THE THERAPEUTIC ALLIANCE: PREDICTING OUTCOME, DETERMINING PRETREATMENT CORRELATES, AND ASSESSING A FEEDBACK INTERVENTION

by

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ABSTRACT

The Therapeutic Alliance: Predicting Outcome, Determining Pretreatment Correlates, and Assessing a Feedback Intervention

The therapeutic alliance has been accepted as a central component of the psychotherapeutic process. Numerous studies have been conducted on theories, measurement issues, and correlates of the alliance, however, researchers only recently have started to acknowledge the possibility of improving the initial development of the alliance. The present studies investigated three facets of the alliance, using it to predict outcome, examining its pretreatment predictors, and using inferential feedback in a pilot study to enhance its development. Results showed that the alliance significantly predicted outcome as measured by level of client distress, experience of overall symptoms, and unusual thinking. Client intake relationship impairment and racial match significantly predicted the quality of the alliance. Finally, there was no statistical support provided for the efficacy of the inferential feedback intervention conducted in the pilot study. Suggestions are made for improvements to the feedback intervention. In addition, directions for future research on the therapeutic alliance are discussed.

Preface

The therapeutic alliance has been accepted as a central component of the psychotherapeutic process. Numerous aspects of the alliance have been examined. The most frequently studied relationship is the one that exists between alliance and outcome. Research has consistently shown that alliance is a moderate yet reliable predictor of outcome. Less frequently studied are pretreatment variables that predict the alliance. Research that has examined pretreatment predictors has been mixed. The most support has been provided for client interpersonal variables in predicting the alliance. Even fewer studies have examined ways in which to improve the therapeutic alliance. Researchers have examined ways in which to repair a damaged alliance, however, no studies have been conducted on improving the early alliance. Studies have shown that the use of feedback aids in repairing ruptured alliances and improving outcomes. Currently no studies have examined the effects of feedback on the initial development of the therapeutic alliance. The present studies investigated three facets of the alliance, using it to predict outcome, examining its pretreatment predictors, and using inferential feedback in a pilot study to enhance its development. The knowledge obtained from this investigation can be used to increase clinicians' and researchers' knowledge about the therapeutic alliance to ultimately improve the practice of psychotherapy.

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CHAPTER 1

Introduction

Although clinicians and researchers have acknowledged the central role of the relationship between a client and his or her therapist in the process of psychotherapy (e.g., Geslo & Carter, 1985; Greenberg & Pinsoff, 1986; Horvath, 1994; Rogers, 1957), little research has been conducted on ways to improve that relationship. The present manuscript contains two studies. The first examines the relationship between the therapeutic alliance and psychotherapeutic outcomes and investigates pretreatment correlates of the therapeutic alliance. The second study is a pilot study that examines a brief intervention utilizing inferential feedback as a potential means of improving the therapeutic alliance.

The following literature review discusses the therapeutic alliance and feedback. First, the therapeutic alliance is reviewed. Specifically, various definitions and measurement issues are presented. Also, the relationship between the therapeutic alliance and psychotherapeutic outcomes is reviewed. Then, pretreatment correlates of the therapeutic alliance are discussed. The second topic reviewed is feedback. Within this section, a definition of feedback is presented along with various types and functions of feedback. Also, variables related to the presentation of feedback are discussed. Lastly, research conducted using feedback within the context of psychotherapy is presented. The literature review concludes with an overview of the two studies.

The Therapeutic Alliance

This section discusses the therapeutic alliance including its definitions, issues in measurement, relationship to psychotherapeutic outcomes, and pretreatment correlates.

First, an historical account of the various definitions of the alliance is presented, which concludes with the current definitions. Then, numerous measurement issues are discussed including when to measure the alliance, different perspectives for measurement, and the types of measures that have been developed. The subsequent section reviews the relationship between the therapeutic alliance and psychotherapeutic outcomes. Lastly, research examining pretreatment correlates of the therapeutic alliance is presented.

