

# Relationships and Responsiveness in the Psychological Treatment of Trauma: The Tragedy of the APA Clinical Practice Guideline

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The therapeutic relationship and responsiveness/treatment adaptations rightfully occupy a prominent, evidence-based place in any guidelines for the psychological treatment of trauma. In this light, we critique the misguided efforts of the American Psychological Association's (APA, 2017) Clinical Practice Guideline on Posttraumatic Stress Disorder in Adults to advance a biomedical model for psychotherapy and thus focus almost exclusively on treatment methods for particular disorders. Instead, the research evidence, clinical expertise, and patient preferences and culture (the necessary triumvirate of *evidence-based practice*) should converge on distinctive psychological guidelines that emphasize the therapy relationship, treatment adaptations, and individual therapist effects, all of which independently account for patient improvement more than the particular treatment method. Meta-analytic findings and several trauma-specific studies illustrate the thesis. Efforts to promulgate guidelines without including the relationship and responsiveness are seriously incomplete and potentially misleading. The net result is an APA Guideline that proves empirically dubious, clinically suspect, and marginally useful; moreover, it squanders a vital opportunity to identify what actually heals the scourge of trauma. We conclude with recommendations for moving forward with future APA practice guidelines.

## Clinical Impact Statement

**Question:** How useful is the American Psychological Association's (APA) Clinical Practice Guideline for treating traumatized clients and what are the consequences of ignoring the therapy relationship and responsiveness in this guideline? **Findings:** The APA Guideline for trauma adheres to a biomedical model that focuses on identifying particular treatment methods that work, but ignores the research evidence that most treatments for posttraumatic stress disorder produce similar outcomes and that relationship and responsiveness/adaptation factors contribute strongly to treatment success. **Meaning:** APA Guidelines are too narrowly focused on identifying treatments for particular disorders and should be expanded to include evidence-based relationships and adaptations. As written, the guidelines will not produce more effective treatment. **Next Steps:** Psychologists should advocate for practice guidelines that will result in more effective services.

**Keywords:** trauma, posttraumatic stress disorder, psychotherapy relationship, responsiveness, treatment adaptations, guidelines

The early Greek tragedies typically featured a single actor wearing a mask, allowing him to impersonate a god or demigod in the performance. As the genre evolved, tragedies presented main

characters on noble quests with unhappy endings, particularly concerning the downfall of the main characters. Hubris, greed, and rigidity frequently served as the protagonists' fatal flaws.

The American Psychological Association's (APA, 2017) Clinical Practice Guideline on Posttraumatic Stress Disorder in Adults strikes us as such an unfortunate tragedy. The quest was noble indeed, but the ending proved largely unhappy and unproductive. We think it is not stretching the metaphor to suggest that the fatal flaws involved rigid positions and doctrinaire decisions predicated on a biomedical model as opposed to a psychological or contextual model. The tragic decisions led to serious neglect of, inter alia, the therapeutic relationship and clinical responsiveness and thus ignore factors that would lead to more effective services for patients suffering from the effects of trauma.

In this article, we focus on the rightful, evidence-based place of the therapeutic relationship and responsiveness/treatment adapta-

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tions in any guidelines for the psychological treatment of trauma. We begin by briefly reviewing our highly ambivalent take on the APA Clinical Practice Guideline in general. From this perspective, we critique APA's efforts to advance a biomedical model for psychotherapy and thus focus almost exclusively on treatment methods for particular disorders. Instead, we argue that the research evidence, clinical expertise, and patient preferences and culture (the necessary triumvirate of *evidence-based practice*; APA Presidential Task Force on Evidence-Based Practice, 2006; Norcross, Hogan, Koocher, & Maggio, 2017) converge on distinctive psychological guidelines that emphasize the therapy relationship and treatment adaptations (responsiveness), both of which independently account for patient improvement more than the particular treatment method. Efforts to promulgate treatment guidelines without including the relationship and responsiveness are seriously incomplete and potentially misleading. The net result will be that such psychotherapy guidelines will frequently prove empirically dubious, clinically suspect, and marginally useful; moreover, they squander the vital opportunity to identify what actually heals the scourge of trauma. We conclude with recommendations for moving forward with future APA clinical practice guidelines.

### **Hallelujah! Psychological Guidelines at Last . . . Now Cease and Desist!**

We the authors are psychotherapy and behavior change researchers committed to infusing psychological practice with what is scientifically known about the problem, the person, and the treatment. When we first learned of APA's decision to produce clinical practice (or treatment) guidelines, we were delighted that distinctive psychological guidelines on psychological therapies would be forthcoming. Indeed, one of us (the optimistic one) distinctly recalls thinking (and perhaps saying), "Hallelujah! Psychological guidelines at last."

