

# **THE THERAPEUTIC RELATIONSHIP IN COGNITIVE BEHAVIOURAL THERAPY**

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# **PART I**

## **THE THERAPEUTIC RELATIONSHIP IN CBT**

# 1

## THE FOUNDATIONS OF THE THERAPEUTIC RELATIONSHIP: THERAPIST CHARACTERISTICS AND CHANGE

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### CHAPTER OVERVIEW

Carl Rogers identified what he thought were the essential characteristics a therapist should embody to promote growth and change – genuineness, positive regard, empathy and unconditional acceptance. Cognitive behaviour therapists have generally accepted that these therapist characteristics form the foundations of the therapeutic relationship. But what is the evidence for an association between these factors and therapy outcome? This chapter reviews the evidence and focuses on empathy, a key requirement for building a collaborative relationship, formulating problems and employing effective change methods. Some of the pitfalls that arise from being too empathic or insufficiently empathic are considered together with ways to help therapists empathise with challenging clients.

### CORE CONDITIONS OF PSYCHOLOGICAL THERAPY

In the seminal text on the cognitive therapy of depression, Beck cites warmth, accurate empathy and genuineness as therapist characteristics which facilitate the application of cognitive therapy (Beck et al., 1979: 45): a therapist “who carefully utilizes these qualities can substantially increase his effectiveness”. The core therapist conditions were identified by Carl Rogers over 60 years ago and the theory remains highly influential. Person-centred therapists believe that these elements are *essential* for change, while therapists from other backgrounds generally see them as *necessary but not sufficient* for therapeutic benefit. According to Rogers, *genuineness*

entails the therapist expressing their true feelings, not hiding behind a false professional façade; *positive regard* involves valuing the client and behaving warmly towards them; *empathy* requires the therapist to understand what the client's emotions feel like to them and show that they understand them; and *unconditional regard* means accepting the client regardless of what they say or who they are (Rogers, 1957; Rogers, 1961). Although the primary goal of CBT is to change cognitions and behaviour, these factors may facilitate the process. By acting in a genuine way, the therapist models the normalising rationale of therapy. Valuing the client encourages them to engage in CBT tasks, while the therapist needs *empathy* to understand and support the client in exploring alternative thoughts and strategies. Finally, all therapists would consider it a *sine qua non* that they do not pass moral judgement on their clients. Keijsers' review of the evidence (Keijsers et al., 2000) found that, while cognitive behavioural therapists were more active and directive and gave higher levels of emotional support than insight-oriented therapists, they were not more superficial, cold or mechanical: they showed as much empathy and unconditional regard as therapists from other traditions. Rogers' core conditions may be part of therapeutic conventional wisdom, but are they really *necessary* even if not sufficient?

### HOW IMPORTANT ARE THE CORE CONDITIONS?

Numerous studies have been conducted since Rogers suggested the importance of these therapist behaviours, and there is general consensus that clients with better outcomes rate their clinicians more highly on them (Bozarth et al., 2002; Elliott et al., 2011, Klein et al., 2001). In 2010, a task force commissioned by the American Psychological Association's Divisions of Psychotherapy and Psychology published a review of evidence-based therapy relationships (Norcross and Lambert, 2011). Eminent researchers conducted meta-analyses of studies which had explored the link between the therapeutic relationship and outcome. These studies consistently found an association between Rogers' core characteristics and treatment outcome. Positive regard or non-possessive warmth had a moderate association with outcome (effect size  $r = 0.27$  from 18 studies); the only moderator identified was ethnicity: as the percentage of racial/ethnic minority groups in the study increases, the overall effect size also increases. Therapist empathy also showed a moderate association (effect size  $r = 0.30$  from 57 studies), which was strongest for client rated empathy. Therapist genuineness/congruence refers to the combination of the therapist's self-awareness and communication of his or her experience to the client: 'the feelings and attitudes which are at the moment flowing within him' (Rogers et al., 1967: 100). The effect size was 0.24 (from 16 studies). Thus, there seems to be a small, but significant, association between these factors and therapy outcome - each factor explaining between 6 and 9% of the variance - which is common across different therapies. One of the main methodological criticisms of these studies, however, is that the evaluation of the therapeutic relationship was often obtained retrospectively, so it is possible that, if your therapist gets you better, you perceive him or her to be more warm, genuine and empathic. This interpretation is reinforced by the finding that it is the client's rating of these factors, rather than therapist or observer rating, that is most strongly correlated with outcome (see Chapters 2 and 4 for evidence that symptom change predates positive rating of alliance in CBT for depression). It has been

