

The patient-provider relationship in chronic pain

Kevin Vowles & Miles Thompson

Current Pain and Headache Reports

This is the author's version of a work that was accepted for publication in Current Pain and Headache Reports

Changes may have been made to this work since it was submitted for publication. In other words, changes resulting from the publishing process, such as peer review, editing, corrections, structural formatting, and other quality control mechanisms may not be reflected in this document.

The definitive version is published in Current Pain and Headache Reports
<http://dx.doi.org/10.1007/s11916-012-0244-4>

NB: E-mail addresses in the manuscript may no longer be valid. Miles Thompson can be contacted via this web site: www.mvdct.org.uk

Vowles, K., & Thompson, M. (2012). The Patient-Provider Relationship in Chronic Pain. Current Pain and Headache Reports, 5, 122-126.
<http://dx.doi.org/10.1007/s11916-012-0244-4>

The Patient-Provider Relationship in Chronic Pain

Kevin E. Vowles, Ph.D.^{1,2*} & Miles Thompson, D.Clin.Psy.³

¹ Interdisciplinary Musculoskeletal Pain Assessment and Community Treatment Service,

The Haywood Hospital, High Lane, Burslem ST6 7AG, United Kingdom

²Centre for Primary Care Sciences, Keele University, Keele University, Keele,

Staffordshire ST5 5BG, United Kingdom

³Department of Psychology, Goldsmiths, University of London, New Cross,

London SE14 6NW, United Kingdom

KEYWORDS: Chronic Pain; Patient-Provider Relationship; Therapeutic Relationship;
Psychotherapy; Contextual Behavioral Science

Abstract

The relationship between patient and provider has long been the subject of study within the psychotherapy literature with the available data suggesting a modest, but reliable, association between the strength of this relationship and treatment outcome. Conversely, there has been little work focused on the patient-provider relationship in chronic pain settings in spite of the complexities and difficulties that are often involved in this area. The primary purpose of the present review was to provide a brief, broad overview of the literature on the patient-provider relationship and identify key aspects that are specifically relevant to chronic pain settings. In addition to reviewing the literature in this area, a series of recommendations for future clinical and academic work are offered.

Introduction

Modern healthcare increasingly relies on the evidence-based treatment literature to identify the necessary components of treatment. This search for crucial ingredients can often focus on technical issues, such as specific techniques, therapist expertise, or structural aspects of the treatment environment. Progress in evidence-based practice is often quantified using the results of either tightly controlled studies (e.g., randomized controlled trials) or meta-analytic reviews of the data from these studies. Such analyses often are principally concerned with the difference in outcomes achieved by distinct treatment approaches or specific treatment components (e.g., “sham” versus “active” interventions).

In contrast, in certain areas of psychology, such as psychotherapy and counselling, there has historically also been a focus on specific aspects of the relationship between patient and provider and how this relationship influences treatment outcomes. Some have argued that a collaborative and close working relationship between patient and provider is actually the *primary* determining factor in achieving treatment success over and above the role of evidence based practice or specific components of treatment (see Norcross & Lambert¹ for further discussion).

While examination of this patient-provider relationship has predominately occurred outside of medical and physical health settings, there is evidence to suggest it is highly relevant to treatment outcomes in these areas as well. Provider communication skills, for example, have long been recognized as having a significant impact on outcomes for a range of clinical conditions²⁻⁴ and specific competency guidelines have been established (e.g., the Kalamazoo Consensus Statement⁵).

The present review sought to explore the relevance of the patient-provider relationship within the area of chronic pain specifically. This seemed a particularly important area to explore given the complexities that are often inherent in chronic pain settings⁶ and how these complexities can contribute to a less effective working relationship among patients and providers⁷.

We begin with a general examination of the influence of the patient-provider

relationship on treatment outcome, drawn from meta-analyses conducted within the psychotherapy literature. We next define specific aspects of the relationship, and consider the available evidence examining the relevance of these aspects within chronic pain settings. Finally, we consider contemporary developments in the wider field of the behavioral and psychological sciences before concluding with a series of recommendations for treatment providers and researchers in this area.

With regard to terminology, the relationship between provider and patient has been referenced in a number of ways historically (e.g., therapeutic relationship, rapport, working or helping alliance). Within the present review, we used the term patient-provider relationship as we feel it most accurately captured the essence of the concept.

