EVIDENCE-BASED PRACTICE FORUM

Client-Centered Practice, Therapeutic Relationship, and the Use of Research Evidence

Linda Tickle-Degnen

This article offers suggestions for using research evidence in the daily practice of client-centered occupational therapy. Although others have shown that evidence-based practice and client-centered practice are congruent with and complementary to each other for clinical decision making (e.g., Egan, Dubouloz, von Zweck, & Vallerand, 1998; Law, Baum, & Dunn, 2001), no one to the best of my knowledge has combined them by way of a model of effective interpersonal relationship. Such a model can offer useful guidance for when and how to use research evidence in daily practice.

A particular type of interpersonal relationship is central to the definition of client-centered occupational therapy. Law, Baptiste, and Mills (1995) described client-centered occupational therapy as “an approach to service which embraces a philosophy of respect for, and partnership with, people receiving services” (p. 253). This approach is close kin to the therapeutic alliance described in psychotherapy (Gelso & Carter, 1985; Luborsky, 1994) and other health interventions, including rehabilitation (Prigatano et al., 1994). The therapeutic alliance involves the formation of at least two general types of relationship bonding: rapport and the working alliance.1 Rapport is formed as individuals grow to like one another and experience the other as genuinely warm, respectful, and understanding (Rogers, 1957). The working alliance is formed as individuals collaborate with one another to develop common goals and as they develop a sense of shared responsibility for working on tasks that are involved in achieving those goals (Bordin, 1979).

Elizabeth Gavett and I (Tickle-Degnen & Gavett, in press) recently reviewed two bodies of literature about relationship—one on therapeutic relationship and one on the formation of close intimate relationships—and found that interpersonal relationships of different forms, including that of client-centered occupational therapy, could be conceptualized as involving the development and maintenance of rapport and the working alliance.

This article attempts to answer the following question: How can research evidence be used over the course of a therapeutic relationship in a manner that contributes to the formation and maintenance of rapport and the working alliance? Because interpersonal communication is a primary means by which therapists and clients bond to one another (Crepeau, 1991; Mattingly & Fleming, 1994), my suggestions for the use of evidence during therapy are based on functions of communication that emerge and change over an effective therapeutic relationship.

A Model of Communication Functions and Relationship Development

In her review of research on client-centered practice, Law (1998) demonstrated that respect and collaboration elements of the therapeutic relationship were important predictors of rehabilitation outcome. Research findings consistently show that the critical development of the two types of bonding is achieved within the first few sessions of therapy and that ultimate therapy outcomes can be predicted from the quality of this initial bonding (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). It is generally agreed that the development of rapport is a prerequisite for the development of a working alliance (Gelso & Carter, 1985; Horvath & Luborsky, 1993) and that bonding must be maintained through difficult changes and challenges that the client faces together with the therapist. A review of the research and theoretical literature on relationships suggests that different communication functions appear to signal and support bonding at each of three overlapping periods in the relationship (Tickle-Degnen & Gavett, in press): (a) the development of rapport, (b) the development of the working alliance,

1The terms rapport, working alliance, and therapeutic alliance have been used in many different and overlapping ways in the therapeutic literature (Horvath & Luborsky, 1993), with various terms applied to the same construct (e.g., rapport also is called the liking bond). For this article, I have defined the terms rapport and working alliance as the lower-level constructs representing two types of bonding involved in a higher, more general construct: the therapeutic alliance or client-centered occupational therapy. I am not including in this conceptualization bonding elements related to the psychodynamic construct of transference, although this may be an important bonding element in client-centered occupational therapy.
and (c) the maintenance of a working relationship until goal achievement. These periods, the communication functions underlying bonding within each period, and the integration of research evidence into communication at each period are described in the following sections.

**First Period: The Development of Rapport**

Three communication functions are central to the early establishment of rapport: gathering information about one another, displaying cooperative intent and friendliness, and regulating and influencing interpersonal involvement. According to a biological evolutionary perspective, these functions originate in adaptive actions that enhance survival (Burgoon, Stern, & Dillman, 1995; Darwin, 1872/1965; Papousek & Papousek, 1997). Suggestions for how to use research evidence in relation to each communication function follow.