Therapeutic Alliance Definition

There is general consensus that the therapeutic alliance represents the collaborative relationship that develops between a client and his or her therapist (Bordin, 1976; Horvath & Greenberg, 1989; Marmar, Weiss, & Gaston, 1989; Strupp & Hadley, 1979). Several theoretical formulations of the therapeutic alliance have been proposed.

Historical views. Freud was one of the first to comment explicitly on the importance and impact of the relationship between the therapist and the client (Freud, 1912/1958, 1913/1966). He identified three aspects of the therapeutic relationship, the last of which was labeled as the therapeutic alliance (Freud, 1913/1966). The first aspect of the relationship was transference, or the client's unconscious identification of the therapist with significant figures from his or her past. The second aspect was labeled countertransference, which was defined as the therapist's unconscious linking of the client with significant figures or unresolved conflicts from the past. The third and final aspect was the client's friendly and positive linking of the therapist with benevolent persons from the past, which was subsequently referred to as the therapeutic alliance.

Freud's psychodynamic conceptualization was dominant until Rogers (1951) introduced a different point of view. He interpreted the ideal therapeutic relationship as an existential encounter rather than simply a meeting between a therapist and a client. As such, he identified three therapist qualities that make this healing relationship possible: empathy, genuineness, and unconditional positive regard. Rogers claimed that a relationship with a therapist who was able to offer these facilitative conditions was both a necessary and sufficient cause for activating the innate health and growth potential of every client.

Some psychologists (e.g., Heppner, Rosenberg, & Hedgespeth, 1992; LaCrosse, 1980; Strong, 1968) noted that Rogers' conceptualization dealt exclusively with the therapist's contribution to the relationship. They challenged this notion by proposing the social influence theory of the therapeutic alliance, which made the client's attributions about the therapist central to the success of therapy. Specifically, clients' perceptions of therapist expertness, trustworthiness, and attractiveness were emphasized. The theoretical assumption was that the degree to which a client believed that the therapist possessed these socially valued qualities determined the therapist's power to influence the client's thinking, feeling, and behavior, thus promoting therapeutic change.

A transitional period. In contrast to models that emphasized the therapeutic value of the relationship between the therapist and the client, early classical behaviorists (e.g., Skinner, 1985) challenged the notion that interpersonal aspects of therapy played an important role in behavioral change. Skinner, who emphasized the relationship between the person's behavior and its environmental consequences, viewed successful therapy as a learning process in which the quality of the therapist's interventions influenced

outcome rather than the relationship between the participants. This debate between the behavioral and non-behavioral perspectives of therapy was of focus in the early 1950s. Fueling this debate, Eysenck (1952) published an article that questioned the efficacy of non-behavioral therapies. Eysenck and other behavioral therapists were highly critical of the quality of therapy research generated outside the behavioral framework. They argued that if psychotherapy (non-behavioral therapy) was to earn the respect of the public and the scientific community, it must be able to demonstrate its efficacy using empirically sound methodology similar to other sciences.

These criticisms led researchers outside of the behavioral framework to use improved research designs and evaluate data with increased statistical sophistication. As a result, by the late 1970s it was possible to summarize the results of hundreds of studies across a variety of treatment modalities and client problems (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977). One major finding of this new approach was that although most therapies were beneficial, there did not appear to be obvious differences in terms of outcome among treatments based on broadly diverse theories. This observation led to the conclusion that there was a common feature across different treatments. This common feature, the therapeutic alliance, was thought to be responsible for a significant portion of the beneficial results of therapy.

Consequently, numerous questions arose about the therapeutic alliance. As such, there grew a need for a broadly based, generic formulation of the therapeutic relationship (Bordin, 1975). In contrast with both the client-centered focus on the therapist's qualities and the social influence theorists' emphasis on the client as the arbitrator of these qualities, the new formulation of the alliance focused on the collaborative and interactive

elements in the relationship. Researchers such as Luborsky (1976) and Bordin (1975, 1979, 1980, 1989, 1994) argued that the alliance, viewed as a positive, reality-based component of the therapeutic relationship, was ubiquitous and universal in all successful helping endeavors.