Influence of the Patient-Provider Relationship on Outcomes

As noted, the discussion of patient-provider relationship originates and has predominantly been discussed within the psychotherapy literature (e.g., ⁸). In recent decades there have been three primary, peer-reviewed, and comprehensive meta-analyses which have examined the influence of the relationship on outcome^{9,10}, with the largest and most recent including over 200 studies¹¹. Each of these meta-analyses has expressed the effect size of the patient-provider relationship as a Pearson Product Moment correlation, with 0.1 equating to a small effect size, 0.3 as a medium effect size, and 0.5 as a large effect size¹².

Effect size values from these meta-analyses have ranged from $r = 0.22$ to 0.28 , with the latter being the result of the most recent, and largest, review. The magnitude of these effect sizes, which lie at the upper range of a small effect, suggest a fairly modest effect, explaining approximately 5% to 8% of the variance in treatment outcome. However the consistency is rather remarkable given the wide range of studies, treatment approaches, patient populations and measures that have been used. It suggests that the quality of the patient-provider relationship has a stable and predictable influence on outcome and that it is potentially one of the hallmark ingredients of effective intervention (e.g., ¹¹).

Components of the Patient-Provider Relationship and Relevance to Chronic Pain

Contemporary work (e.g.,^{1,10}) has identified two broad components of the patient-provider relationship: (a) characteristics of the provider which serve to strengthen rapport between patient and provider, and (b) collaboration and congruence between patient and provider in the identification of treatment goals and objectives. We will review these two components and their relevance in chronic pain settings in the following sections.

Provider characteristics in establishing rapport

Within the wider psychotherapy literature, a number of provider characteristics have consistently been related to a higher quality relationship and better treatment outcomes in both individual and group settings. These characteristics include being perceived by patients as being genuine, non-judgemental, attentive, respectful, and empathetic¹³⁻¹⁶. Such behaviours on the part of the provider seem to enhance affective rapport with patients and this is presumed to influence adherence and the effect of specific interventions^{17,18}.

To our knowledge, there have been no direct studies regarding the influence of these specific provider characteristics on treatment outcome in chronic pain settings. There are, however, studies suggesting that providers, and more specifically provider behaviour, are an influential variable in the determination of treatment outcome.

For example, in one study examining outcomes across three large-scale randomized-controlled treatment trials for low back and neck pain, the amount of variance in treatment outcomes accounted for by between-provider differences was greater than that accounted for by the specific interventions themselves, with the former ranging from 3% to 7% and the latter being less than 2%¹⁹. Interestingly, these “practitioner effects”, as the authors termed them, were most pronounced when treatment involved issues relevant to psychosocial functioning or was more psychosocial in nature. There are parallel findings in group settings as well, where differences in treatment outcome through a one month follow-up were influenced by the treatment group to which patients were assigned²⁰.

With regard to patient characteristics that may influence provider behavior, De Ruddere and colleagues²¹ recently published the results of an experimental study suggesting that the pain of patients who were less liked by observers was taken less seriously in

comparison to more likeable patients. On a related note, providers, as well as patients, judge the “working alliance” to be less robust when patients are more depressed and hostile⁷. In tandem, these two studies potentially indicate that patients who are more demonstrably in distress or pain are deemed to be more difficult to work with, which may adversely influence the ability of both patients and providers to work together in a useful way.

In addition to the above, an examination of a long established database from a national level pain service in the United Kingdom²⁰ indicated that times of high staff turnover were associated with poorer treatment outcomes in domains of psychosocial functioning (i.e., self-efficacy) and physical performance (i.e., walking distance). Further, the quality of provider communication tends to be inversely correlated to a patient’s pain duration and age²².

In conclusion, specific provider characteristics appear to have a reliable influence on treatment outcomes. While no studies specifically examine these provider characteristics in chronic pain settings, it would seem reasonable to hypothesize that patients who are less liked, communicated with more poorly, deemed to be harder to work with, or who are treated in more “unsettled” treatment environments may develop weaker relationships with providers and this will, in turn, diminish the probability of beneficial treatment results.

Collaboration and congruence

With regard to collaboration and congruence in the identification of treatment goals, the evidence within the psychotherapy literature again provides fairly consistent evidence indicating that better outcomes are achieved when provider and patient are working together towards compatible treatment objectives²³. Consistent with the data on provider characteristics, this collaboration is also important in group settings and extends to the patient group as well, where concordance among group members in their working towards common outcomes is influential on outcomes¹³. There are similar outcomes in chronic pain settings where the more patients feel that decision making is shared, the more satisfied they are with treatment and the better their outcomes²⁴⁻²⁶.

