention available to clinicians. A separate, formally accredited course teaches clinicians to use the therapeutic relationship to help clients with complex relational trauma develop new internal working models of self and other, while also teaching them to assess when and how such relational work is appropriate. A psychotherapy practice's own clinical writing goes further, stating that the therapeutic relationship does more than support change: in many cases, it functions as the mechanism of change.

Together, these claims assign the relationship increasingly expansive roles: as the most powerful intervention, as a specific and assessed intervention, and as the mechanism of change. The last makes the strongest claim: that the therapeutic relationship itself explains what produces therapeutic change.

The therapeutic relationship is important. A different, more specific claim is now present in contemporary clinical training and practice: that the relationship itself explains what produces change, rather than serving as one condition, context, or contributor within a broader account of psychotherapy.

Outcome research provides substantial evidence that several specifically defined relational and collaborative variables are associated with clinical outcomes. Among the most extensively studied is the therapeutic alliance, a construct that includes relational bond together with agreement about the goals and tasks of treatment. These population-level findings show that particular relational and collaborative features of psychotherapy are associated with outcome across groups of clients and treatments. They answer a different question from the one a clinician must answer about what will produce change for a particular client. A condition that supports treatment, a statistical association with outcome, and a causal explanation of change are three distinct claims. Some contemporary clinical discourse moves among them without acknowledging the difference.

What Common-Factors Research Actually Established

The idea that different psychotherapies may work through factors they share predates Rogers's 1957 paper, although Rogers's account deserves to be represented on its own terms. Rogers's conditions were embedded in a specific theory of the self. Psychological disturbance arose from incongruence between a client's organismic experience and self-concept. A relationship

characterized by the therapist's congruence, unconditional positive regard, and empathic understanding, accurately perceived by the client, was proposed as sufficient to resolve that incongruence over time (Rogers, 1957). This was a falsifiable, theoretically bound claim about a specific mechanism of personality change, distinct from the common-factors argument that varied and theoretically incompatible schools of therapy may work in part through elements they share.

Saul Rosenzweig's 1936 paper proposed that diverse psychotherapies might produce comparable results despite claiming different theoretical mechanisms, because potent factors implicit across therapies could matter more than the methods they deliberately employ. Among the common elements he identified were therapist effects, the organizing consistency of a therapeutic explanation, and alternative ways of formulating psychological experience (Rosenzweig, 1936). Rosenzweig illustrated the argument with the Dodo bird's verdict from Alice's Adventures in Wonderland, in which every competitor in a race is declared a winner. His paper was a theoretical proposal about why comparable outcomes across different schools might occur. The empirical case for relatively small differences among therapies developed over subsequent decades, through comparative outcome research and meta-analysis that Rosenzweig's paper did not itself contain.

Jerome Frank extended this line of thought considerably in Persuasion and Healing, first published in 1961 and revised with Julia Frank in a third edition thirty years later. Frank and Frank (1991) argued that forms of psychological healing across cultures and centuries share several structural elements: a relationship with a socially sanctioned healer, a shared conceptual framework or myth that explains the client's suffering, and a set of procedures that both participants believe will help. In their account, psychotherapy counters demoralization (a loss of meaning, competence, and hope) through relationship, explanation, and procedure together, not through relational contact alone. The model therefore assigns real therapeutic work to the shared explanatory framework and its associated procedures alongside the relationship.

Bruce Wampold's contextual model, developed most fully in Wampold and Imel's The Great Psychotherapy Debate (2015), is a major contemporary formulation of the common-factors argument. It deserves precise description because it is frequently invoked in support of a claim it does not make. The contextual model proposes three interconnected pathways through which psychotherapy produces change: the real relationship between client and therapist; the client's expectations, generated by a credible explanation of the client's difficulty and a coherent treatment rationale; and the client's engagement in health-promoting therapeutic actions that follow from that rationale (Wampold & Imel, 2015). The second and third pathways are not relational contact. They require a coherent account of the client's difficulty and a set of actions understood by both participants to address it. Wampold's contextual model therefore requires relationship, explanation, and therapeutic action, rather than treating relationship as a sufficient account of change.