Promulgation of clinical practice guidelines aims to advance effective care. Our clients deserve the most effective care; our practitioners need research-guided compilations of what works (and what does not); family members deserve guidance on what to seek in psychotherapy; policymakers demand to know what to fund and train. Properly constructed, guidelines are praiseworthy intentions to distill research into clinical applications and to guide practice and training. In principle, at least, if not always in consequence.

Within organized psychology, APA guidelines can demonstrate that, in a climate of accountability, psychotherapy stands up to empirical scrutiny with the best of health care. The effect sizes of our psychological therapies routinely rival those of biomedical treatments (Rosenthal, 1990; Wampold & Imel, 2015). Psychological guidelines can proactively counterbalance documents that accord primacy to biomedical treatments for behavioral disorders and largely ignore the evidence for psychological therapies.

What, then, is not to like about APA's clinical practice guidelines? In aspiration and principle, nothing to contest. We remain ardent supporters of rigorously bringing psychological research to psychological therapy. But in application, in decision points, and in interpretation, we find APA's (2017) Clinical Practice Guideline on Posttraumatic Stress Disorder in Adults seriously flawed.

Progenitors of the APA Guideline unwisely followed the biomedical model down the proverbial rabbit hole to identify only particular treatment methods for specific disorders. They did so despite knowing beforehand that numerous meta-analyses had already demonstrated that all bona fide psychological therapies worked about equally well for trauma and that the particular treatment method exercised little impact on the effectiveness of psychological therapy for trauma (Benish, Imel, & Wampold, 2008; Frost, Laska, & Wampold, 2014; Gerger, Munder, & Barth, 2014; Gerger, Munder, Gemperli, et al., 2014; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010; Tran & Gregor, 2016).

At the same time, the APA Guideline largely ignored the therapy relationship, responsiveness/adaptation of therapy to the individual patient, and the person of the therapist. The Guideline, literally and figuratively, depicts disembodied therapists applying manualized interventions to discrete *ICD/DSM* disorders. Focusing on what hardly impacts psychotherapy outcome (selection of particular treatment methods) and practically ignoring what strongly determines psychotherapy outcome (relationship, responsiveness) constitutes fatal flaws, in our opinion.

Our initial excitement about psychological guidelines for psychological therapies has thus given way to disappointment and alarm. We now recommend that APA cease and desist with creation of clinical practice guidelines until (or unless) those guidelines become psychological guidelines on what actually heals and what will improve the quality of care.

### **What Heals Trauma?**

Suppose we asked a representative sample of health service psychologists to compile their most pressing questions on caring effectively for traumatized clients. We respectfully conclude that the practitioners would immediately inquire:

1. How do we cost effectively assess and diagnose various manifestations of trauma?
2. How can we best develop and maintain trusting relationships with traumatized, mistrusting clients?
3. How do we balance and manage the patient's avalanche of symptoms and disorders (comorbidity)?
4. Which particular treatment methods work best in general?
5. When clients are not progressing with one particular treatment method, when do we switch to another method and to which other methods?
6. How can we best adapt or tailor trauma methods to particular patients?
7. How do we incorporate or attend to culture in trauma work?
8. How can we protect ourselves from the ravages of compassion fatigue and vicarious traumatization in working with this population?

9. And how, on God's green earth, are we supposed to do all of this within the session limits of the insurance carrier and my agency?

The APA Guideline on trauma brings research evidence to bear on only one (number 4) of these urgent questions. A practitioner reading the document learns solely the consensus recommendations for particular treatment methods. (An accompanying APA website does catalog posttraumatic stress disorder [PTSD] assessment instruments.) No single document can address all practice needs, of course, but we doubt the wisdom and utility of the Guideline decisions.

Suppose, too, we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing, and teaching. Henry (1998) concluded that the panel would say the following:

The answer [is] obvious, and empirically validated. As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical research. (p. 128)

That is now the main thrust of 5 decades of research, research largely ignored by the APA guideline on trauma.

On both practice and research grounds, we find this APA Guideline seriously incomplete, clinically suspect, and marginally useful. Moreover, we believe that it constitutes a missed vital opportunity to inclusively identify what works in healing trauma.

### Looking in the Wrong Places

In the biomedical tradition, the APA (2017) Guideline for PTSD in adults looked vainly for differences in effectiveness among treatment methods. The guideline developers did so knowing in advance that the randomized controlled trials (RCTs) on psychotherapy for trauma and the multiple meta-analyses of those RCTs produced little evidence for any meaningful outcome differences (Benish et al., 2008; Bradley, Greene, Russ, Dutra, & Westen, 2005; Frost et al., 2014; Gerger, Munder, & Barth, 2014; Gerger, Munder, Gemperli, et al., 2014; Powers et al., 2010; Tran & Gregor, 2016), a pattern that has existed for at least 20 years (Bisson et al., 2007; Sherman, 1998; Van Etten & Taylor, 1998). APA spent a small fortune on staff time and on an external analysis looking for consistent evidence of differential efficacy of psychological treatments when they were aware (or should have been aware) that such robust differences did not exist. And the Guideline developers did so instead of aggregating practitioner-friendly guidance on what actually does make a difference. To paraphrase the American humorist Dave Barry: "We are not making this up."