observed that it is unlikely that 'patient and therapist evaluations of Rogerian therapist variables are directly reflective of the *actual therapist behavior* [our italics] during the treatment' (Keijsers et al., 2000: 270). Although the empirical evidence that Rogerian factors mediate change in CBT is contested, from a clinical and theoretical perspective a case can be made that they enhance the collaborative relationship and encourage the client to participate in therapy. Manipulating how warm therapists are when implementing systematic desensitisation has been shown to improve outcome with snake phobics (Morris and Magrath, 1979), though this does not seem to apply to therapist aided exposure for height phobia (Morris and Suckerman, 1974). Generally, it is felt that if the client perceives the therapist as warm, genuine and understanding, they will be more likely to engage in the tasks of therapy and consequently be more appreciative of the therapist's positive qualities if they recover. In this sense, the core characteristics act to enhance the working alliance. The therapy alliance, and in particular CBT's unique version of it which is termed *collaborative empiricism*, will be covered in depth in Chapter 2. In the rest of this chapter, we will focus on the role of empathy in CBT, because the therapist needs to have an accurate understanding of what the patient is thinking and feeling in order to help them discover alternative perspectives.

## EMPATHY

The psychologist Hoffman defines empathy as 'an emotional state triggered by another's emotional state or situation, in which one feels what the other feels or would normally be expected to feel in his situation' (Hoffman, 2008: 440). He identifies five empathy-arousing modes: mimicry, conditioning, direct association, verbally mediated association and perspective taking. The first three are automatic: passive, involuntary and triggered by stimuli. They operate preverbally and are found in infants and primates. The final two modes require language and cognitive processing. Multiple modes can be activated together:

Facial, vocal, and postural cues are picked up through *mimicry*; situational cues through *conditioning* and *association*; distress expressed orally, in writing, or by someone else can arouse empathy through the cognitive modes. (Hoffmann, 2008: 442).

For clinical convenience, we collapse these modes into the categories of emotional and cognitive empathy. *Emotional empathy* (sometimes termed *sympathy*: see, for instance, Gilbert, 1989) refers to the automatic response to another's distress where we feel similar emotions to those experienced by the sufferer. This type of empathy can be evoked without the subject being aware of the goal of the experiments (Blakemore et al., 2005; Singer et al., 2004). It is preverbal and may be associated with so-called *mirror neurones*, which fire when the individual feels an emotion and also when they witness the emotion in someone else (Botvinivk et al., 2005; Cheng et al., 2008; Iacobi and Lenzi, 2002; Iacobi et al., 2005; Morrison et al., 2004). *Cognitive empathy*, on the other hand, requires a conscious engagement with another's suffering where we put ourselves in their shoes and imagine what it might be like to be experiencing the same emotions. It is therefore effortful and requires a developed theory of mind. The left anterior insula is associated with both types of empathy, while the right

anterior insula may be more active in emotional empathy and the left anterior medial cingulate cortex in cognitive empathy (Fan et al., 2010). Roger's concept of empathy is closer to cognitive empathy than emotional empathy:

the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view.... to see completely through the client's eyes, to adopt his frame of reference.... It means entering the private perceptual world of the other ... (Rogers, 1980: 85).

*Emotional empathy* is an automatic response where we feel similar emotions to another person.