Where the Drift Can Be Observed

Common-factors research identifies multiple features shared across otherwise different psychotherapies and examines their relationship to outcome. Across Rosenzweig, Frank, and

Wampold, the account is consistently multicomponent: therapeutic change involves some combination of relational conditions, a credible explanatory framework, expectations, therapeutic procedures or actions, and client participation. Relationship is one part of the account, not the account itself.

The movement toward treating relationship as the account of change itself can be observed at several distinct points in the literature and in practice. The appearance of similar claims across different sources does not establish a causal line of influence from one to another.

Duncan, Miller, and Hubble's Escape from Babel (1997) is often cited as an example of the field elevating relationship over technique, and the book does move firmly in that direction. The authors urge clinicians to set aside allegiance to particular masters and models and orient instead around relationship, hope, and a plan for the client's future (Duncan, Miller, & Hubble, 1997). Read in full, however, their account preserves a role for technique and model, treating them as sources of structure and novelty that support the more basic common factors rather than as irrelevant. The book marks an intellectual movement toward common-factors primacy. It does not reduce psychotherapy to relationship alone.

That nuance can be lost when outcome research is translated into clinical psychoeducation for prospective clients. One psychotherapy practice states that how well a client connects with the therapist matters more than which specific approach, whether cognitive-behavioral, psychodynamic, or otherwise, the therapist practices. Another cites Wampold's Great Psychotherapy Debate by name in support of the claim that no single treatment method is more effective than any other, then concludes that what matters most is simply the relationship and the client's own engagement in the process. In both cases, aggregate findings from comparative outcome and common-factors research are converted into direct claims about what will work for the individual client reading the page. The credible explanatory framework required by Wampold's own model disappears from the account.

A related move appears in continuing education addressed to licensed clinicians. Continued, an accredited provider, offers Relational Interventions for Working With Complex Trauma across multiple mental health professions. Its stated objectives include teaching clinicians to use the therapeutic relationship to create new internal working models of self and other, and to assess when and how such relational interventions are appropriate. This is a claim about relationship as an intervention within an assessed clinical approach, not as a complete explanation of treatment. Separately, clinician-facing educational content from a major continuing education provider states directly that the therapeutic relationship itself, rather than any technique or protocol, is the most powerful intervention available to clinicians. That claim moves closer to treating relationship as an adequate explanation of change.

A further problem appears when alliance and relationship are used as though they name the same construct. Bordin's (1979) influential model defines the working alliance through three elements: an affective bond between client and therapist, agreement on the goals of treatment, and agreement

on the tasks by which those goals will be pursued. Research using this tripartite construct reliably finds stronger alliance associated with better outcomes. That is a finding about bond accompanied by agreement on goals and tasks, not about bond alone or about diffuse relational qualities such as warmth, safety, attunement, or rapport considered independently of that agreement.

Two substitutions can follow. The first is a construct substitution: alliance becomes relationship in general, which then becomes rapport, safety, or attunement considered on their own. The second is a causal substitution: an association between alliance and outcome becomes evidence that alliance produces change, then that alliance is the mechanism of change, and finally that relational qualities constitute the most powerful intervention available. Each step moves farther from what the underlying research measured and found.

Alliance, understood as bond plus agreement on goals and tasks, is associated with outcome across large samples. That finding establishes neither that warmth, safety, attunement, or rapport alone produce change, nor that any of these qualities constitutes the mechanism of change or the most powerful intervention available to a clinician.

What Outcome Research Actually Establishes

The alliance-outcome association is one of the most extensively replicated findings in psychotherapy research. Flückiger, Del Re, Wampold, and Horvath's (2018) meta-analysis examined 295 independent studies involving more than 30,000 patients, published between 1978 and 2017. The overall alliance-outcome correlation was approximately r = .28.

The Interdivisional APA Task Force on Evidence-Based Psychotherapy Relationships and Responsiveness addressed a broader set of relational and collaborative constructs, including alliance, empathy, collaboration, goal consensus, positive regard, and other variables. It identified nine relationship elements as demonstrably effective, seven as probably effective, and one as promising but insufficiently studied (Norcross & Lambert, 2018). Its umbrella conclusion was that the psychotherapy relationship makes a substantial and consistent contribution to outcome independent of treatment type. That conclusion aggregates findings across distinct constructs; it does not establish a single empirical variable called relationship. It should be granted its full weight at the level of aggregation the research supports.