Of course, there is sometimes an inevitable mismatch between patient and provider

goals for treatment when chronic pain patients present to treatment seeking durable pain reduction and the provider is aware that no such treatment is available. In fact, the available data suggest that patients tend to expect large reductions in pain intensity from treatment, and that these reductions can exceed what can be achieved with currently available treatments^{27,28}, which can contribute to difficulties in patient management⁶. If these discrepancies are left undiscussed and unresolved, chronic pain patients and their treatment providers are likely to be working at cross-purposes and this discordance in goal selection may have an adverse influence on outcomes in terms of decreased faith in providers, as well as increased emotional difficulties for patients themselves, which may, in turn, decrease rapport or diminish benefit from treatments²⁹⁻³¹.

Some have argued that effective treatments for chronic pain may require a “re-calibration” of expectations of pain relief and perhaps even a refocusing of goal selection onto areas involving improvements in functioning^{28,32}. It is possible that these methods of fostering consensus between patient and provider are a viable alternative when progress cannot be achieved in terms of pain reduction. We return to this point in the following section.

Recommendations for Clinicians and Researchers

A special issue on the patient-provider relationship was recently published in the journal *Psychotherapy* (see introduction by Norcross & Lambert¹). The issue provides an in-depth review of many aspects of this diverse literature and provides specific advice for treatment providers. We summarize some key recommendations from the articles within this special issue, as well as summary statistics regarding their association with outcome, in Table 1.

In addition to the content of Table 1, there are three further aspects of provider behaviour to consider. While these considerations are likely applicable in most healthcare settings, they seem particularly relevant to chronic pain.

The first concerns provider behaviours that do *not* help to establish a more effectual relationship and may even undermine treatment outcomes. These include a style that is

consistently confrontational, critical, or blaming or provider behaviours that are rigidly directive and inflexible³³. It is highly unlikely that any of these provider behaviours in chronic pain settings will contribute to more beneficial outcomes. Given the complexity often inherent in providing treatments for chronic pain, which can give rise to provider feelings of frustration or distress, it is perhaps particularly important not to engage in these unhelpful ways of interacting with patients.

The second consideration concerns the ability to communicate effectively. Effective treatment of chronic pain is far more complex than simply providing diagnostic, prognostic or procedural information to patients³⁴. To date, there is good evidence that treatment providers from a diversity of professional backgrounds can be effectively taught more successful communication skills by incorporating accurate and genuine reflection and empathy in their responses to patient behaviour and that these behaviors provide a direct and beneficial contribution³⁵. The literature on Motivational Interviewing³⁶, in particular, indicates the widespread applicability and feasibility of these techniques even when the time for direct patient contact is limited. A recently published trial of this approach combined with physiotherapy for chronic low back pain, for example, indicated superior outcomes across various measures of relationship quality, physical performance, and general health in comparison to physiotherapy alone³⁷.

The final point returns to the issue highlighted in the previous section regarding the risk of discrepancy in the identification of treatment goals between patient and provider when durable pain relief is sought by the former and deemed either impossible or unrealistic by the latter. Perhaps one area where concordance in goal identification can be achieved is through expanding conversations around treatment outcomes beyond the reduction or control of symptoms of pain or distress to outcomes that focus on effective functioning within a context of continued pain. For example, in a large scale survey, individuals with chronic pain noted a strong desire for improvement in areas such as enjoyment of life activities, overall energy, sleep, concentration, family and social relationships, employment and recreational activities³⁸. More focused assessment of patient-desired outcomes in these areas may allow

for improved collaborative efforts and seem to be a key area for future research and clinical efforts^{39,40}. There is, in fact, preliminary work in this area that supports both the importance and feasibility of treatment efforts focused on achieving more effective and meaningful functioning within a context of continuing pain^{41,42}.

Future developments

Before we conclude, it seems pertinent to consider the potential for future progress in this area, particularly with regard to areas of contemporary research and practice that might provide a useful framework for both understanding, and even empowering, the therapeutic relationship. One possibility is the emerging contextual behavioural approaches to treatment, including Acceptance and Commitment Therapy (ACT⁴³); Functional Analytic Psychotherapy (FAP⁴⁴); and Dialectical Behavior Therapy (DBT⁴⁵). Each of these approaches at least partially focuses on the quality of the patient-provider interaction and suggests methods that providers may use to enhance the quality of this interaction.