*Cognitive empathy* is the conscious engagement with another's suffering where we imagine what it is like to be experiencing the thoughts and feelings of the other person.

Mercer and Reynolds (2002) identify three functions of empathy in a clinical setting: (i) to understand the patient's situation, perspective and feelings, (ii) to communicate this and check its accuracy, and (iii) to act on that understanding with the patient in a helpful way. For the CBT therapist to help the client explore and change their unhelpful beliefs, it is first necessary to understand their cognitive world. During a panic attack, for instance, the patient will often fear they are in imminent danger of dying, but the catastrophic thoughts will be specific for the individual. They may fear they will have a heart attack, a stroke or suffocate, usually based upon a misinterpretation of bodily symptoms (e.g. palpitations, dizziness and headache, or breathlessness respectively). Demonstrating that the therapist understands how frightening the situation is and how real it feels at the time is an important part of establishing rapport and ensuring that the therapist has accurately identified the relevant thoughts. Understanding the personal meaning of the symptoms is essential in order to set up effective behavioural experiments to test the catastrophic fears. Each of the Mercer and Reynolds' three stages of clinical empathy contributes to effective therapy: asking questions to understand the client's view of the world, summarising and reflecting back this understanding and demonstrating how this understanding can make a difference.

## ESTABLISHING EMPATHY IN CBT

### 1. UNDERSTANDING THE CLIENT'S PERSPECTIVE

The secret to empathy in CBT practice is curiosity. Can I make sense of how the person before me is caught up in their problems? The therapist must suspend judgement to listen carefully for the explicit and implicit meanings in the client's communications, asking the key question: If I saw the situation in this way, would I feel the same way? If the answer is No, then the therapist has not yet

grasped the full personal meaning of the situation for the client, and further exploration is needed. The general cognitive model (appraisals drive emotions and behaviour) and disorder specific models (e.g. catastrophic misinterpretations of bodily symptoms in panic) guide us in the questions we might ask to clarify our understanding. So, if a client with panic disorder reports they had an overwhelming sense of dread but no cognitions, we need to inquire further about what they felt in their body at the time and what was the worst thing they thought might happen? Showing the client that you really want to understand what it was about the experience that made it so dreadful helps build the relationship, and finding that their experience fits the cognitive model of panic makes their symptoms more comprehensible. The therapist should not, however, hold on too strongly to a model if the patient does not feel it fits their experience. A patient described anxiety attacks which were overwhelming and filled him with dread but he was unable to identify any specific cognitions beyond a felt sense of impending doom. When the therapist attempted to elicit catastrophic thoughts about death, he got nowhere and the patient felt he was not getting the point. Reframing the problem as one of intolerance of the feeling of doom allowed them to discuss cognitions such as 'I can't stand this' and 'it's not going to stop' and set up appropriate experiments to test these beliefs.

## 2. CHECKING YOU HAVE UNDERSTOOD AND SHOWING YOU UNDERSTAND

The therapist often feels more closely connected with the client when they have understood their appraisal of the upsetting situation. Putting oneself in the client's position and allowing a felt sense to arise can help us get in touch with how they are feeling. This allows the therapist to genuinely say 'I can see how that must have been very upsetting for you.' Paraphrasing what the client has said, and using verbatim their hot thoughts alongside these empathic comments, helps the patient see the therapist is on track. For instance, a client with anger control problems may have described an incident of road rage. The therapist might summarise:

So when the other driver cut you up, the first thought that went through your mind was, 'What a \*\*\*\*! He's not looking where he's going. He needs to be taught a lesson!' You thought he was being selfish and inconsiderate and that made you want to get back at him. Have I got that right?

Here, the therapist is exploring the belief that a person who breaks the social rule of courtesy needs to be punished. The therapist might then say, "Most of us who drive have been in this sort of situation, but it seems to have been particularly upsetting for you. I'd like to understand what it was that made your anger go into the red zone." This might lead the client to describe how his life is full of people who treat him disrespectfully: this is just another example of the self-centredness around him. The therapist might then empathically respond:

I understand now that although in some ways this was a minor incident, it symbolised all those occasions when people disrespect you. You felt incredibly angry that here was a complete stranger doing it again.