Luborsky's conceptualization. Luborsky's (1976) conceptualization of the alliance was similar to the original psychodynamic conceptualization (Freud, 1912/1958, 1913/1966) in that he viewed the alliance as that which binds the client to the therapist. He noted that the therapeutic alliance is not therapeutic in itself. He posited two basic components of the alliance, labeling them "Type 1 alliance" and "Type 2 alliance." Type 1 alliance reflects the client's experience of being nurtured by the therapist. Type 2 alliance is based on a sense of the client and the therapist working together against what is distressing to the client. Empirically, Luborsky's conceptualization was not as applicable to other types of therapy as was originally hypothesized because it was developed from a large-scale investigation of psychodynamic therapies only.

Bordin's conceptualization. The only empirically supported, transtheoretical model of the therapeutic alliance to date (Raue & Goldfried, 1994) was developed by Bordin (1979). Consequently, this conceptualization provides the framework for the present studies.

Bordin identified three common factors that constitute the therapeutic relationship regardless of the type of therapy: agreement on goals of therapy, agreement on tasks in therapy, and emotional bonding between client and therapist. He argued that these three factors were necessary for the successful application of therapeutic interventions.

Agreement on the goals of therapy refers to the extent to which the client agrees with the therapist's conceptualization of his or her difficulties and possible solutions to those difficulties. Once the client communicates his or her problems, the therapist provides the client with a conceptualization of those problems and together they determine the change goal(s) for therapy. This change goal is the end that the client wishes to achieve in therapy. Consequently, the extent to which the client agrees with the therapist on the goals of treatment is an important aspect of the therapeutic alliance.

The tasks in therapy refer to specific activities that the therapist and client engage in to facilitate change. The therapist is the one who selects the therapeutic tasks given his or her expertise, but the client must understand the relevance of these activities in order to engage in them adequately. Therefore, according to Bordin's theory, the extent to which the client agrees with the therapist on therapeutic tasks is another important aspect of the therapeutic alliance.

The third aspect of the alliance is emotional bonding. This refers to a sense of mutual liking, respect, and trust that develops from the therapist's and the client's experience in a shared event, which is therapy. Subsequent to the work of Bordin and based on a comprehensive meta-analysis of psychotherapy treatment research, Orkinsky and Howard (1986, 1987) divided the emotional bond into three subcomponents. Role investment is the degree of emotional energy or investment that the client and therapist invest into the work of therapy, that is, into their respective roles as client and therapist. Empathic resonance refers to the client's sense that the therapist accurately understands his or her thoughts, feelings, and actions. Mutual affirmation reflects the client's and the

therapist's sense that therapy is being conducted in an atmosphere of respect, warmth, mutual liking, and acceptance.

These facets of the collaboration between therapist and client, agreement on goals, agreement on tasks, and emotional bonding determine whether the client and therapist effectively form a partnership against the real source of the client's distress (Ackerman & Hilsenroth, 2003; Horvath & Greenberg, 1987). This relationship not only provides the client with a safe environment to explore the self, but the process of developing this relationship might also highlight the client's key relational issues. Therefore, through the development and maintenance of the therapeutic alliance, the therapist can simultaneously attend to the content of the client's relational difficulties and foster a course of treatment conducive to client change.

Measurement Issues

In addition to many theoretical considerations, there are numerous issues to consider when measuring the therapeutic alliance.

Timeframe for measurement. The therapeutic alliance has been generally divided into two phases: early alliance and later alliance (Horvath & Greenberg, 1994). The early alliance includes the initial development and formation of the therapeutic alliance, which typically takes place within the first five sessions, peaking during session three (Horvath, 1995). It is during these first five sessions that the therapist focuses on promoting client continuance in therapy by establishing satisfactory levels of collaboration and trust, by joining the client as a participant in the therapeutic process, by establishing agreement on what needs to be accomplished in therapy, and by encouraging the development of faith in the tasks of therapy (Rainer & Campbell, 2001). If the therapist does not facilitate

these conditions, client disengagement from therapy will likely be the result (Horvath & Greenberg, 1994; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Tracey, 1986).

