Conceptualizing the Therapeutic Relationship: Mediator or Moderator of Change?

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Although the therapy relationship has long been recognized as an essential factor in the change process, there has been disagreement concerning whether the relationship is itself curative or rather supports the benefits of specific therapeutic techniques. To advance and clarify this conversation, this article conceptualizes the therapy relationship as both a mediator and/or moderator of change that can be used strategically in accord with case formulation for treatment goals. We begin with a brief overview of the relevant literature on the therapy relationship versus technique and the role of the therapy relationship as mediator or moderator across theoretical orientations. We then suggest an integrative framework by which clinicians and psychotherapy researchers may conceptualize the therapeutic relationship based on case conceptualization, where the requirements in each case and not theoretical orientation should determine the therapist's use of the therapy relationship. Finally, we discuss implications for psychotherapy research and practice.

Public Health Significance Statement
This article discusses the role of the therapist–client relationship in promoting positive treatment outcomes. We review debates about the importance of the therapy relationship versus specific therapeutic techniques and describe how different types of psychotherapy frame the relationship. We argue that it is essential for psychotherapy practitioners and researchers to develop a flexible view of how to use the therapeutic relationship with regard to specific clinical problems and relevant evidence-based techniques.

Keywords: therapy relationship, process research, common factors, psychotherapy integration, case conceptualization

In 1967, Gordon Paul (1967) posed a foundational question about the process of change in therapy: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances, and how does it come about?" (p. 111). Although this question has not been answered in totality, much empirical and clinical literature has examined the means and processes

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by which treatments work. One factor long emphasized in the therapeutic change process is the therapy relationship (Rosenzweig, 1936). However, the precise nature of this relationship—a driver of change in and of itself, or a common, nonspecific factor alongside specific therapeutic techniques—has been the subject of much debate (Barber, 2009; Goldfried & Davila, 2005).

Several reviews, meta-analyses, and frameworks have explored how aspects of the relationship function in therapeutic change (e.g., Baier et al., 2020; Flückiger et al., 2018, 2020; Norcross & Lambert, 2018; Zilcha-Mano, 2017), yet have been limited in how they conceptualize the relationship. In particular, interventions vary in the extent to which they emphasize the therapy relationship relative to other treatment components, with the focus most often determined by the practitioner's underlying theoretical framework or that of the treatment approach utilized (Messer & Fishman, 2018). Thus, considerations of the therapy relationship within the literature have been largely limited by the stated role of the relationship or the theoretical context in which it occurs. Given that some have argued that the precise role of the therapy relationship in the change process remains an open empirical question (Cuijpers et al., 2019), it may be more useful to ask not whether, but rather how the relationship leads to change, such as the importance of maintaining a good therapy alliance (Safran & Muran, 2006). To that end, this article offers a conceptual clarification of the role of the therapy relationship, whereby clinicians can and should use the relationship to maximize therapeutic benefit based on case conceptualization.

Although several definitions of the therapeutic relationship have been offered (Gelso, 2014; Wampold & Budge, 2012), none have been uniformly adopted (Norcross & Lambert, 2018). Consistent with the interdivisional APA Task Force on Evidence-Based Therapy Relationships (Norcross & Lambert, 2018), we prefer the broader definition of the therapeutic relationship as "the feelings and attitudes that [therapist and client] have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1985, p. 159). We note that the latter half of this definition translates to actionable decisions in practice that leverage aspects of the therapy relationship for therapeutic change (e.g., building/repairing the therapeutic alliance, empathy, collaboration with the client, managing countertransference, etc.; Norcross & Lambert, 2018). We suggest that the therapy relationship may serve as a mediator and/or moderator of change, which should be determined by case conceptualization and not theoretical orientation of the therapist. We ground this framework through a brief discussion of the literature on the therapy relationship versus technique and on the role of the relationship among diverse theoretical orientations. Practically, we offer an integrative lens through which clinicians and psychotherapy researchers may view the therapeutic relationship and encourage deliberate use of the relationship in line with this framework.

The Therapeutic Relationship in Evidence-Based Practice

The importance of the therapy relationship in the development of empirically supported treatments (ESTs) has often been contested (Barber, 2009), particularly within the generation of psychotherapy research that has primarily focused on manual-based interventions for *DSM* diagnosis (Goldfried, 2019). The role of the therapy relationship is also seen in the historic debate in the literature on what matters more—the technique or the relationship (Barber, 2009; Chambless & Ollendick, 2001; Goldfried & Davila, 2005). In this light, we briefly review distinctions between the two to offer a perspective on how the therapy relationship may be used more flexibly.

Therapy Relationship Versus Technique in Empirically Supported Treatments

ESTs are intervention packages with demonstrated treatment efficacy through controlled research involving randomized controlled trials (RCTs; Chambless & Hollon, 1998) that require the use of and adherence to treatment manuals typically designed to treat a specific disorder. In his presidential address to the Society of Psychotherapy Research, Barber (2009) raised the concern that therapeutic technique is defined primarily by the content of treatment manuals, without much regard for the therapy relationship. In essence, the EST movement may have unintentionally brought therapeutic technique to the forefront over the therapeutic relationship (Barber, 2009; Goldfried & Davila, 2005).