Further exploration might elicit thoughts and feelings of helplessness and impotence, allowing the therapist to empathise with the vulnerable emotions beneath the angry compensatory response:

Although you felt so angry, you say that underneath was a feeling of powerlessness and the rage.

### 3. DEVELOPING EFFECTIVE CHANGE METHODS

Accurate cognitive empathy allows the therapist to devise appropriate interventions, while emotional empathy allows the client to feel heard so they engage and contribute to these interventions. With our angry client, the identification of the sequence:

"I'm being dissed. I'm nothing. I'm powerless."

|

VULNERABLE

|

"What a \*\*\*\*! He's not looking where he's going. He needs to be taught a lesson!"

|

ANGRY

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*DRIVING FAST TO OVERTAKE AND GESTICULATE AT OTHER DRIVER* can give him a perspective on his angry reaction. Empathising with the underlying feeling of vulnerability and recognising how the angry reaction is a compensatory strategy to manage the helplessness may allow the client to look at the validity and usefulness of his response. This can generate some in-session interventions:

1. Examining the pros and cons of responding in the way he did.
2. Devising alternative strategies to manage anger in a similar situation.
3. Examining the initial appraisal – is there evidence the driver did this deliberately?

and between-session work:

1. Monitoring angry reactions.
2. Using alternative strategies – count to ten before doing anything; leave at least ten minutes before answering an email that makes him angry.
3. Noticing the underlying hurt and learning strategies for self-soothing.
4. Empathy exercises to understand the other person's perspective.

## PROBLEMS IN EMPATHISING

### Some problems in empathising too much

*Emotional overidentification* – through emotional contagion, the therapist mirrors the client's emotional response and becomes overwhelmed by feelings of hopelessness. Assumptions may be made about what the client *must* be thinking if they are feeling this way.

*Cognitive overidentification* – the therapist 'buys into' the client's world view and is unable to establish sufficient distance to help them find alternative ways of thinking or acting.

Joan is a 28-year-old single parent with a two-year-old daughter. She has been depressed for the last year following the ending of a relationship and receiving a diagnosis of breast cancer. She has been successfully treated with a lumpectomy and chemotherapy but remains depressed. She is socially isolated and has very little that gives her any pleasure in life. She has not responded to a variety of antidepressants and feels pessimistic that CBT can help.

Her automatic thoughts are:

'There's no point in doing anything, my life's over.'

'I've got nothing to look forward to.'

'I'm not a fit mother.'

'I'm damaging my daughter.'

She had a stable but strict family upbringing. Her father was highly critical of any mistakes. Her mother was 'a doormat' who seems to have been crushed by her husband's dominant control. Joan has a younger sister who she feels was the favourite, who was not scrutinised as much by the father as Joan. She has not worked since having the baby. When the child was a year old, she was diagnosed with breast cancer, and her partner could not cope. He left, and she has been berating herself for getting involved with him in the first place, since her father had warned her he was no good from the start.

### Reflective question

Read through the brief description of Joan's case. What would be your emotional reactions if you were Joan's therapist? What empathic traps might a therapist fall into when treating her?