Another widely repeated claim requires similar precision. Michael Lambert's frequently cited estimate assigns roughly 40 percent of outcome variance to extratherapeutic factors, 30 percent to relationship factors, 15 percent to expectancy, and 15 percent to specific technique. These figures originated as an interpretive synthesis of the broader outcome literature rather than as the result of a single controlled study statistically partitioning outcome variance into those proportions (Lambert, 1992). Lambert and Barley's (2002) later discussion likewise described the estimate as a characterization of patterns across a broad body of research rather than a direct meta-analytic calculation. That qualification does not always carry over when the percentages enter clinical training as settled empirical findings.

The causal direction of the alliance-outcome association is also unsettled. Several studies of cognitive therapy for depression found that early alliance no longer predicted subsequent symptom change once prior improvement was taken into account, while prior symptom change did predict later alliance ratings. These findings suggest that measured alliance may partly reflect improvement already underway rather than only precede that improvement (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999). Gaston, Marmar, Gallagher, and Thompson (1991) found a comparable pattern in older adults receiving behavioral, cognitive, or brief dynamic therapy: the alliance-outcome association lost statistical significance after prior symptom improvement was controlled. Barber and colleagues (1999) reported the same pattern in a large sample of patients treated for cocaine dependence.

Other findings point in a different direction. Barber, Connolly, Crits-Christoph, Gladis, and Siqueland (2000) found that alliance continued to predict subsequent change in a separate sample of patients with depressive, anxiety, and personality disorders after prior improvement was controlled. Falkenström, Granström, and Holmqvist (2013, 2014), using a large primary-care sample and multilevel modeling, found evidence of reciprocal influence: alliance predicted subsequent symptom change even after prior improvement was taken into account, while prior improvement also predicted later alliance.

Taken together, these findings establish alliance as a meaningful part of the therapeutic process while leaving its causal role variable and incompletely specified. *They do not provide the evidentiary basis for treating the therapeutic relationship itself as the explanation for therapeutic change.*

When Relationship Becomes the Clinical Explanation

The clinical problem begins when findings about alliance and other specific relational constructs are converted into a general explanation centered on the therapeutic relationship. When a stalled treatment is explained primarily as the client needing more safety, more trust in the clinician, or more time in a secure relationship, the explanation can absorb any outcome. Improvement confirms it. Lack of improvement need not disconfirm it; the same account can simply be extended to require still more safety, time, or relational provision.

> *An explanation compatible with every possible outcome has stopped functioning as a clinical hypothesis.*

A claim that a client needs greater safety can still function as a legitimate clinical hypothesis. It becomes accountable when the clinician specifies what greater safety is expected to permit and what observation would count against the hypothesis. If increased safety is expected to allow the client to disagree, sustain contact during conflict, access anger directly, or reduce automatic accommodation, the clinician has stated a testable prediction. The hypothesis can then be evaluated against what actually occurs. Without such a prediction, safety becomes an all-purpose account that requires nothing further of the clinician and yields no new information when the treatment fails to progress.

A related pattern involves an inversion of clinical authority. A clinician may reject the stance of expert authority, emphasize client autonomy, and decline to claim to know what the client should do or think. Yet the same clinician may assign substantial causal power to their own relational presence, holding that what the client needs is a relationship with someone who provides sufficient safety, attunement, consistency, acceptance, or responsiveness. Authority has not disappeared; it has shifted from expertise about the client's problem to expertise about the relational conditions the client requires. That claim is no more clinically accountable than the directive claim it has replaced, unless the clinician specifies what the relational experience is expected to alter in this client. The concern is not warmth or relational engagement, both of which can be clinically appropriate and well founded. The concern is therapist centrality asserted without the formulation needed to explain what that centrality is for.

Tzur Bitan, Shalev, and Abayed's (2022) study of 107 licensed therapists, predominantly psychodynamic and integrative in orientation, offers a bounded piece of evidence. When asked what they believed produced change in psychotherapy, *participants named the therapeutic bond more frequently than any theory-driven mechanism*, therapist characteristic, or client factor. The sample does not support conclusions about the profession as a whole. Within this sample, however, the therapeutic bond was not merely one factor clinicians believed mattered. It was the mechanism they named most often when asked what produces change.