Although disorder-specific ESTs have been developed through RCT designs that are scientifically rigorous, some have raised concerns about how their limitations and restrictions may unintentionally

hinder their clinical validity (Calhoun et al., 1998; Garfield, 1996; Goldfried & Wolfe, 1998). Notably, RCT funding is often tied to the medical model of clinical issues (Hershenberg & Goldfried, 2015) that emphasizes a *DSM* diagnosis and involves random assignment to intervention, not case conceptualization or use of mediators or moderators to determine treatment. RCT designs are derived from pharmaceutical trials where the active treatment under investigation is a drug designed to target mechanisms thought to cause or maintain a disorder; in psychotherapy trials, the active ingredient is a manual-based treatment and operates under similar assumptions. Manuals often note the importance of the therapy relationship (e.g., collaboration, strong alliance) and, at the same time, assume that the relationship must be "good enough" without much further enumeration relative to other techniques. Indeed, RCTs have been found to focus more on the nature of the treatment defined in the manual rather than relational factors (Castonguay et al., 1996), although there are notable exceptions to this trend (e.g., Coyne et al., 2019; Kramer et al., 2014).

Consequently, the emphasis on disorder-specific ESTs, which has at times also excluded psychotherapy process and outcome research outside of RCT designs, has generated much controversy (Chambless & Ollendick, 2001; Goldfried & Wolfe, 1996, 1998; Tolin et al., 2015). For example, the APA's *Clinical Practice Guideline for the Treatment of PTSD in Adults* (American Psychological Association, 2017) has been criticized for near-exclusive reliance on RCT evidence (Courtois & Brown, 2019), despite a wealth of well-controlled research substantiating the therapeutic relationship as important in successful trauma treatment (Norcross & Wampold, 2019). Such controversy surrounding EST advocacy may reflect a stringent view of the therapeutic technique and relationship as separable, where technique is often defined as therapist competence in clinically adhering to a treatment manual and anything else as common or "nonspecific" factors (Barber, 2009). At the same time, the EST controversy largely centers around how manual-driven treatments are empirically supported, which, as noted above, often provides less detailed emphasis on the therapeutic relationship.

We hold, as others do, that there is a necessary interplay of the therapy relationship and technique beyond what is delineated in treatment manuals. If nothing else, a notion of the "good enough" therapy relationship—one that allows a clinician to implement the techniques in a manual—is a necessary

condition for therapeutic change. This is the case even if one assumes that (a) the technique is the only curative component in psychotherapy and (b) the relationship is thought of as separate from technique. However, we argue that therapeutic technique and relationship must be considered simultaneously (Goldfried & Davila, 2005; Safran & Muran, 2006). Conceptual models of the relationship–technique interplay highlight how client involvement, therapist technique, and the relationship are intertwined (Hill, 2005). Such models are backed by evidence that variability in treatment outcomes across therapists can be accounted for by therapist interpersonal skills (Anderson et al., 2016; Barkham et al., 2017; Hansen et al., 2015; Pereira & Barkham, 2015). Moreover, techniques from all theoretical orientations contain common elements of the therapeutic relationship (Barber, 2009; Goldfried & Davila, 2005).

Empirically Supported Relationships

Beyond any individual EST or theoretical orientation, the therapeutic relationship, defined following Norcross and Lambert (2018) as the feelings and attitudes felt and exchanged between therapist and client, remains a relevant treatment factor for clinicians to manage. Although there has been less attention given to the therapeutic relationship in ESTs, there is considerable empirical support for its association with improved treatment outcome (Flückiger et al., 2018; Norcross & Lambert, 2018). Similar to Chambless and Hollon's (1998) EST designation and the APA Clinical Practice Guidelines, the APA Task Force on Evidence-Based Therapy Relationships has empirically substantiated the beneficial role of the therapeutic relationship in treatment outcome based on expert committee reviews of quality research evidence (Norcross, 2001; Norcross & Lambert, 2011, 2018). Indeed, as Norcross and Lambert (2018) point out, the weight of evidence for a relational element to be designated as demonstrably effective by the task force is as rigorous as the Chambless and Hollon (1998) EST criteria. Although much of the research on the therapeutic relationship is correlational, the most recent Norcross and Lambert (2018) report is based on numerous meta-analytic findings.

Several elements of the therapeutic relationship have been designated as "demonstrably effective" (Norcross & Lambert, 2018), including: the

therapeutic alliance; client collaboration; goal consensus; cohesion in group therapy; empathy; positive regard and affirmation; and collecting and delivering client feedback. Elements designated as "probably effective" include: congruence/genuineness; the real relationship; emotional expression; cultivating positive expectations for change; promoting treatment credibility; managing countertransference; and repairing alliance ruptures. By and large, research evidence supports the assertion that these components of the therapeutic relationship substantially matter for psychotherapy outcome, even when controlling for patient characteristics assessed at intake and therapist competence/adherence (Flückiger et al., 2020). Despite the technique–relationship divide noted earlier, models of therapeutic change support the argument that the relationship accounts for about as much variance in outcome as technique (Norcross & Lambert, 2011, 2018). Thus, there is strong research support that the therapeutic relationship can be strategically used to optimize outcome.