Let us say it again: There are no clinically meaningful differences between the four "strongly recommended therapies" (cognitive behavioral therapy [CBT], cognitive processing therapy, cognitive therapy, prolonged exposure therapy) and the three "conditionally recommended therapies" (brief eclectic psychotherapy, eye movement desensitization and reprocessing, narrative exposure therapy). Indeed, present-centered therapy, a treatment that was designed intentionally to omit components of effective treat-

ments (viz., exposure, cognitive restructuring, and focus on trauma), has been shown to be as effective as the three "strongly recommended therapies" in a meta-analysis (Frost et al., 2014; see also Foa et al., 2018). Interpersonal therapy, a treatment without exposure, is also effective for PTSD (Markowitz et al., 2015). Finally, dismantling studies consistently show that removing an ingredient of treatments for PTSD does not attenuate effectiveness (Wampold, 2019).

If you dare, wade though Appendix C: Evidence Profiles Prepared for APA by RTI-UNC Scientists for details. The difference in recommendations resides in the number of RCTs conducted on each treatment (see Table 4 of the Guideline, for example). If numbers are good, more numbers must prove better!

We understand the decision to elevate those trauma psychotherapies that possess more studies—"strength of evidence"—to the category of strongly recommended. However, at the risk of stating the obvious, more studies do not mean more effectiveness. We find the reasoning dubious here. Practitioners seek what is effective for their patients, not what is most studied.

Facetiously, we can therefore save APA millions of dollars. Because psychotherapy RCTs overwhelmingly consist of variants of cognitive-behavioral therapies, declare them to be the most recommended and save the expense of additional Guidelines!

### Therapeutic Relationships

The APA (2017) Guideline for PTSD references relationship factors in passing, unfortunately lumping them together under the rubric of "common factors" in one place and under "Role of Patient and Therapist Factors" for two pages in another place. In an otherwise detailed, 139-page report with 12 appendixes, the therapy relationship in trauma work receives faint lip service. No reader would ever suspect from the Guideline document alone that the relationship serves as the curative foundation of effective psychotherapy for trauma.

That's the huge paradox in trauma treatment (Bloom, Yanosy, & Harrison, 2013) and the lamentable disconnect between many researchers and practitioners. The relationship is the heart of healing trauma. Relational damage is the core of trauma. Yet, we estimate that 90% of federal grants, outcome studies, treatment guidelines, and continuing education on trauma focus on particular treatment methods. No wonder that practitioners protest: What the hell!

The decision in the APA Guideline to focus on RCTs conducted on particular treatment methods derives, we believe, from a fruitless attempt to impose a biomedical model onto psychological healing. There are a dozen books and hundreds of articles devoted to the therapeutic relationship in trauma. At least 19 research studies have examined the effects of therapy relationship in the psychological treatment for traumatized adults; the vast majority found that the therapeutic alliance was predictive of or associated with a reduction in symptomatology (Ellis, Simiola, Brown, Courtois, & Cook, 2018). When one goes beyond the diagnosis-specific focus of the APA guideline, there are thousands of rigorous empirical studies on the relation of the therapeutic relationship to psychotherapy outcome.

Let us illustrate with a synopsis of meta-analytic findings on the therapy relationship and a couple of trauma-specific studies. Table 1 summarizes the meta-analytic associations between relationship components and psychotherapy outcomes from Norcross and Lam-

Table 1  
*Meta-Analytic Associations Between “Demonstrably Effective” Relationship Components and Psychotherapy Outcomes*

Relationship element	No. of studies	No. of patients	Effect size	
	( <i>k</i> )	( <i>N</i> )	<i>r</i>	<i>d</i> or <i>g</i>
Alliance in individual psychotherapy	306	30,000+	.28	.57
Alliance in child and adolescent therapy	43	3,447	.20	.40
Alliances in couple and family therapy	40	4,113	.30	.62
Collaboration	53	5,286	.29	.61
Cohesion in group therapy	55	6,055	.26	.56
Collecting and delivering client feedback	24	10,921		.14–.49 <sup>a</sup>
Empathy	82	6,138	.28	.58
Goal consensus	54	7,278	.24	.49
Positive regard and affirmation	64	3,528		.28

Note. Adapted from Norcross & Lambert, 2019.