The Missing Formulation develops the broader accountability problem created when a clinical explanation cannot be disconfirmed. The relational version is one instance of that problem. *An explanation immune to disconfirmation protects the clinician's confidence at the direct expense of the client's progress.*

The Relationship Inside a Formulation

None of this requires treating relational work as secondary or provisional. It requires treating relational work as clinically specific rather than assuming that more safety, time, or attunement is inherently curative.

Consider a client who has organized her relationships around an expectation that expressing anger or disagreement will produce rejection. She accommodates automatically, suppresses disagreement before it becomes fully conscious, and monitors the therapist closely for signs of the withdrawal she anticipates.

A clinician working from a formulation uses the therapeutic relationship deliberately as a setting in which disagreement can occur without the withdrawal or retaliation the client has learned to expect. The clinician is not simply providing warmth and safety in the abstract. The work is organized around a specific hypothesis: the client should become increasingly able to sustain disagreement while remaining psychologically engaged. That change, rather than general comfort or satisfaction with therapy, would indicate that the relational work is doing what it is intended to do. If disagreement continues to produce accommodation and withdrawal despite months of

relational safety, that finding bears on the formulation. It calls for revising the account rather than providing still more safety on the same terms.

Nomothetic and idiographic claims answer different questions. Research on specific relational and collaborative constructs makes a nomothetic claim: variables such as alliance, empathy, collaboration, and goal consensus are associated with outcomes across groups of clients and treatments. A clinical formulation makes an idiographic claim: this particular relational configuration, used in this particular way, is expected to alter the specific psychological process maintaining this client's difficulty. The first claim is well supported and belongs in clinical training and supervision. It cannot substitute for the second. Only the idiographic claim tells the clinician what to expect with this client and what would indicate that the work is not proceeding as intended.

This distinction has direct implications for how relational work is taught and supervised. A supervisor asking why a clinician is emphasizing relational safety with a particular client should expect an answer that identifies the expectation the client holds, the behavior that expectation currently prevents, and the change that would indicate the relational work is succeeding. An answer that stops at safety being generally important, or treats continued attendance and reported comfort as sufficient confirmation, has not yet reached the specificity a formulation requires.

> *The need is not for more relational effort. It is for a clearer account of what the relational effort already being made is intended to accomplish.*

A More Defensible Position

The APA Task Force's conclusion should be granted in full: the psychotherapy relationship makes a substantial and consistent contribution to outcome, independent of treatment type (Norcross & Lambert, 2018).

The therapeutic relationship provides clinically important conditions for psychotherapy and, in some cases, may be a central mechanism through which change occurs. Its clinical meaning in a particular case depends on what the clinician understands the relationship to be doing in relation to that client's specific difficulty. A defensible relational account specifies why this relationship, in this form, is expected to alter the psychological process maintaining that difficulty. It is understood that some issues for which psychotherapy is sought have causal factors external to the client’s psychology.

Clinical accountability also requires explicit and shared responsibility. The clinician contributes professional judgment, transparency about clinical reasoning, an explicit therapeutic alliance, and a working formulation that can be examined and revised. The client contributes lived experience of the difficulty being addressed, consent to the approach being taken, disagreement when the approach does not fit, and active participation in the clinical work.

CEI's model of an explicit therapeutic alliance builds on Bordin's goals-tasks-bond framework by making the working agreement transparent, discussable, and revisable. As a result, both

participants understand what the treatment is for, what they are trying to accomplish, how the clinical work is expected to proceed, and what each person is responsible for contributing. The client can question the frame, disagree with it, and participate in revising it rather than merely trusting the therapist or complying with the treatment.

> **Related CEI Training:** *Building an Explicit Therapeutic Alliance: Beyond Rapport Toward Real Clinical Agreement*
> *This training begins where the usual instruction that alliance matters leaves off. It distinguishes rapport, relational bond, and therapeutic alliance, then teaches clinicians how to construct the alliance explicitly: establishing shared agreement about the purpose, goals, and tasks of treatment; clarifying therapist and client roles; making the clinical direction transparent enough to question and revise; and maintaining the alliance when the work becomes difficult. https://www.sarahozolshore.com/building-alliance*

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