It seems clear that the therapy relationship can be intentionally used to help clients change—but how? Across theoretical orientations, psychotherapy researchers in the past have addressed the question of tailoring the relationship for client needs based on case formulation. For example, Henry & Strupp (1994) have framed the relationship as an interpersonal process in psychodynamic therapy, using the Structural Analysis of Social Behavior (SASB; Benjamin, 1979) model of interpersonal behavior. More recently, Benjamin's (2018) interpersonal reconstructive therapy describes how SASB may be used to shape case formulation as well as the nature of the relationship, based on the client's learning history in close relationships, to engender change. The SASB interpersonal model has also been used by researchers studying process–outcome associations in time-limited dynamic psychotherapy (Henry et al., 1986, 1990), and the same method was later used to look at cognitive behavior therapy (Critchfield et al., 2007) and experiential therapy (Wong & Pos, 2014). Another approach, Plan Analysis (Caspar, 1997), employs an individualized case formulation to hypothesize important interpersonal and intrapersonal client factors related to problematic behaviors; this formulation is then used to craft a motive-oriented therapeutic relationship intended to help meet clients' basic needs (e.g., acceptance from close others) without fueling problematic behaviors (e.g., social withdrawal to avoid rejection). These approaches, which have not been considered in ESTs that were developed from structured RCTs, demonstrate how formulation-driven psychotherapy methods can transcend theoretical or diagnostic boundaries when the relationship is emphasized.

In keeping with these empirical traditions, we suggest reframing the question "Does the relationship lead to change?" to instead ask "How and when does the relationship lead to change?" In doing so, we can better understand the role of the therapeutic relationship in the change process as it is implemented across theoretical orientations and clinical issues. In addressing the question of how and when the therapy relationship results in change, we propose examining the relationship as either a mediator and/or moderator of change. Defining the therapy relationship as a mediating or moderating variable in psychotherapy can offer a useful conceptual heuristic. Mediators and moderators modify, in different ways, the relationship between two variables. Conceptually, mediators and moderators can be thought of as terms that describe the types of processes, such as therapeutic change, that exist. In the most general sense, moderators are the conditions or context within which a process occurs; mediators are "how" a process occurs. Consider an applied example related to obsessive–compulsive disorder that manifests as obsessions related to interpersonal relationships and is maintained by compulsions of excessive reassurance-seeking. The therapeutic relationship could be used as a moderator of change to facilitate engagement in an exposure-based protocol, such that the client trusts the therapist enough to complete exposures that prevent engagement in reassurance-seeking in the presence of obsessions. The therapeutic relationship could also be used as a mediator of change by specifically addressing the interpersonal impact of excessive reassurance-seeking that manifests in the client-therapist relationship. How a moderating and mediating conceptualization of the role of the therapy relationship differs across schools of therapy is considered next.

Differences Among Theoretical Orientations

Systems of psychotherapy have varied in how each views the role of the relationship within therapy as a mediator and/or moderator of change. In this section, we cover how three major theoretical

orientations—psychodynamic, behavioral/cognitive–behavioral, and experiential/humanistic—have historically understood the role of the therapy relationship. Our goal here is not to revisit each system's internal debates on the therapy relationship, but rather to describe how each school has tended to view the therapy relationship as a mediator and/or moderator. Although the three theoretical systems described below are not the full spectrum of psychotherapy, we focus on these to illustrate variation both within and across orientations to ground our framework in which the relationship may be utilized more deliberately.

Prochaska and Norcross (2018) suggest that each system of therapy tends to view the relationship as some combination of precondition for change, process of change, or content to be changed. In this vein, systems that view the relationship as a precondition for change cast the relationship as a moderator, whereas those that frame the relationship as a process of and/or as content to be changed position the relationship as a mediator. In delineating key differences and similarities between schools, it is important to consider therapist behaviors that facilitate the relationship and the value each school places on the relationship relative to other factors.

Psychodynamic Approaches

In psychoanalysis and its psychodynamic descendants, the therapy relationship can be understood as having multiple functions. Perhaps the signature role of the relationship in traditional psychoanalysis is to facilitate *transference*, wherein the patient's unconscious conflicts manifest via their reactions to and feelings about their therapist (Freud, 1912/1964). These unconscious conflicts then become the content to be changed in treatment (Prochaska & Norcross, 2018). To achieve transference, the analytic therapist traditionally takes a reserved, neutral stance toward their patient, proffering themselves as a blank screen onto which the client may project their conflicts. The scope of the analytic therapist's communications is narrow: the therapist minimizes unnecessary communication, facilitating insight with subsequent interpretations. In essence, the interaction between therapist and client mediates change.