<sup>a</sup> The effect sizes depended on the comparison group and the feedback method; feedback proved more effective with patients at risk for deterioration and less effective for all patients.

bert (2019). These associations are for those seven elements of the relationship deemed as “demonstrably effective” (Another seven elements were determined by an expert panel to be “probably effective.”)

Consider the strength or magnitude of the therapy relationship. Across thousands of individual outcome studies and hundreds of meta-analytic reviews, the typical effect size converted from correlation to the equivalent standardized difference (*d*) between psychotherapy and no psychotherapy averaged .80 to .85 (Lambert, 2010; Wampold & Imel, 2015), a large effect size. The effect size (*d*) for any single relationship factor in Table 1 ranges between .14 and .62. The alliance in individual psychotherapy, for example, demonstrates an aggregate *r* of .28, which is equivalent to a *d* of .57, with treatment outcome, making the quality of the alliance one of the strongest and most robust predictors of successful psychotherapy.

Compare these medium effect sizes for, say, strong versus weak alliance or high empathy versus low empathy to the small, non-significant effect size differences between particular treatment methods in the APA Guideline. Then one appreciates why the Interdivisional Task Force on Evidence-Based Relationships and Responsiveness concluded that “The psychotherapy relationship makes substantial and consistent contributions to patient outcome independent of the specific type of psychological treatment” and “The therapy relationship accounts for client improvement (or lack of improvement) as much as, and probably more than, the particular treatment method” (p. x). These relationship factors are robustly effective components and predictors of patient success. We need to proclaim publicly what decades of research have discovered, what hundreds of thousands of practitioners have witnessed, and what clients have experienced and benefitted from: The relationship is central to healing.

It would probably prove advantageous to both practice and science to sum the individual effect sizes in Table 1 to arrive at a total of relationship contribution to treatment outcome, but reality is not so accommodating. Neither the research studies nor the relationship elements contained in the meta-analyses are independent. Thus, the amount of variance accounted for by each element or construct cannot be added to estimate the overall contribution. In short, although the relationship elements all “work,” they work together and interdependently.

Perhaps in no other mental disorder is the inseparability of the relationship and the method in such compelling relief than in trauma. The world becomes unsafe; a human betrays fundamental trust; restless sleep morphs into nightmares; close relationships turn anxious; daily life becomes a continual threat. Do treatments cure the effects of trauma or do relationships heal traumatized people? “Both” should be our immediate crescendo and the evidence-based response.

We contend that the available evidence—best available research, clinical expertise, and patient values and culture—converge to put the relationship at the heart of trauma therapy. By contrast, the APA Guideline narrowly focused on the brand-name treatment package and marginalized the therapy relationship. We do not wish to commit the same error: The research argues for a balance of “both” interpersonal and instrumental strategies to enhance clinical care and ultimately help traumatized patients heal. The therapy relationship is not prized as instead of the acronym-plagued treatments, but as alongside and in optimal combination with them. Not as the polarizing either/or but as the both/and—just as the research evidence consistently attests.

Here’s one such example from an RCT conducted on Internet-based cognitive-behavioral therapy for PTSD (Knaevelsrud & Maercker, 2007). Ninety-six patients with PTSD received CBT via Internet over a 5-week period. From baseline to 3 months post-treatment, PTSD severity and other symptoms significantly decreased (*d* = 1.0 to 1.60). Significant improvement of the online working alliance in the course of treatment and a substantial correlation between the quality of the online relationship at the end of treatment and treatment outcome emerged. The correlations (*r*) between the alliance measure and various outcome measures were .35 to .50. Here, even in digital delivery of CBT, one facet of the therapy relationship continues to shine through. To estimate the variance accounted for therapeutic relationship on the main outcome variable, multiple regression analyses were used to explore possible mediator or suppressor effects of the patients’ ratings of the working alliance. Results revealed that the working alliance measured at the end of therapy predicted 15% of the outcome variance. Patients who had a better therapeutic relationship post-treatment benefited more from treatment. In fact, the alliance is as strong a predictor of outcome in electronically mediated treatments as it is in individual face-to-face therapy (Flückiger, Del Re, Wampold, and Horvath, 2018).

Similar results are evident for other effective elements of the therapy relationship in trauma. Consider the impact of empathy in group therapy for survivors of interpersonal trauma (Payne, Liebling-Kalifani, & Joseph, 2007). In this small uncontrolled study, patients varied widely in whether they perceived the group as providing empathy, but those who perceived that there was empathic listening benefited from the group and evidenced greater positive changes (reduced posttraumatic symptoms, increased positivity, decreased negativity). In statistical terms, the relation of empathy to outcome was an *r* of .69, an impressive effect.