## 1. EMOTIONAL OVERIDENTIFICATION

In the presence of great distress, we naturally feel similar emotions to the person before us. This form of emotional empathy may lead us to feel tense with an anxious patient or sad with a depressed patient. Confronted by Joan's deep sadness, it is understandable that the therapist will feel sad and his or her emotions and body language will mirror hers. Feeling the client's sadness is an important part of the therapist's emotional response, but there are dangers in becoming too identified with the client's suffering. One possibility is that what might be termed our *empathic countertransference* (Moorey, 2014; our reaction generated by our identification with the client's emotional state) might lower our mood to such an extent that we feel hopeless ourselves. As our mood drops, we naturally think in a more negative way, and this may make it harder to find alternatives to what seems a realistically negative situation. A second danger is that our emotional empathy may trick us into thinking we have accurate cognitive empathy with Joan. This is a common problem when working with life-threatening illness. Our own thoughts and feelings about death may lead us to believe that we know why the patient is distressed without checking out the idiosyncratic meaning for them. We will discuss this further in Chapter 12. Finally, the strength of our own empathic suffering can be difficult to bear. Hoffman (1978) coined the term *empathic overarousal* for the tendency to feel overwhelmed in the presence of another person's suffering. This can lead us to shut off emotionally and use distancing tactics, such as intellectualisation, to manage our emotions. This can be a challenging balance between approach and distancing: we need the courage to genuinely explore the meaning of difficult situations for the patient while being able to stand back enough not to be totally absorbed by negative feelings. Supervision can be very useful in helping the patient achieve this balance.

## 2. COGNITIVE OVERIDENTIFICATION

When we truly understand the thoughts and feelings of someone who is in great distress, we can lose our objectivity, in effect 'buying into' their world view. This is particularly an issue in depression (see Chapter 4) but can occur with any disorder. We begin to believe the client really is a failure, or that they are too damaged to ever get better, or too lacking in coping skills to successfully engage in behavioural experiments. The challenge for the therapist is to empathise sufficiently to have emotional contact with the client while holding onto the possibility that there may be alternative, more constructive, ways to view and manage the situation. A therapist working with Joan may be influenced by the external difficulties she faces (serious illness, abandonment by her partner, social isolation) and start to agree with her hopeless construction. This may lead the therapist to conclude that CBT is not the right treatment and that another therapy, like supportive counselling, may be more appropriate. It is important to stand back from the situation and balance empathy with a rational assessment of the client's thoughts. A few methods include:

1. Examining the client's thoughts for cognitive biases.
2. Doing our own thought record to look at our reactions to the client's beliefs.
3. Bringing the case to supervision.

**Reflective question**

Imagine the ways in which the therapist might 'buy into' Joan's view. What are the distortions in Joan's thinking? How might the therapist address these while remaining empathic?

**3. FAILURE TO EMPATHISE****Difficulties in empathising**

We may find it hard to empathise because we are frightened of empathising too much. The threat of empathic overarousal makes us shut down and distance ourselves from the client.

Or we may find the client's world view so different or unpalatable that we cannot imagine ourselves in their situation.

We cannot empathise with all our patients. While it is easy to identify with some patients, others seem very alien to us. Their ethnic or cultural background may be very different from ours. Their values, priorities or ethics may be so far away from our own that it is very hard to walk in their shoes. Nonetheless, an inquiring, curious approach to building a conceptualisation of the person's beliefs and their origins can help to bridge these divides. Devising not only a maintenance conceptualisation of the problems but also a fuller developmental conceptualisation may be important here. What are the cultural, family and personal experiences that shaped this person's beliefs? Can I create a story that explains how these beliefs came about? Can I see how I might have come to similar conclusions about the world if I had had these experiences? Getting a deeper understanding of culture and religion may be important with clients from different backgrounds to our own (see Chapter 16). Feeding back our understanding and showing positive regard (Norcross and Lambert, 2011) may be especially important when working with clients from different cultures. These gaps can usually be bridged, because it is possible to empathise with the form of the person's suffering even if the context and content are different. There is a universality about loss, grief, fear which we can usually empathise with, even if the person's background is very different from our own. Empathy becomes more difficult when the client's beliefs elicit a negative response from the therapist. This is often the case with people with a diagnosis of personality disorder. Piers was a successful 30-year-old entrepreneur who came to therapy because of lifelong feelings of dissatisfaction and self-hatred. He spent much of the therapy session either talking about the amount of money he was making, describing angry ruminations about the people who had put him down in his work and private life or subtly undermining the therapist's competence. Piers coped with his painful feelings through alcohol and cocaine use and compulsive use of prostitutes. The therapist's emotional reaction

was to feel angry, defensive and repulsed by Piers' narcissistic lifestyle. He used a number of approaches to feel more empathy towards his patient:

1. Enquire about Piers' childhood to understand where his feelings of emptiness and self-hatred originated.
  - i. He discovered Piers was an only child. His parents were cold and distant, gave him lots of material gifts but little love and sent him to boarding school from an early age. His father was a high flyer in the City who expected him to succeed, and so the only positive rewards he received were for success.
2. Try to imagine Piers as a child experiencing coldness and withholding of affection and how this might have felt.
3. Empathise with the vulnerability beneath the compensatory strategies of being dismissive and self-aggrandising, or escaping into maladaptive self-soothing.
4. Recognise that, while his strategies for achieving his goals were unhelpful and put others off, his underlying goals to feel worthwhile and to be loved were legitimate.

We will return to Piers' story in Chapter 3, where we will explore the therapist-patient relationship in the context of interpersonal schemas.

You may find the following empathy exercise helpful if you have a client with whom you find it difficult to empathise.

### **Empathy Exercise**

#### **Step One**

1. Choose a client who evokes strong negative emotions in you.
2. Sit comfortably in a chair, close your eyes and allow yourself to rest in the present moment. Notice the sensations of your feet on the floor, your bottom on the chair, your hands resting on the arms of the chair or on your body. Let go as best you can of thoughts about the future and past and be present.
3. Imagine your client sitting opposite you. How do they look? What are their body movements? Are they saying anything to you? What emotions and body sensations do you feel as you picture them in front of you?
4. Open your eyes and reflect on the exercise.

#### **Step Two**

1. Revisit your formulation for your client. Can you create a narrative linking their life experiences, beliefs and behaviours that helps you understand how they are approaching therapy?
2. Now close your eyes again and focus on the present moment, spending a few seconds grounding yourself.

3. Imagine you are your client, sitting opposite the therapist. What emotions do you feel; what body sensations? What thoughts are going through your mind?
4. Open your eyes and reflect on the exercise.

### Step Three

1. Close your eyes and ground yourself.
2. Imagine your client sitting in front of you. What does this evoke now? What thoughts, feelings and body sensations arise as you picture your client?
3. Has anything changed? Do you have different understanding of their experience and attitude towards you? Can you empathise with their situation?

This exercise often produces a shift in affect and some insights into what the patient may be experiencing in the session. Occasionally, the new insight leads to a sense of overwhelming identification with the client with empathic overload. One therapist mentioned how empathising with the client's hopelessness changed their affect from irritation and resentment to hopelessness. If this occurs in the imagery exercise, it can be helpful to review the evidence for the client's beliefs and hold in mind that, as therapists, we can be responsible for doing our best for the client but, ultimately, they are on their own life journey and we cannot live it for them.

## CHAPTER SUMMARY

This chapter has reviewed the evidence for the small, but consistent, association between the 'core conditions' (genuineness, positive regard, empathy and unconditional acceptance) and outcome which is found across all therapies. Limitations of the research studies mean that it is not possible to conclude that these factors are necessary preconditions for effective CBT, but clinicians would generally agree that a therapist who did not possess these qualities might struggle to deliver good treatment. Empathy has a particularly important place in CBT, because without an understanding of the client's cognitive world it is not possible to formulate, identify relevant beliefs or explore adaptive alternatives, and the therapist needs to demonstrate that understanding in order to engage the client in the therapeutic journey. Some tips for establishing empathy are suggested and the traps of emotional overidentification, cognitive overidentification and failure to empathise are described, together with ways to manage them. Finally, an experiential exercise is introduced which can be used when empathy seems to fail.

## FURTHER READING

Beck AT, Rush AJ, Shaw BF and Emery G (1979) The therapeutic relationship: application to cognitive therapy. In: *Cognitive Therapy of Depression*. New York: Guilford Press.