A second way in which the therapy relationship contributes to change in psychoanalysis involves the *working alliance*, the patient's realistic, rational

attitudes toward their therapist (Gelso & Carter, 1994; Greenson, 1965; Prochaska & Norcross, 2018). Although the idea of alliance in psychoanalysis has elicited controversy among psychodynamic theorists (for a review, see Messer & Wolitzky, 2010), Freud wrote early and often on the importance of a good working relationship between patient and therapist; he described therapist–patient "rapport," or "unobjectionable positive transference" as an important precondition for analysis (Freud, 1912/1964, p. 105). The working alliance thus functions as a moderator of (that is, a precondition for) change.

Psychodynamic therapies—which evolved from psychoanalysis and are typically briefer and more varied—focus more on the relational dynamics between therapist and client in a somewhat different way in facilitating change. Whereas psychoanalysis casts the therapist as an often-silent observer who helps the client develop insight into unconscious drives, relationally oriented psychodynamic approaches require therapists to play a more active role during the course of therapy. In a dual role described by Harry Stack Sullivan (1954) as a "participant-observer," relationally oriented therapists gather information about clients and participate in in-session exchanges whereby the relationship mediates change. At the same time, this dynamic interplay requires that the therapist and client have a strong working alliance (Messer & Wolitzky, 2010; Muran & Barber, 2010; Muran & Eubanks, 2020). The working alliance can therefore be considered within the context of transference–countertransference enactments that happen during treatment. Such enactments can impair the alliance, as when patients express anger toward therapists and therapists respond defensively, thereby weakening the bond. By repairing such relational ruptures as they transpire, the therapy relationship can illuminate how patients negotiate interpersonal difficulties, thereby generating the content to be changed in the course of treatment (Muran & Barber, 2010; Muran & Eubanks, 2020). To develop these functions of the relationship, psychodynamic therapists traditionally aim to establish a relationship that is: warm enough to engender trust; not so transparent that transference is undermined; nonjudgmental, though not necessarily characterized by unconditional positive regard; and accurately empathetic (Prochaska & Norcross, 2018).

In sum, psychoanalytic and psychodynamic approaches conceptualize the relationship as

having at least two distinct components: transference, a mediating variable that entails the patient expressing attitudes and feelings toward the therapist rooted in unconscious conflicts that the therapist then uses to encourage insight and, subsequently, change; and rapport, a moderating variable characterized by collaborative cooperation between therapist and patient. Overall, the relationship acts as a mediator and, to a lesser extent, moderator of change.

Behavioral and Cognitive-Behavioral Approaches

In general, behavioral and cognitive–behavioral therapies (CBT) center on helping clients acquire improved coping and/or cognitive processing skills, with the relationship framed as an educational, collaborative tool that enables specific therapeutic techniques. The CBT literature has traditionally focused on specific techniques as the presupposed mechanisms of therapeutic change, lumping the relationship alongside other "nonspecific factors" (Goldfried & Davila, 2005). Techniques that rely on social reinforcement (e.g., cognitive-behavior modification, operant conditioning) require that the therapist cultivate a warm, empathetic relationship, such that clients value the positive regard of their therapist (Wilson & Evans, 1977). In contrast to the unconditional positive regard central to humanistic psychotherapies, however, therapist expressions of positive regard are designed to facilitate the client engaging in therapeutically beneficial behaviors, such as completing homework or willingness to try a difficult exposure. Here, the therapy relationship can be considered a moderator of change that is necessary (but not sufficient) to engender between-session change through social influence.

Others have posited that "any behavior therapist who maintains that principles of learning and social influence are all one needs to know in order to bring about behavior change is out of contact with clinical reality" (Goldfried & Davison, 1976, p. 56). Indeed, despite the emphasis on empirically supported techniques in CBT, ratings of therapist empathy and warmth are generally similar between behavior therapists and other more relationally focused orientations (Glass & Arnkoff, 1992; Prochaska & Norcross, 2018). This may be because the relationship serves as a precondition for behavioral treatment: there must be enough trust, credibility, and positive expectancy to apply techniques and retain the client. Exposure-based therapies for anxiety exemplify behavioral treatments in which the relationship functions chiefly as a moderator. Here, the therapist provides the structure and framing of the experience; affirms the importance of the treatment plan; normalizes the distress clients will feel during exposure as integral to change; and instills confidence that the plan will work—much like "an effective but firm parent" (Prochaska & Norcross, 2018, p. 182). During exposure, the therapist also employs social reinforcement by encouraging the client's persistence and commenting on anxiety reductions as they occur. In other words, when the relationship is strong, exposure treatment proceeds more smoothly.

The relationship in cognitive therapy (CT) is characterized by *collaborative empiricism,* a method by which clients are led to make their own discoveries through a series of Socratic therapist questions (Beck et al., 1979). Here, the therapist and client collaborate to discover which thoughts are dysfunctional and how they might be changed. Although a warm, empathic dynamic is encouraged in CT, the active ingredients are techniques of identifying and challenging thoughts, rather than the relationship itself (Safran & Segal, 1990). Illustrating the relationship as a necessary (if not sufficient) component of change in CT, one study of CT for depression found that when an alliance rupture occurred, therapists continued to emphasize the techniques prescribed in the manual, rather than repairing the rupture (Castonguay et al., 1996). Retreat to technique following alliance ruptures was related to worse outcomes; however, this negative relationship disappeared in cases where the alliance ruptures did not occur, suggesting an interaction between alliance rupture and outcome (Castonguay et al., 1996).