Our argument is that any practice guideline in psychotherapy should faithfully follow the research and include the therapeutic relationship. This would prove an overdue correction to Guideline preoccupation with method at the expense of relationship in traumatology. We have so often confused the transcendent message—we care, we feel your pain, we are here with you, we will help you through this hellish experience—with the quotidian intervention.

### Therapist Responsiveness

The APA Guideline developers tasked the external research group conducting the meta-analyses with four “Key Questions.” One of those was, “Which treatments work best for which patients? In other words, do patient characteristics or type of trauma modify treatment effects?”

Sadly, none of the ensuing Guideline Recommendations addressed that key question. The document states,

Treatment effect heterogeneity (sub-group effects) was evaluated in the RTI-UNC Systematic Review. Its authors concluded that the research evidence was insufficient to determine treatment effect heterogeneity by many of the subgroups that were examined. Members of the current guideline development panel agreed that the randomized trials included in the review do not sufficiently address the important issue of which treatments are best for which patients and constitutes an important future research need. (2017, p. ES-7)

The authors of the APA PTSD Guideline lament the paucity of research on tailoring or adapting psychotherapy to the individual patient in the examined RCTs for adult trauma. True enough, but the authors fail to acknowledge this paucity of studies was entirely attributable to their insistence on diagnosis-specific RCTs. Had they looked more inclusively across disorders, they would have

discovered hundreds of studies on their key question, as colleagues and we did (Norcross & Wampold, 2019).

Table 2 summarizes the meta-analytic results on the efficacy of treatment adaptations (the preferred term in CBT circles) or relational responsiveness (the preferred term in psychodynamic and humanistic circles) to six patient transdiagnostic characteristics (Norcross & Wampold, 2019). The strength of the research evidence is designated in the table by the descriptor of demonstrably effective or probably effective. (Several additional patient characteristics—attachment style, gender identity, sexual orientation—were also investigated, but there was insufficient research to judge their effectiveness as a basis for adapting psychotherapy.)

There are indeed transdiagnostic features that reliably indicate which therapies work best for particular patients. Practitioners will find that fitting the therapy to the client’s racial/ethnic culture, religious/spiritual identity, and therapy preferences will demonstrably improve treatment outcomes, and doing so to clients’ coping style, reactance level, and stages of change will probably do so as well.

In Table 2, the meta-analyses employed the weighted *d* or *g*, standardized mean differences between two treatments or conditions; in this case, the difference between the conventional or unadapted therapy and the adapted or matched therapy. In all of these analyses, the larger the value of *d*, the higher the effectiveness of the specific adaptation or tailoring. As a reminder, a *d* of .20 in the behavioral sciences is generally considered a small effect, .50 a medium effect, and .80 a large effect (Cohen, 1988).

The meta-analytic effect sizes in that table range from 0.13 to 0.60 and average about 0.50 (indicating a medium effect). Compare those numbers to the 0.0 to 0.20 average effect sizes for the differential efficacy of one bona fide psychotherapy over another for trauma (Benish et al., 2008; Frost et al., 2014; Gerger, Munder, & Barth, 2014; Gerger, Munder, Gemperli, et al., 2014; Powers et al., 2010; Tran & Gregor, 2016). That’s why the recent Task Force confidently concluded, “Adapting psychological treatment (or responsiveness) to transdiagnostic client characteristics contributes to successful outcomes at least as much as, and probably more than, adapting treatment to the client’s diagnosis” (Norcross & Wampold, 2019, p. 1896).

The meta-analytic findings on adapting psychotherapy to patient race/ethnicity, preferences, and religion/spirituality are particularly

Table 2  
*Meta-Analytic Results on the Efficacy of Treatment Adaptations/Relational Responsiveness to Patient Transdiagnostic Characteristics*

Patient characteristic	No. of studies ( <i>k</i> )	No. of patients ( <i>N</i> )	Effect size <i>d</i> or <i>g</i>	Consensus on evidentiary strength
Coping style	18	1,947	.60	Probably effective
Culture (race/ethnicity)	99	13,813	.50	Demonstrably effective
Therapy preferences	51	16,269	.28	Demonstrably effective
Reactance level	13	1,208	.78	Probably effective
Religion and spirituality	97	7,181	.13–.43	Demonstrably effective
Stages of change	76	21,424	.41 <sup>a</sup>	Probably effective

Note. Adapted from Norcross & Wampold, 2019.

<sup>a</sup> Represents correlation between pretreatment stages of change and psychotherapy outcome; patients further along the stages experience better treatment outcomes.

impressive. For cultural identity, the researchers analyzed 99 studies involving 13,813 patients. The mean effect size of .50 in favor of clients receiving culturally adapted treatments demonstrates that “cultural fit” works. Likewise, religious/spiritual-adapted psychotherapy resulted in greater improvement in clients’ psychological ( $g = 0.33$ ) and spiritual ( $g = 0.43$ ) functioning compared with nonadapted psychotherapies. In more rigorous additive studies, accommodated religious psychotherapies were equally effective to standard approaches in reducing psychological distress ( $g = 0.13$ ), but resulted in greater spiritual well-being ( $g = 0.34$ ).