After the first five sessions, a different phase in the therapeutic alliance begins. The second phase focuses on dealing with ruptures in the alliance and potential conflicts in session as the client's interpersonal thematic patterns are directly encountered and resolved. Consequently, the alliance after session five is considered to be different from the early alliance (Rainer & Campbell, 2001) and is referred to as the later stages of the therapeutic alliance (Horvath & Greenberg, 1994).

Therefore, based on the distinction between the early and late alliance, potentially different phenomena within the therapeutic alliance could be measured at different points in treatment. As such, when the therapeutic alliance is measured depends on what aspect of the alliance the researcher seeks to study, its initial developmental process or its maintenance and repair process. In the present studies, the focus was on the early alliance.

Perspectives in measurement. There are two measurement techniques that have been used in the therapeutic alliance literature, observer ratings and participant ratings. The first attempts to measure the alliance were based on observers' judgments (Luborsky, 1976). Subsequent measures were developed based on participants' ratings of the therapeutic alliance. Currently, most instruments measuring the therapeutic alliance are available both as observer's rating scales and as self-report measures (Horvath, 1994). Both perspectives were considered in the current studies.

The counting sign method and the global rating method are the two rating systems developed for use by trained observers (Henry, Strupp, Schacht, & Gaston, 1994). In the

counting sign method, independent observers identify client statements that reflect on the alliance. These statements are rated for intensity on a Likert scale, and a mean score is computed and generalized for all sessions. In the global rating method, either an entire or a partial therapy session is reviewed. Then a series of impressionistic ratings are made on a Likert scale for items that reflect alliance behaviors. Due to strong correlations between these rating methods and the tedious work involved in the counting sign method, the global rating method has become the prominent methodology when using an independent rater to assess the therapeutic alliance.

Measures of the therapeutic alliance also can be taken from a participant's perspective. That is, the therapist and the client can rate the therapeutic alliance based on their own perceptions of it. This involves the use of self-report questionnaires with the client or the therapist rating numerous statements pertaining to the alliance on a Likert scale.

Research suggests that clients' and therapists' ratings of the relationship have consistently been divergent (Bachelor & Horvath, 1999; Bordin, 1994; Golden, & Robbins, 1990; Gurman, 1977; Horvath & Greenberg, 1994; Horvath & Marx, 1990; Tichenor & Hill, 1989). Although the source of this discrepancy is not entirely clear, it might be that therapists and clients use a different reference base in evaluating the therapeutic relationship (Bachelor & Horvath, 1999). Several explanations have been offered. One explanation is that therapists draw primarily on their theoretical perspective in making judgments, whereas clients might evaluate the relationship relative to other close personal relationships or on the basis of their expectations of the ideal therapist (Mallinckrodt, 1991). Another explanation is that clients might not necessarily read the

therapist's intentions and messages in the way they were intended (Hill, Helms, Spiegel, & Tichenor, 1988; Hill & O'Grady, 1985; Horvath, Marx, & Kamann, 1990). Predisposing variables might play an important role in the client's response to the therapist's intended communications. Similar variables might influence a therapist's perceptions and misperceptions of the relationship (Horvath & Luborsky, 1993). One last potential reason for the disparity between client and therapist ratings of the alliance is that the client and therapist might differentially emphasize components of the relationship that contribute most to favorable outcome. Therapists tend to emphasize the role of the clients' contributions in client change, whereas clients tend to value therapist characteristics (Bachelor & Horvath, 1999).

Given participants' differential evaluation of the therapy relationship, it appears advisable to understand the client's feelings about and perceptions of the therapeutic encounter. In the end, it is the client's perception of the therapeutic relationship that is most important to the continuance of treatment as he or she ultimately makes the decision to engage in or disengage from treatment by attending scheduled appointments or dropping out of treatment (Bachelor & Horvath, 1999).