All things considered, although the therapy relationship plays a more central role in facilitating change in some behavioral and CBT techniques than others, the relationship in these orientations is more likely to function as a moderator than mediator of change.

Experiential and Humanistic Approaches

Carl Rogers is one of few theoreticians to argue that the therapeutic relationship contains both the *necessary* and *sufficient* conditions for change

(Rogers, 1957). Rogers specified several conditions by which the relationship mediates change in person-centered psychotherapy, regardless of the type of client, therapy, or clinical problem. In terms of therapist behaviors, he emphasized that the relationship is most importantly characterized by unconditional positive regard toward the client, which is essential to helping clients shift their internalized sense of worth. Particularly important is the expression of accurate empathy, whereby therapists communicate that they are in tune with the client's inner world, offering reflections to enhance client awareness (Prochaska & Norcross, 2018; Rogers, 1957).

Another important aspect of the relationship in the person-centered approach is the therapist's *genuineness*—that is, their honest awareness of and ability to express their own experience in the context of therapy in a manner the client perceives as authentically caring (Rogers, 1957). Later theorists working in the Rogerian tradition (e.g., Wexler, 1974; Zimring, 1974) have conceived of person-centered therapy as a "process of expanding consciousness or awareness through therapists' helping to bring about more effective information processing in clients" (Prochaska & Norcross, 2018, p. 110). In general, the relationship in person-centered therapy can be understood as mediating change through consciousness raising and corrective emotional experiencing in the context of the relationship.[1]

Among the experiential approaches, early Gestalt therapy (Perls, 1969) is unique in that it subsumes the relationship almost entirely to technique. Perls' writings and workshops centered on such specific procedures as "hot seat" and empty-chair techniques that were designed to facilitate increased awareness, often through confrontational dialogue with self, significant others, other group members, or the therapist. Perls eschewed an emphasis on a positive therapy relationship; indeed, as observed by Prochaska and Norcross, "To the extent that Gestalt books suggest that people can radically expand their consciousness and cathartically release their energies by participating in the prescribed exercises, they imply that the therapeutic relationship is not necessary" (Prochaska & Norcross, 2018, p. 143). Contemporary evolutions of Gestalt therapy, such as Emotion-Focused Therapy (EFT; Greenberg & Goldman, 2019) blend Gestalt techniques with a more intentional therapy relationship characterized by Rogerian acceptance (Greenberg & Pascual-Leone, 2006). In EFT, emotional

experiencing remains a focus, but the relationship takes on an important role as a vehicle for "acceptance and positive regard of the client's moment-by-moment experience" in the course of experiential procedures such as two-chair technique (Watson & Kalogerakos, 2010, p. 197). Considered together, traditional Gestalt and contemporary EFT illustrate how the therapy relationship can evolve from a primarily moderating to an integrated mediating and moderating intervention as a therapy system evolves.

The Role of the Therapeutic Relationship as a Function of Client Needs

As reviewed in the previous section, the function of the therapeutic relationship as a mediator or moderator of change has often been determined by the theoretical orientation guiding the treatment approach or clinician. However, using the therapeutic relationship solely based on theory limits flexibility in addressing client needs—that is, factors related to a client's learning history, attachment style, identity, and so forth—that maintain or are otherwise associated with the issues being addressed in therapy. Many clinicians borrow treatment approaches from a variety of theoretical orientations for a particular client; in doing so, we maintain it is important for clinicians to consider flexible use of the therapeutic relationship when working both within and across orientations. In this section, we consider how to marshal the therapy relationship to target specific client needs.

The idea that client needs should dictate the planning and course of treatment is reflected in a broader movement within psychotherapy toward integrating contributions from each theoretical camp (Norcross & Goldfried, 2019). Messer (1992) described this trend as "assimilative integration," in which a therapist who is primarily rooted in a single theoretical orientation makes use of interventions from other modalities when the theoretical home base cannot adequately address client needs. However, assimilative integration necessarily requires some conceptual expansion of theoretical orientations, so that what the therapist does is more of a function of the client's needs than the dictates of the theoretical orientation. In many ways

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[1] Although the relationship might at times function as a moderator within Rogerian therapy, the primary function nonetheless is that of mediator.

therapists may "bend" techniques for specific clients regardless of the theoretical orientation guiding their approaches. Such flexibility can also be conceptualized in terms of appropriate therapeutic responsiveness, or a therapist's ability to respond appropriately to emerging context, such as clients' changing behavior, within and across therapy sessions (Kramer & Stiles, 2015).