These contextual approaches do not promote a model of abnormal behaviour or 'psychopathology' in isolation; instead they offer a broader, more general model of human behaviour that can be applied equally to patient behaviour, therapist behaviour and the patient-provider relationship itself. At the centre of these models is the notion of flexible responding such that effective functioning, well-being, or relating to another person is maximized. In the ACT model, for example, this is referred to as psychological flexibility. In the FAP model, clinically relevant behaviours which indicate this effective responding is occurring are specifically assessed for and reinforced within the treatment environment. Within DBT, which was originally developed for individuals diagnosed with Borderline Personality Disorder, there is a focus on distress tolerance, emotional regulation and interpersonal effectiveness – essentially, flexible responding to difficult situations such that it is more adaptive over the longer term. See Hayes and colleagues⁴⁶ for an orientation to and review of this area.

Within each of these approaches, while there is a focus on maximizing treatment outcomes, there is also a focus on the role of the provider in flexibly maximizing the

effectiveness of their own behaviour to facilitate a shift in patient behaviour. They each argue that the therapeutic approach, including its underlying model of behaviour, is as relevant to the therapist as it is to the client. They suggest that a more present and willing stance toward one's own experiences in clinical situations may enable the therapist to better relate and respond to the client, his or her experiences and the developing process of treatment as it occurs. See Pierson and Hayes⁴⁷ for a chapter length discussion of these issues.

Conclusions

The relationship between patient and treatment provider has long been the subject of study within the psychotherapy literature. The evidence base has consistently indicated that the quality of this relationship accounts for a small, albeit consistent and noteworthy, amount of the variance in treatment outcome (e.g., ¹¹).

While this relationship has been the focus of much less study within chronic pain, it seems reasonable to conclude that there may be similar effects based on the studies examined in the present review. An issue of particular relevance was recently raised by Jamison³, where it was noted that medical training in chronic pain has become increasingly dependent on technique or technical expertise and that this focus has perhaps inadvertently contributed to decreased focus on "nonspecific" aspects of treatment, which principally involve issues examined within this review. Essentially, there is evidence to suggest that positive response to treatment depends at least as much on the relationship between patient and provider as it does on the technical aspects of the intervention itself³.

Of course, there are limitations within the existing data, which affects the strength with which we can draw conclusions. Perhaps foremost among these is the fact that much of the available data are correlational in nature, making it impossible to establish causal connections despite the robustness of the effect. In addition, although various components of the patient-provider relationship have been examined, it is difficult to determine the extent to which they overlap or which, if any, is of exceptional importance. While it might be possible to identify unique and overlapping contributions statistically, it may also be necessary to investigate the individual contributions of these specific aspects of the patient

provider relationship in future research.

Even with these limitations in mind, the seemingly universal relation between the patient-provider relationship, regardless of how it is defined and measured, and treatment outcomes perhaps indicate there may be little practical value in causal tests or component analyses.

An alternative perspective, suggested in various parts of this review, is to seek continued progress in this field not just by collecting more data that argues for the importance of the patient-provider relationship but by carrying out research that allows us to better predict and influence the relationship itself. It is perhaps the case that to do this we need to move away from the imprecision of terms we currently use to describe this interaction (be that relationship, bond, or alliance). Instead progress may be seen by trying to view this phenomena from the perspective provided by different contextual approaches such as motivational interviewing, ACT, FAP, or DBT. Until such time as this occurs, the evidence seems fairly clear in its indication that treatment effectiveness is far more complex than simply treatment format or structure; the way this format or structure is applied by the provider matters as well, perhaps even more so.

In relation to the opening of this review, which suggested a continuum where focus on evidence-based practice was at one end and a focus on the patient provider relationship at the other, another point could be made. Far from being an antithesis of evidence based practice, the argument that the patient-provider relationship has a reliable impact on the outcome of therapy is consistently confirmed through evidence based practice. Indeed, it could be argued that the dichotomy presented at the start of this article unnecessarily impedes progress by polarizing parties into two opposing camps¹. A more progressive position to take might be one which understands that both the patient-provider relationship and treatment effects have impacts on outcome and that progress in both areas will be maximised through the careful selection of research questions, collection of data and publication of evidence.

References

*1. Norcross JC, Lambert MJ. Psychotherapy relationships that work II. *Psychother* 2011, 48:4-8.

Introduction to a special issue on the patient-provider relationship in psychotherapy.

The article provides an overview of the area and, in addition to the rest of the articles within the issue, specifies aspects of the relationship that are reliably related to outcomes.

2. Mumford E, Schlesinger HJ, Glass GV. The effect of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. *Am J Public Health* 1982, 72:141-51.