Various measures. Attempts to operationalize, measure, and research the alliance did not begin until the 1970s. By the late 1970s and early 1980s, a number of instruments were developed independently and simultaneously to measure the alliance. Both empirically derived scales and theoretically derived scales were developed. Both types of scales were used in the current studies.

The first measures developed to assess the therapeutic alliance were empirically derived. That is, they were constructed by developing clinically sound items aimed at

reflecting aspects of the alliance described in theoretical papers. Underlying alliance dimensions were identified statistically through exploratory factor analysis. There were three measures developed in this manner: the Vanderbilt Scales (Hartley & Strupp, 1983), the Penn Helping Alliance Scales (Alexander & Luborsky, 1987), and the Therapeutic Alliance Rating Scale (Marziali, 1984). Although these first empirical efforts were important steps because they confirmed the prognostic value of the alliance in predicting psychotherapy outcome (Henry, Strupp, Schacht, & Gaston, 1994), these instruments tended to be drawn from a diverse assortment of theoretical writings and were not designed to measure specific theoretical constructs. The next set of alliance measures that were developed accounted for these weaknesses.

Development of more recent alliance measures has been primarily guided by theoretical conceptualizations. Two such measures have been developed. The California Psychotherapy Alliance Scales (Marmar, Horowitz, Weiss, & Marziali, 1986) were designed to assess four theoretically derived alliance dimensions taken from an eclectic theoretical position (Horvath, 1994). The four scales that comprise these measures are Patient Commitment, Patient Working Capacity, Therapist Understanding and Involvement, and Working Strategy Consensus. While some of these scales emphasize the contribution of either the client or the therapist, all ratings on these measures are viewed as influenced by the interactive context.

The second theoretically derived measure is the Working Alliance Inventory (WAI; Horvath & Greenberg, 1987, 1989). The WAI is theoretically homogenous in that it is based solely on Bordin's (1979) conceptualization of the therapeutic alliance (Horvath, 1994). Therefore, it has three scales, Goals, Tasks, and Emotional Bond.

Research has consistently supported the validity and reliability of this measure and its numerous versions (e.g., Hanson, Curry, & Bandalos, 2002; Horvath, 1994; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989)

Relationship between Therapeutic Alliance and Psychotherapeutic Outcomes

The quantification of the therapeutic alliance has allowed researchers to conduct studies relating the alliance to outcome across a variety of psychotherapies. Research has shown that the therapeutic alliance is positively correlated with psychotherapeutic outcomes across a variety of treatment modalities and clinical concerns (Castonguay & Beutler, 2005; Constantino, Castonguay, & Schut, 2002).

The therapeutic alliance has been examined in dynamic (e.g., Barber, Crits-Cristoph, & Luborsky, 1990; Gomes-Schwartz, 1978), experiential (e.g., Gomes-Schwartz, 1978; Horvath & Greenberg, 1989), eclectic (e.g., Gaston, 1991; Horvath & Greenberg, 1989), cognitive-behavioral (e.g., Gaston, 1991; Gaston, Marmar, Gallagher, & Thompson, 1991; Krupnick, Sotsky, Simmens, & Moyer, 1992; Marmar, Gaston, Gallagher, & Thompson, 1989), and group psychotherapy (e.g., Bourgeois, Sabourin, & Wright, 1990; Gaston & Schneider, 1992). The association between therapeutic alliance and psychotherapeutic outcome was also tested in pharmacotherapy (e.g., Frank & Gunderson, 1990; Krupnick et al., 1992). The strength of this association has been examined across a variety of populations, from relatively well-functioning individuals (e.g., Marmar, Weiss, & Gaston, 1989) to elderly clients with depression (e.g., Marmar, et al., 1989), clients with opioid dependence (e.g., Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985), and clients with schizophrenia (e.g., Frank & Gunderson, 1990).