As noted earlier, contemporary psychodynamic approaches are heralded for their emphasis on the therapeutic relationship as a mediator of change, although this may not always be the case. Some within the psychodynamic tradition have written about exercises akin to exposure, which positions the relationship more as a moderator of change. As Barber and Luborsky (1991) note, a classic example is that of Freud, who spoke about the use of exposure for simple phobias. Similarly, in *Problems of Psychoanalytic Technique*, Fenichel (1941) noted:

> When a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less. (p. 83)

Some psychodynamic therapists have also advocated for the integration of between-session homework assignments in psychodynamic treatment (Frank, 2002; Stricker, 2006), with some evidence suggesting that it can be used in a theoretically consistent manner without loss of efficacy (Nelson & Castonguay, 2017). Homework is typically a unique signifier of CBT-based approaches, with the assumption that sessions between client and therapist (and, therefore, the therapeutic relationship) are not sufficient to bring about change. Thus, using exposure-like exercises and assigning homework by contemporary psychodynamic therapists, the therapeutic relationship is also utilized as a moderator of change in service of advancing therapeutic goals.

Although the therapeutic relationship is not typically delineated as a mediator of change in CBT approaches, some cognitive and behavioral techniques do make use of the relationship as such. For example, the in-session interaction between therapist and client may serve as a behavioral sample of a clinical issue that can be used as a working example to facilitate therapeutic progress, such as a passive client being unassertive with their therapist (Goldfried & Davison, 1976). Working therapeutically with in-session behavioral samples provides

therapists opportunities to observe potential contributing factors to clients' distress that may not be easily reported by the client (e.g., a critical interpersonal style). Additionally, strategic and appropriate use of therapist self-disclosure related to the therapist–client relationship can further promote therapeutic gains, such as fostering greater awareness of the client's interpersonal impact (Goldfried et al., 2003). Consistent with social learning theory (Bandura, 1969), the therapeutic relationship may be used to model or reinforce adaptive client behavior in session. Although the theory underlying change in CBT relies on cognitive and behavioral principles, in practice some of these techniques may utilize the therapeutic relationship as the vehicle through which such principles are introduced or employed (i.e., as a mediator of change).

As noted earlier, contemporary humanistic and process-experiential approaches, such as EFT, in addition to using Gestalt techniques, also focus on the therapeutic relationship as a mediator of change. Techniques to facilitate adaptive emotional responses, such as chair work, situate the therapeutic relationship as a necessary, but not sufficient, condition for change. Thus, although the relationship in EFT is emphasized as a secure base for the client that can mediate change, therapists also use the relationship to moderate change with awareness-enhancing techniques. Another example of assimilative integration within EFT is that, while traditional experiential approaches are based on the assumption that awareness alone will produce change, EFT makes use of homework and between-session practice as used by CBT therapists (Greenberg & Goldman, 2019).

Other explicitly integrative treatment approaches further illustrate how interventions can go beyond theoretical orientations to make use of the therapy relationship based on client needs. One example is Cognitive Behavioral Analysis System of Psychotherapy (CBASP), which was developed specifically for clients with chronic depression and interpersonal difficulties (McCullough, 2000). CBASP leverages key change ingredients from both CBT and psychodynamic-relational therapy to improve interpersonal issues and chronic depression simultaneously, focusing on in-session interactions between therapist and client (per the psychodynamic tradition) as samples that are then used to target depressive cognitions and behaviors (per the CBT tradition). Given the nature of the difficulties this approach is designed to address, the therapeutic relationship serves as both a

moderator and mediator of change in CBASP. Other integrationist, formulation-based approaches to therapy, as detailed in the introduction, include Caspar's (1997) Plan Analysis, a transtheoretical approach that hypothesizes the individual motives underlying problematic functioning and uses them to craft a motive-oriented therapeutic relationship, and Benjamin's (2018) Interpersonal Reconstructive Therapy, which matches therapist interpersonal style to patient learning styles based on a SASB formulation.

The common thread that underlies these examples is how therapists can leverage the therapeutic relationship to facilitate the greatest change possible. We maintain that therapists need to move toward an integrative approach that views the role of the relationship not merely as prescribed by a specific theoretical orientation, but as a set of intentional behaviors guided by clients' needs. Therapist actions are most beneficial for treatment outcomes when the right action is chosen, performed at the right time, and adjusted as needed (Stiles & Horvath, 2017). Therapeutic responsiveness requires a nuanced understanding of what function therapist actions serve in facilitating change. For instance, as suggested by Barber and Luborsky (1991) in their commentary on prescriptive matching, exposure treatment may be generally indicated as a primary treatment for agoraphobia, yet an individual client may respond better to a psychodynamic approach if their symptoms are closely tied with underlying relationship issues. This notion suggests that interventions need to be chosen and implemented flexibly for each individual client, which is consistent with evidence that treatment adaptations based on client preferences are demonstrably effective for treatment outcome (Norcross & Lambert, 2018) and with research using Benjamin's (1979, 2018) SASB interpersonal behavior model to match therapist interpersonal styles to patients' needs based on social learning history. Indeed, viewing the therapeutic relationship as a set of therapist actions to be taken, this line of thinking applies directly to how therapists use the therapeutic relationship as a mediator or moderator of change. Although various theoretical orientations may be categorized as primarily relationship-focused or nonrelationship-focused in theory and in therapist actions, the therapeutic relationship can be regarded as a more general "common theme" to be used flexibly depending on the goals at hand (Messer & Fishman, 2018). What might work for

one client may not work for another—a vital question for moving research, practice, and theoretical orientations forward (Messer, 2011).