Effect size numbers capture and convey limited information. The small-to-medium effect size (0.28) of accommodating psychotherapy to patient preferences proves a case in point. In 28 studies, clients not receiving preferences were almost twice as likely to drop out (odds ratio = 1.79). That constitutes an important impact clinically.

Unlike the elements of the psychotherapy relationship summarized in Table 1, these treatment adaptations enjoy evidence of direct causal impact. The adaptation methods are smaller in number but more powerful in demonstrating causation. The meta-analyses included largely randomized or quasi-randomized controlled trials, in contrast to the largely correlational research designs in the therapy relationship.

Table 2 presents the treatment adaptations/responsiveness methods here as separate, stand-alone practices, but every seasoned psychotherapist knows this is certainly never the case in clinical work. The variance in outcomes for psychotherapy patients is not easily partitionable into independent contributions of treatments, relationships, therapists, and patients (Krause & Lutz, 2009). These adaptations never act in isolation from the psychotherapy relationship, such as empathy, collaboration, or support. Nor does it seem clinically possible to adapt psychotherapy in meaningful ways to the distinctive client and not routinely ascertain her feedback on the therapeutic process. All treatment adaptations probably interconnect—if only in spirit and intent—and prove symbiotic. The design and analysis of psychotherapy outcome studies need to be improved if we are to learn who successfully treats whom and how (Baldwin & Imel, 2013; Krause & Lutz, 2009).

Amid the torrent of meta-analyses, let us not lose our overarching message: The meta-analyses establish that responsiveness works. As Sir William Osler (1906), father of modern medicine, wrote, “It is much more important to know what sort of a patient has a disease than what sort of disease a patient has.” Take a mindful moment to consider the direct practice implications: Adapting therapy to the entire person improves success and decreases dropouts; the power of responsiveness exceeds that associated with Treatment Method A for Disorder Z; this represents not clinical lore but established fact.

In the interminable debate on which psychotherapy works best, we are convinced that the dispassionate, evidence-based answer is “It depends.” It depends in particular on the patient, including diagnostic features but more importantly transdiagnostic features. And it probably depends more upon the relationship and responsiveness than a particular therapy method.

Put another way, we endorse Jerome Frank’s conclusion, in his classic *Persuasion and Healing* (Frank & Frank, 1993):

My position is not that technique is irrelevant to outcome. Rather, I maintain that . . . the success of all techniques depends on the patient’s sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient’s personal characteristics and view of the problem. (p. xv)

Finally, we implore colleagues to imagine the predictable consequences of continued insistence on diagnosis-specific RCTs to determine what works in psychotherapy. Estimate conservatively 50 brand-name therapies subjected to RCTs. Estimate conservatively 25 major mental disorders. Estimate conservatively at least 50 facets of psychotherapy process and outcome: relationship components, adaptation methods, patient features, treatment methods, therapist characteristics, practice parameters. Then multiply to approximate the number of 10 RCTs on each possible permutation needed to compile disorder-specific conclusions, as currently envisioned by the APA Clinical Practice Guidelines. We are not the first to issue the warning of the endless hall of mirrors of this strategy for Guideline development. We would collegially remind readers that this approach fallaciously assumes that there are meaningful outcome differences across particular treatment methods.

### Therapist Effects

It is now well established that some psychotherapists consistently achieve better outcomes with their patients than other therapists (Baldwin & Imel, 2013; Johns, Barkham, Kellet, & Saxon, 2019; King, Orr, Poulsen, Giacomantonio, & Haden, 2017; Wampold & Imel, 2015). That includes clinical trials, where adherence to a treatment protocol is required, as well as routine practice settings, although the effect for the former is smaller (Baldwin & Imel, 2013; Wampold & Imel, 2015). These therapist effects are manifest within treatments, indicating that some therapists administering a particular treatment (for instance, one of the treatments identified by the APA guidelines) will achieve better outcomes than others. This finding suggests that the therapist conducting the treatment is probably more important than the treatment being delivered, a fact ignored by the APA guideline. Indeed, it appears that the differences in effectiveness among therapists are due to their relationship skills (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016; Anderson, McClintock, Himawan, Song, & Patterson, 2016; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Wampold, Baldwin, Holtforth, & Imel, 2017), providing evidence (again) for the centrality of relationship factors.