**Gathering information.** The therapist can use assessment research evidence to select the most appropriate, valid, and reliable methods for gathering information about the client. In client-centered occupational therapy, selection would focus on methods that include strong measures of client preferences, personal goals, and valued occupations. The therapist also may seek descriptive evidence that provides information about the lives, needs, and occupations of other clients with characteristics like this client. The therapist can use this type of evidence to stimulate discussion about how the client’s needs and concerns are similar or dissimilar to those of other individuals. Such a discussion demonstrates that the therapist recognizes the unique needs of the client while also recognizing that knowledge about the lives and experiences of others may expand and enrich the discussion about the client’s own needs and concerns.

Rapport is a two-way street, so both therapist and client must gather information about the other. The client needs to know information about the expertise and friendliness of the therapist, about what occupational therapy is, and about expected outcomes of involvement in occupational therapy. In response, the therapist could discuss intervention effectiveness evidence in the form of quality assurance or program evaluation findings from studies conducted on site and the results of general occupational therapy effectiveness studies and research syntheses (e.g., meta-analyses) published in the literature. The therapist need not gather new intervention effectiveness information to discuss with the client as long as the therapist and colleagues keep an accessible, up-to-date file system of general occupational therapy information and outcomes.

**Cooperative intent.** Within the first few sessions of therapy, the therapist can show cooperative intent by responding favorably and respectfully to the client’s preferences, knowledge, and capabilities. The manner in which evidence is used rather than the content of that evidence is most important in displaying cooperative intent. For example, the therapist and client can schedule into their sessions a regular time for information sharing and decision making. For example, during one of these scheduled times, the client might say, “I’ve heard that treatment X works for my problem.” The therapist can listen respectfully and, if possible, engage the client in a mutual search for valid evidence about treatment X through either the therapist’s files or the Internet, if the therapist has strong searching skills and computer Internet services are available.

The therapist likely will note the degree to which the client has a collaborative, cooperative intent, using this recognition explicitly to develop an approach to the client that will enhance interest in taking a collaborative stance. Early in the relationship, a mutual understanding should be reached that the relationship is not about the imposition of the will of one individual upon the will of the other but, rather, a mutual search for and discussion about information that will aid informed, wise decision making.

**Regulating involvement.** The therapist and client respond implicitly without awareness to a great deal of the other’s communication acts (Burgoon et al., 1995; Hatfield, Cacioppo, & Rapson, 1994). One method for obtaining control over implicit processes is to focus attention on processes that are accessible to consciousness, noting when they arise and what they may mean. For example, the therapist can pay attention to how the client responds to conversations about research evidence and to using it to make decisions. Does the client appear to need more or less abstraction, quantification, or precision in the content of communication about research? The intent of evidence-based occupational therapy is not to educate the client in the language and concepts of research but to enable the client to make wise decisions about factors that will affect his or her quality of life. Therefore, the therapist must modulate the content and timing of communication about research evidence in order to maximize the client’s potential for continued involvement in a relationship centered around collaborative and informed decision making. Pictures; graphs; and brief, simple, and nonquantitative explanations may be used, depending on the client’s preferred learning style (Redman, 1997).

**The Second Period: The Development of the Working Alliance**

After first encounters, individuals have the beginnings of a shared history, a sense of their ability to cooperate with one another, and their willingness to continue involvement in the emerging relationship. Their focus on the tasks and goals of therapy intensify over the next few encounters while their rapport continues to develop. The communication functions in this second period are the following: selecting and learning the tasks of therapy, responding to task success and failure, and developing a working relational culture. Suggestions about how to incorporate the use of research evidence into these emerging communication functions follow.

**Tasks of therapy.** The therapist and client must make informed decisions about what therapeutic tasks will be most useful for obtaining the client’s goals. Together or separately they could search for research evidence about tasks—either descriptive research about occupational tasks within the client’s population or task effectiveness research about obtaining goals similar to those of the client. Then they could discuss the quality of the evidence and whether the tasks they have discussed would be most appropriate for meeting client needs and goals. The tasks should be ones that evi-
dence suggests are appropriate and effective for the client’s population in terms of age, gender, and diagnosis while simultaneously being ones that can be carried out in the current context of care (e.g., clinic, home, community). All discussions involving research evidence should be predicated on the understanding that research evidence about humans is based on variations within and across individuals and, consequently, offers probabilistic rather than deterministic solutions. The therapist and client can use their prescheduled decision-making time to discuss various options and arrive at a plan that is mutually agreeable.