Rather than theoretical purism, we advance an integrationist approach whereby the decision to employ the therapeutic relationship as a mediator or moderator of change is most optimally made based on a clear conceptualization of a client's presenting problem. We maintain that the therapist must clearly identify treatment targets consistent with their case conceptualization, which can then be used to plan how the therapeutic relationship can be used to address those targets in tandem with other therapeutic techniques. A therapist using CBT approaches may use the relationship as a mediator in pointing out maladaptive behaviors and cognitions in session that lead to a negative interactional style as experienced by the therapist. A therapist using psychodynamic approaches may use the relationship as a moderator in helping the client feel comfortable enough to process traumatic experiences and gain insight about them in session. These examples highlight the need for flexibility and integration across orientation to be responsive to client needs and characteristics. By framing the relationship as a mediator or moderator of change outside the confines of how it is prescribed by any individual theoretical orientation, therapists can fine-tune the use of the relationship as a roadmap by which the route to most effective change is prioritized.

Conclusions and Future Directions

The therapy relationship is an important factor in how psychotherapy works, yet its precise role in the change process is not always clear. Although recognized as a component of evidence-based practice, the relationship has sometimes been underplayed relative to specific therapeutic techniques. In this article, we have addressed an important issue: how the therapy relationship relates to change. We offer a framework for understanding the therapy relationship as a mediator or moderator of change. In tracing how different systems of psychotherapy have historically framed the relationship, we saw that the function of the therapy relationship in the change process has often been determined by the theoretical orientation of one's treatment approach. Drawing on empirical and theoretical work advocating psychotherapy integration and case formulation-driven use of the relationship, we contend that it is not the theory of the treatment or practitioner,

but the patient's needs that should determine how the therapy relationship is used in treatment. In essence, we suggest that the therapy relationship can (and should) be used flexibly, as a mediator or moderator of change, and that intentional use of the relationship should be determined by the therapist's case conceptualization.

Our central conclusion is that the therapy relationship can be more advantageously used based on case conceptualization (Eells, 2007), not therapeutic orientation. As we have elaborated, we believe that an evidence base and rationale for doing so already exists, and that future research could further substantiate this implication. This flexible conceptualization of the therapy relationship aligns with the perspective that "one size does not fit all" in treatment—one that may have consensus across the field (Gaines et al., 2021). It is also consistent with the movement away from packaged treatments toward more personalized psychotherapy (Cuijpers et al., 2016; Schneider et al., 2015; Teachman, 2019). We add to this call by suggesting that personalizing the use of the therapy relationship is (a) possible, as evidenced by research on the therapeutic benefit of the relationship as well as historical trends of its use within and between orientations, and (b) need not necessitate reinvention of the wheel (i.e., "new" approaches). Instead, we suggest that personalized treatments will benefit from considering how the therapy relationship functions in the change process (i.e., as a mediator or moderator), and should draw on existing integrationist principles of change and models for understanding differential use of the relationship tailored to the client. We hope this heuristic will prove useful to clinicians in their current practice and to psychotherapy researchers in future work.

Personalizing the use of the therapeutic relationship is not realistically attainable without therapist flexibility beyond what is dictated by theoretical orientation. In line with integrative frameworks, this requires therapists to select intervention strategies and perhaps adapt them to produce change based on the needs of a given client, not fidelity to a system of psychotherapy. As a basic example, in order to more fully accomplish therapeutic goals, therapists utilizing CBT approaches will need to consider how and when the relationship alone may bring about change whereas therapists utilizing psychodynamic approaches will need to consider when to encourage between-session experiences. Therapist flexibility in using techniques from diverse theoretical orientations is indeed linked

with positive client outcomes following alliance ruptures (Chen et al., 2020), suggesting that further inquiry into this area holds promise. As we note above, clinical decisions about therapist flexibility are best guided by strong case conceptualizations. In essence, what we propose is what is already being done by many clinicians. Researchers conducting clinical trials must contend with the importance of therapist flexibility and responsiveness in designing their research protocols (Kramer & Stiles, 2015). Doing so would move research more in the direction of studying the mechanisms of change.

Extending from our conceptual argument, we suggest three directions for future research. First, as has been suggested (see Eells, 2013; Persons, 1991), research is needed to explore the possibility of randomization to treatments based on case conceptualization instead of diagnostic status. For example, randomization in an RCT for a depression intervention is generally predicated on a depression diagnosis determined by standardized assessment. However, there are a number of causal and maintaining factors that could influence any individual diagnosis, such as faulty thinking, problematic interpersonal behavior, lack of engagement in positively reinforcing activities, or environmental constraints. Using a personalized case conceptualization, therapists need to identify central features of the presenting problem (e.g., patients whose depression is primarily caused or maintained by faulty thinking), and subsequently randomize to treatment (including prescribed use of the relationship as a moderator or mediator) as indicated by the core causal and/or maintaining factors to patients' central symptoms. This would allow researchers to directly test the therapeutic relationship as a mediator or moderator of change in outcome by using the relationship in tandem with techniques tailored to the client's specific clinical presentation. Although not directly focusing on the therapy relationship, research has found that in the treatment of depression, tailoring techniques based on individual differences can lead to better outcomes. For example, behavioral activation was found to be more efficacious than cognitive therapy for more severely depressed and functionally impaired patients (Coffman et al., 2007). As noted earlier, studies using the SASB interpersonal model of therapist–client relationships serve as examples of formulation-driven psychotherapy process research (Benjamin, 2018; Critchfield et al., 2007; Henry et al., 1986, 1990; Wong & Pos,

2014). Findings such as these support the value of personalizing treatment based on clinical presentation and case formulation.