Consider the results of a study (Laska, Smith, Wislocki, Minami, & Wampold, 2013) examining therapist effects in cognitive-processing therapy (CPT), one of the treatments strongly recommended by the APA guideline, in a Veterans Affairs PTSD specialty clinic. All therapists were trained by one of two national CPT trainers and supervised by one of the trainers. Patients completing at least 12 sessions of CPT took the PTSD Checklist (PCL) at the beginning of treatment and at the end of treatment. Results showed that 12% of the variability in PCL scores at the end of treatment, taking into account pretreatment PCL scores, was due to the therapist. This is quite remarkable, given that at most 2% of the variability in outcomes is due to differences among treatment methods. Here is another convincing example that the effectiveness of PTSD treatment is due largely to who provides it, even

when the therapists are delivering a first-line, manualized treatment under rigorous training and intensive supervision. Among the skills of the more effective therapists, according to the supervisor, were “flexible interpersonal style, and ability to develop a strong therapeutic alliance” (Laska et al., 2013, p. 31).

### The Model Matters

The biomedical model has enhanced tremendously the health and longevity of the population. The model’s reliance on RCTs comparing medications for specific disease states has resulted in impressive medical successes across the world. Make no mistake: We value the biomedical model in the right domains, and we have personally profited from it in our own health histories.

The APA (2017, p. i) Guideline for PTSD explicitly states that it “used methods recommended by the Institute of Medicine report, *Clinical Practice Guidelines We Can Trust* (IOM, 2011).” Again, later (2017, p. ES-4): “It fully follows and builds upon the standards set forth by the Institute of Medicine (IOM) (now the National Academy of Medicine) of the National Academies of Sciences, Engineering, and Medicine standards for developing high-quality, independent, and reliable practice guidelines (IOM, 2011a & 2011b).”

The APA decision to validate and recommend only treatment methods or technical interventions, as opposed to the therapy relationship or responsiveness, is not preordained or inevitable. The largest psychological association in the world can decide to proceed with its own strategy commensurate with its own research evidence and professional values. The APA decision both reflects and reinforces the ongoing biomedical movement toward high-quality comparative effectiveness research on brand-name treatments.

Yet, that biomedical model is not strongly supported by decades of careful research on psychotherapy (Wampold & Imel, 2015) and not for the psychological treatment of trauma (Wampold et al., 2010). For PTSD and most mental disorders, there are no clinically meaningful outcome differences among the recommended treatment methods; the particular treatment method does not constitute the most active ingredient of patient success in psychotherapy; the therapeutic relationship, therapist responsiveness, individual therapist effects, and an active patient assume the lion’s share of outcome variance. A distinctively psychological or contextual model best explains psychotherapy research and the treatment of trauma. That model includes treatment methods to be sure, but does not privilege them as the exclusive or main source of healing.

What the APA Guideline on PTSD did, they did well. But the numerous methodological decisions in commissioning and crafting the Guideline are masked in quasi-objective language of “best practices” and “industry standard.” There is no honest acknowledgment that those decisions favor brand-name treatments, that reliance on controlled research privilege some studies over others, and that the alleged best practices “we can trust” relate to a biomedical model, not a psychological or contextual model.

### Moving Forward

Our charge in this invited article was to review the research corpus and advance the evidence-based case for the therapeutic relationship and therapist responsiveness in the effective care of clients suffering from trauma, with particular attention to the

APA’s (2017) Clinical Practice Guideline on Posttraumatic Stress Disorder in Adults. To complement our critique of that guideline document, we conclude with suggestions for improving the process and product of future APA clinical practice guidelines, which we reiterate, we support in principle and in aspiration.

- ◆ *Temporarily suspend development of APA clinical practice guidelines.* They provide at present empirically limited and potentially misleading recommendations for improving care. Stop squandering important opportunities (and funds) on dubious reports about what is already known on particular treatment methods from existing meta-analyses.
- ◆ *Attend seriously to the concerns of psychological practitioners of all persuasions, not the purported best practices of biomedical standards.* Serious attention constitutes more than CBT-committed Steering Committee and guideline development panel writing articles defending current practices. Serious attention means questioning current procedures, revising methodological decisions, and recrafting plans. When more than 55,000 psychologists and graduate students sign a petition *Protect PTSD Treatments that Work!* ([www.thepetitionsite.com/480/492/776/protect-ptsd-treatments-that-work/](http://www.thepetitionsite.com/480/492/776/protect-ptsd-treatments-that-work/)); by the Alliance for the Inclusive Integration of Science and Practice in Psychology), APA comes off as rigid, unresponsive, and stacking the cards in favor of certain therapies. This protest hails from a largely disengaged membership: Only 7% to 10% of the membership of late voted in recent APA presidential elections and by-laws change (Garnett Coad, personal communication).
- ◆ *Capitalize on distinctively psychological, contextual, evidence-based care.* That aim begins with reorienting away from reliance on the biomedical model of particular treatment methods for particular disorders. Guidelines need not be disorder specific, nor method specific. Guidelines can indeed rely on effectiveness studies and more than symptom reduction. In preparing new guidelines, follow the extant evidence on what works—patient contributions, therapy relationships, therapist responsiveness, among others. Of course, include treatment methods but not only them. Address practitioners’ urgent questions, not researchers’ funding priorities.
- ◆ *Follow APA’s own policy on evidence-based practice.* “Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006). Even the most charitable analysis of APA’s clinical practice guidelines will find them seriously deficient in attending to two of the three necessary pillars of EBP: clinical expertise; and patient characteristics, culture, and preferences. Let’s practice our own policies.
- ◆ *Realize that the most studied therapy is not the most effective therapy.* Cognitive-behavioral therapies are obviously the most frequently studied treatments in RCTs for both youth and adult patients. Identifying them as “first line” or “strongly recommended” therapies because they are the most studied is not compelling. The most effective therapies are just that: consistent superiority in therapy engagement, com-