3. Jamison RN. Nonspecific treatment effects in pain medicine. *Pain Clinical Updates* 2011, 9:1-7.

4. Safran DG, Taira DA, Rogers WH, et al. Linking primary care performance to outcomes of care. *J Family Practice* 1998, 47:213-220.

5. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Acad Med* 2001, 76:390-393.

**6. Wasan AD, Wootton J, Jamison RN. Dealing with difficult patients in your pain practice. *Region Anesth Pain Med* 2005, 30:184-192.

Provides practical advice on effectively managing the various difficulties that can arise in chronic pain settings.

7. Burns JW, Higdon LJ, Mullen JT, Lansky D, Wei JM. Relationships among patient hostility, anger expression, depression, and the working alliance in a work hardening program. *Ann Beh Med* 1999, 21:77-82.

8. Rogers CR. The necessary and sufficient conditions of therapeutic personality change. *J Consult Psychol* 1957, 21:95-103.

9. Horvath AO, Symonds BD. Relation between working alliance and outcome in psychotherapy: a meta-analysis. *J Couns Psychol* 1991, 38:149-139.

10. Martin DJ, Garske JP, Davis MK. Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *J Consulting Clin Psych* 2000, 68:438-450.
11. Horvath AO, Re AC Del, Flückiger C, Symonds D. Alliance in individual psychotherapy. *Psychother* 2011, 48:9-16.
12. Cohen J. *Psych Bull* 1992, 112:155-159.
13. Burlingame GM, McClendon DT, Alonso J. Cohesion in group therapy. *Psychother* 2011, 48:34-42.
14. Elliott R, Bohart AC, Watson JC, Greenberg LS. Empathy. *Psychother* 2011, 48:43-49.
15. Farber B, Doolin EM. Positive regard. *Psychother* 2011, 48:58-64.
16. Kolden GG, Klein MH, Wang C-C, Austin SB. Congruence/genuineness. *Psychother* 2011, 48:65-71.
17. Grencavage LM, Norcross JC. Where are the commonalities among the therapeutic common factors? *Prof Psychol Res Pr* 1990, 21:372-378.
18. Myers S. Empathic listening: reports on the experience of being heard. *J Humanist Psychol* 2000, 40:148-173.
19. Lewis M, Morley S, van der Windt D a WM, et al. Measuring practitioner/therapist effects in randomised trials of low back pain and neck pain interventions in primary care settings. *Eur J Pain* 2010, 14:1033-1039.
20. Williams ACDC, Potts HWW. Group membership and staff turnover affect outcomes in group CBT for persistent pain. *Pain* 2010, 148:481-486.
21. Ruddere L De, Goubert L, Prkachin KM, et al. When you dislike patients, pain is taken less seriously. *Pain* 2011, 152:2342-2347.
22. Gulbrandsen P, Madsen HB, Benth JS, Laerum E. Health care providers communicate less well with patients with chronic low back pain: a study of encounters at a back pain clinic in Denmark. *Pain* 2010, 150:458-61.
23. Tryon GS, Winograd G. Goal consensus and collaboration. *Psychother* 2011, 48:50-57.

24. Frantsve LME, Kerns RD. Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision making. *Pain Med* 2007, 8:25-35.
25. Hirsh AT, Atchison JW, Berger JJ, et al. Patient satisfaction with treatment for chronic pain: predictors and relationship to compliance. *Clin J Pain*. 2005, 21:302-10.
26. Smith MY, Winkel G, Egert J, Diaz-Wionczek M, DuHamel KN. Patient-physician communication in the context of persistent pain: validation of a modified version of the Patients' Perceived Involvement in Care Scale. *J Pain Symptom Manag* 2006, 32:71-81.
27. Thorne FM, Morley S. Prospective judgments of acceptable outcomes for pain, interference and activity: patient-determined outcome criteria. *Pain* 2009, 144:262-9.
28. Robinson ME, Brown JL, George SZ, et al. Multidimensional success criteria and expectations for treatment of chronic pain: the patient perspective. *Pain Med* 2005, 6:336-345.
29. Dobkin PL, Sita A, Sewitch MJ. Predictors of adherence to treatment in women with fibromyalgia. *Clin J Pain*, 22:286-94.
30. Baker SC, Gallois C, Driedger SM, Santesso N. Communication accommodation and managing musculoskeletal disorders: doctors' and patients' perspectives. *Health Commun* 2011, 26:379-88.
31. Benner DE: Who can help me? A chronic pain patient's view of multidisciplinary treatment. In *Chronic Pain Management: Guidelines for Multidisciplinary Program Development*. Edited by Schatman M, Campbell M. New York: Informa; 2007:117-128.
32. Vowles KE, Robinson ME. Progressing towards acceptable treatment outcomes. *Pain* 2009, 144:228-9.
33. Norcross JC, Wampold BE. Evidence-based therapy relationships: research conclusions and clinical practices. *Psychother* 2011, 48:98-102.
34. Leila NM, Pirkko H, Eeva P, Eija K, Reino P. Training medical students to manage a chronic pain patient: both knowledge and communication skills are needed. *Eur J Pain* 2006, 10:167-70.