A second future research direction involves the exploration of methods by which treatments can be better personalized to client needs. Although there is an extensive literature on case formulation (Eells, 2007), approaches to conceptualization are largely driven by theoretical orientation. Thus, more research on standardized quantitative assessments of case formulations (e.g., Haynes et al., 2020), particularly ones that are developed to be transtheoretical in nature, is needed. The incorporation of more idiographic perspectives into understanding clinical issues could be helpful in such a venture. For instance, network models of psychopathology (e.g., Borsboom & Cramer, 2013), which focus on symptom maintenance and covariation, could be helpful in shifting away from diagnosis toward more focused treatments aimed at alleviating immediate distress. These efforts would likely be complemented by the assessment of client characteristics such as cultural factors (e.g., stress related to a minority status, systemic influences on mental health, etc.), which have traditionally been ignored by RCTs, to better center client needs in treatment and outcome research.

A third future direction for research involves considering the interplay of the therapy relationship with other variables relevant to psychotherapy outcomes. Research is needed to examine possible interactions between the strength of the therapy relationship needed to bring about change and client factors such as motivation or expectations for change. For example, treatment for PTSD or trauma-related issues typically involves some level of trauma processing that may be difficult for even motivated clients, and there are many ways in which the therapy relationship may interact with motivation. There is certainly a base level of the therapy relationship needed to engage in any trauma work. However, for clients who are more motivated to change or have clear expectations that therapy will help with distress, the therapeutic relationship may be less important. For clients who are less motivated to change or who have less clear change expectations (and thus are less likely to engage in trauma processing), a stronger therapeutic relationship may be necessary to facilitate treatment engagement. While these all remain empirical questions, they hold promise for future research to further elucidate the most optimal use of the therapy relationship.

Overall, understanding whether and when the therapy relationship may mediate or moderate change is a critical step toward identifying how (and for whom) particular treatments work best. Indeed, it likely reflects one of the key change variables associated with the as-yet answer to Paul's (1967) question posed at the outset of this article. Nuanced considerations of the therapeutic relationship's function should continue to be a focal point for evidence-based practitioners and psychotherapy researchers, particularly in the context of psychotherapy personalization.

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Conceptualizando la Relación Terapéutica: Mediadora o Moderadora del Cambio?

Aunque la relación terapéutica ha sido reconocida durante mucho tiempo como un factor esencial en el proceso de cambio, ha habido desacuerdo sobre si la relación es en sí misma curativa o más bien apoya los beneficios de técnicas terapéuticas específicas. Para avanzar y aclarar esta conversación, este artículo conceptualiza la relación de terapia como mediador y/o moderador del cambio que se puede utilizar estratégicamente de acuerdo con la formulación del caso para los objetivos del tratamiento. Empezamos con un breve resumen de la literatura relevante sobre la relación entre la terapia y la técnica, y el papel de la relación terapéutica como mediador o moderador a través de orientaciones teóricas. Luego sugerimos un marco integrador mediante el cual los clínicos y investigadores de la psicoterapia pueden conceptualizar la relación terapéutica basada en conceptualización del caso, donde los requisitos en cada caso y no la orientación teórica debe determinar el papel del uso que el terapeuta hace de la relación terapéutica. Finalmente, discutimos las implicancias para la investigación y la práctica de la psicoterapia.

relación de terapia, proceso de investigación, factores comunes, integración de psicoterapia, principios de terapia, conceptualización de casos

将治疗关系概念化：变革的调解人还是调解人？

虽然长期以来，治疗关系被认为是一个重要因素 变更过程中，对于是否关系存在分歧 本身就具有治疗作用，或者更确切地说，它支持特定治疗技术的益处。为了推进和澄清这一对话，本文将治疗概念化关系作为可以使用的变化的调解人和/或调解人 策略性地根据治疗目标的病例制定。我们从一个关于治疗关系与技术的相关文献的简要概述 以及治疗关系作为跨理论中介或调节者的作用方向。然后，我们建议一个综合框架，临床医生和 心理治疗研究人员可以基于以下概念来概念化治疗关系 案例概念化，其中每个案例的要求而不是理论要求 定位应该决定治疗师使用治疗关系的作用。最后，我们讨论了对心理治疗研究和实践的影响。

治疗关系, 过程研究, 共同因素, 心理治疗整合, 治疗原则, 案例概念化