pletion, outcomes, satisfaction, and/or maintenance across studies and investigators in dispassionate research not contaminated by theoretical allegiance.

- ◆ *Leverage existing meta-analyses instead of commissioning expensive reports on what is already known.* Instead of farming out meta-analyses to external agencies, the guideline development panels can bring together researchers, practitioners, and clients to review published meta-analytic findings on the guideline topic. Place those meta-analytic findings in the public domain. Allow multiple researchers of diverse theoretical orientations to analyze the data and investigate potential moderators and mediators. That would promote public transparency, psychologist access, and an open process. Plus, it would save APA millions of dollars.
- ◆ *Embrace methodological and theoretical diversity.* The self-characterized “best practices” in the current clinical practice guidelines represent only one incomplete “scientific” direction. It is hubris (and antiscientific) to proclaim that the current procedures are the “best.” We easily envision several alternative, equally scientific decisions for future APA clinical practice guidelines: different foci of the meta-analyses, different rules for which studies to analyze, different priorities in outcome targets, and so on. In the same way that APA has impressively secured theoretical diversity among its Advisory Steering Committee and its GDPs, APA can diversify its Guideline decisions so that it does not marginalize some psychotherapies while privileging others. No inclusion criteria, no methodological decisions, no guideline foci are without cavil and tradeoffs, of course. We applaud the APA guideline for its detailed and transparent identification of its decision rules (although we obviously disagree with several of them). What is needed is honest recognition that those decisions are invariably embedded within sociopolitical and theoretical contexts (see [Orlinsky, 1989](#)). In this regard, it should prove unsurprising that treatment guidelines around the world are not consistent ([Morian, Gálvez-Lara, & Corpas, 2017](#)), although the research evidence is the same. The reality is that guidelines are produced within a political, not only scientific, context.
- ◆ *Hold psychotherapists accountable for outcomes rather than mandate particular treatment methods.* APA Presidential Task Force on Evidence-Based Practice (2006) stated that “monitoring patient progress and adjusting practices accordingly” (p. 276) is a critical component of evidence-based practice in psychology. In one sense, therapists should be allowed to provide any legitimate therapy they choose, provided they achieve outcomes that meet reasonable benchmarks ([Wampold & Imel, 2015](#)). It may well be that a particular therapist delivers one of the treatments recommended in the APA guideline but does not achieve adequate outcomes, whereas another therapist conducts a treatment not mentioned in the APA guideline and achieves commendable outcomes with his or her clients.
- ◆ *In all things, integrate.* Mature disciplines have learned to integrate research and practice, the instrumental and the interpersonal ([Goldfried, 2018](#)). We can avoid and transcend the culture wars in psychotherapy that dramatically pit the treatment method against the therapy relationship. Do treatment methods cure disorders or do relationships heal people?

Does following the manualized intervention (fidelity) or does adapting the therapy to the patient (flexibility) work best? As every half-conscious psychologist has learned, the obvious answers to all such complex questions are “both” and “let’s use all that work.”

We conclude with an admixture of concern and hope. Concern that APA has unwisely followed the biomedical model—RCTs on particular treatments for specific disorders—rather than a quintessential psychological model involving relationships and responsiveness in constructing their guidelines. Concern that early opportunities have been squandered and that an expensive document has provided so little new or useful practice direction. Concern that APA as an organization appears unresponsive to revising its plans for guidelines. Hope because APA has committed to developing guidelines for psychological therapies. Hope that science—and some organizations—can self-correct. Hope because we have much in psychotherapy to celebrate, disseminate, and implement, when we look in the right places for what actually works. Finally, hope that in every Greek tragedy, there are lessons to be harvested and noble quests to pursue anew. Perhaps our personal fatal flaw is naive optimism, but we believe the Greek tragedy of the current APA clinical practice guidelines can still produce a happy ending.

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