35. Baldwin SA, Wampold BE, Imel ZE. Untangling the alliance-outcome correlation: exploring the relative importance of therapist and patient variability in the alliance. *J Cons Consulting Psych* 2007, 75:842-52.
36. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. New York: Guilford Press; 2002.
37. Vong SK, Cheing GL, Chan F, So EM, Chan CC. Motivational enhancement therapy in addition to physical therapy improves motivational factors and treatment outcomes in people with low back pain: a randomized controlled trial. *Arch Phys Med Rehab* 2011, 92:176-83.
38. Turk DC, Dworkin RH, Revicki D, et al. Identifying important outcome domains for chronic pain clinical trials: an IMMPACT survey of people with pain. *Pain* 2008, 137:276–285.
39. Beale M, Cella M, Williams ACDC. Comparing patients' and clinician-researchers' outcome choice for psychological treatment of chronic pain. *Pain* 2011, 152:2283-2286.
- **40. Morley S. Efficacy and effectiveness of cognitive behaviour therapy for chronic pain: progress and some challenges. *Pain* 2011, 152:S99-S106.

A review and commentary on the progressive developments within cognitive and behavioral approaches to chronic pain. It also identifies areas in need of further work and challenges to be addressed.

41. Thompson M, McCracken LM. Acceptance and related processes in adjustment to chronic pain. *Curr Pain Headache R* 2011, 15:144-151.
42. Vowles KE, McCracken LM, O'Brien JZ. Acceptance and values-based action in chronic pain: A three-year follow-up analysis of treatment effectiveness and process. *Beh Res Ther* 2011, 49:748-755.
43. Hayes SC, Strosahl K, Wilson KG. *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change*. New York: Guilford Press; 1999
44. Kohlenberg RJ, Tsai M. *Functional Analytic Psychotherapy: Creating Intense and Curative Therapeutic Relationships*. New York: Springer; 2007.

45. Linehan M. Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press; 1993.

*46. Hayes SC, Villatte M, Levin M, Hildebrandt M. Open, aware, and active: contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annu Rev Clin Psych* 2011, 7:141-168.

A comprehensive review of the emerging contextual approaches which includes both a conceptual overview and empirical review.

47. Pierson H, Hayes S. Using Acceptance and Commitment Therapy to empower the therapeutic relationship. In *The therapeutic relationship in the cognitive behavioral psychotherapies*. Edited by Gilbert P, Leahy RL. New York: Routledge/Taylor & Francis Group; 2007:205-228.

48. Lambert MJ, Shimokawa K. Collecting client feedback. *Psychother* 2011, 48:72-9.

Table 1

Specific Recommendations to Enhance the Patient Provider Relationship and their Association with Outcomes^a

Aspect of the relationship	Enhancing practices	Outcome Association ^b
Empathy ¹⁴	Demonstrate a genuine desire to understand patient perspective and experience; reflect this within clinical interactions.	0.31
Positive Regard ¹⁵	Adopt a caring, respectful, and genuine stance in treatment towards the patient.	0.27
Congruence/Genuineness ¹⁶	Pay attention to patient responses in session and reflect this in provider communication.	0.24
Track Treatment Outcomes /Client Feedback ⁴⁸	Collect ongoing treatment response and feedback data to allow alterations in the course of treatment when necessary.	0.23
Goal Consensus & Collaboration ²³	Agree on treatment goals and methods to reach them; encourage patient feedback and contribution; work to help the patient be an active, rather than passive, contributor to treatment	0.34
Cohesion in Group Treatment ¹³	Emphasize group interaction; works best when group size and duration allow cohesion to build.	0.25

^a This table synthesizes the information from a special issue on patient-provider relationships in psychotherapy. See the specific references for detailed information.

^b Effect sizes of $r = 0.1$ and above are considered to be a small effect size, $r = 0.3$ and above a medium effect size, and $r = 0.5$ a large effect size¹².