Responding to success and failure. Evidence-based practice involves the use of systematic procedures for documenting the effectiveness of therapy with clients (Tickle-Degnen, 2000). The therapist and client can work together to create a recording plan that shows whether a therapeutic task is failing or succeeding in meeting the client’s goals. Part of the recording plan also can document whether the goals are being met in a fashion that is maintaining the client’s satisfaction and mental health. Evidence of both an autobiographical (Puller, 1991) and a research nature (Darragh, Sample, & Krieger, 2001) shows that some occupational therapy clients find it extremely frustrating to confront their inabilities as they attempt what they consider to be minor activities of daily living, such as buttoning or toileting. These findings imply that occupational therapists should incorporate client satisfaction and frustration ratings into their daily outcome records. If able, the client can keep his or her own progress record (e.g., Smits & Smits-Boone, 2000).

Developing a working relational culture. As the therapist and client continue together to create the tasks of therapy in pursuit of mutually agreed-on goals, they begin to develop a working relational culture (Wood, 1982). Montgomery (1994) described how partners in close relationships “work out more and more ways of relating that are particularly effective for them and them alone” (p. 73). This relational culture defines what is to be expected in this particular relationship in terms of future communication processes, tasks, and ways of managing change. In client-centered occupational therapy, the use of and communication about research evidence can become an element of this relational culture. The therapist and client would begin to incorporate research methods and evidence implicitly into their decision making.

The Third Period: The Ongoing Working Relationship

The hard work of therapy begins after a working bond exists. Recent advances have been made in the understanding of the dynamic nature of stability in close relationships, and emerging evidence in therapeutic relationships clarify how relationships are sustained (Tickle-Degnen & Gavett, in press). Cyclical fluctuations appear to occur in relationships in response to individuals’ dialectical needs to have intimate disclosure, affiliation, and collaboration on the one hand and privacy, solitude, and autonomy on the other (Baxter & Montgomery, 1997; VanLeer, 1991). Other origins of fluctuation occur as individuals face the emotional challenges of sustaining interpersonal relationship. People get angry, frustrated, and feel misunderstood, and evidence suggests that they express negativity more freely once bonding is somewhat stable (Tracey, 1993), with some forms of negativity more damaging to the bond than others (Gottman, 1994). The challenges and changes happening in therapy during this period enhance the probability of “errors” during interaction that threaten the continuation of the relationship while providing opportunities for growth and skill development (Safran, Crocker, McMain, & Murray, 1990). The communication functions during this period involve regulating fluctuations in the relational bonds through the exchange of information, emotions, and interpersonal influence and adaptation processes. Suggestions for using research evidence during this period follow.

Regulation through exchange of information. It is important during this period to continue the therapist and client’s scheduled information-sharing times. This period requires mutual sensitivity and responsibility to each other and vigorous attention to cues that new tasks or revised goals are needed. The therapist and client may want to search for new research evidence that has come out since their initial assessment and intervention planning stage and revise accordingly.

Regulation through emotion. The therapist and client must deal with threats to the bond as they emerge. Effective methods to “repair” interactive “errors” that threaten relationship bonds are renewed attention toward each other (Tronick, 1990), the use of humor, and appropriate apologies and genuine attempts to reverse any downward spiral of anger and blame (Gottman, 1994). During this period, the therapist and client may want to use evidence about the effectiveness of therapeutic humor and other methods for dealing with emotionally challenging events. For example, the therapist and client could incorporate tested humor techniques during intervention sessions when frustration is overwhelming. Numerous possibilities relate to managing challenge, and many might be seen as somehow peripheral to “real” occupational therapy but, nonetheless, are central to maintaining rapport and the working alliance.
relationship and progress over time is an emerging field that is supported by recent developments in time-series methods (Warner, 1998).

Conclusion
The partnership of client-centered occupational therapy requires an ongoing communication process that involves the exchange of information. This information is selected and used to help choose therapeutic tasks and goals, to regulate emotion and bond fluctuations that emerge in response to challenging therapeutic tasks, and to support flexible adaptation by therapist and client to the evolving responses and goals of the client during therapy. The therapist and client can use research evidence to enhance the development and maintenance of rapport and the working alliance. The suggestions that I have offered represent ideal conditions for using research in the therapeutic relationship, but some elements of these suggestions may not fit easily into current clinical contexts. Nonetheless, current contexts are adaptable to some degree, and aspects of these suggestions could be implemented easily. The therapist can exercise his or her own creativity in using research evidence, keeping in mind that the targeted outcome of this use is wisely conceived action that sustains the involvement of therapist and client through to goal achievement. If used in the manner and spirit discussed here, research evidence enhances humane, individualized, and client-centered practice. ▲

References

