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Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy

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Abstract
Research has consistently documented that the quality of the therapeutic alliance is related to the outcome of diverse psychotherapies. In this preliminary study, the authors examined whether therapists could learn to improve their alliances with patients. Therapists were trained in alliance-fostering therapy, a 16-session treatment for major depressive disorder that combines interpersonal–psychodynamic interventions with techniques for enhancing the alliance based on Bordin’s model of the alliance. Five therapists with 1 to 3 years of postdoctoral clinical experience treated three patients in each of three study phases: before, during, and after training. From pre- to posttraining, moderate to large increases in the alliance were apparent, although these effects were not statistically significant. Variability between therapists was also apparent. The training produced small improvements in depressive symptoms but larger improvements in quality of life, particularly at follow-up and for cases that had relatively higher levels of alliance-fostering techniques. Limitations of the study, including small sample size, relatively high initial levels of alliance, and lack of control group, are discussed and potential future directions identified.

The therapeutic alliance, characterized by Bordin (1979) as composed of the emotional bond between patient and therapist, agreement on tasks, and agreement on goals, is thought to play a central role in almost all forms of psychotherapy. For many psychotherapies (e.g., Beck, Rush, Shaw, & Emery, 1979), a positive alliance is seen as crucial to setting the stage for technical factors to have an impact on outcome and thus is a necessary but not sufficient cause of therapeutic change. In contrast, other forms of psychotherapy, such as client-centered therapy (Rogers, 1951), supportive–expressive psychotherapy (Luborsky, 1984) and Safran and Muran’s (2000) relational approach to resolving ruptures in the alliance, identify the alliance as a curative factor in its own right. Regardless of whether the alliance sets the stage for techniques or is curative in itself, this facet of the process of psychotherapy outcome is thought to be crucial to the process of change.

Over the past 25 years, extensive empirical literature on the role of the therapeutic alliance in psychotherapy has developed. Most notable in this literature is that the therapeutic alliance has repeatedly been found to be a consistent predictor of treatment outcome. In a meta-analysis of 24 studies, Horvath and Symonds (1991) report an average effect size (correlation coefficient) of .26 between alliance and psychotherapy outcome. A more recent meta-analysis found an average correlation of .22 between alliance and outcome across 68 studies (Martin, Garske, & Davis, 2000). Importantly, alliance has been found to predict outcome subsequent to the assessment of alliance, controlling for improvement up to that point (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003). These findings suggest that alliance might have a direct effect on outcome as opposed to simply being a consequence of improvements that have already occurred because of a positive attitude toward treatment and the therapist.

The empirical literature documenting that alliance consistently predicts therapy outcome raises the question as to whether therapists can be trained to improve their alliances in order to improve outcomes. Studies finding that alliance is related, in part, to preexisting characteristics of the patient (e.g., Connolly Gibbons et al., 2003; Mallinckrodt, Coble, & Gantt, 1995; Muran, Segal, Samstag, &
Crawford, 1994; Piper et al., 1991) might imply that it would be difficult to improve alliance by focusing on therapist behaviors. However, in reviewing 25 studies on the topic of therapist behaviors designed to foster alliance, Ackerman and Hilsenroth (2003) conclude that when the therapist conveys a sense of being trustworthy, affirming, flexible, interested, alert, relaxed, confident, respectful, and empathic and is more experienced and communicates clearly, a more positive alliance is present. In addition, specific techniques such as interacting collaboratively to develop specific goals, exploration of interpersonal themes, and use of supportive techniques were related to alliance (Ackerman & Hilsenroth, 2003). These research findings are consistent with numerous clinical writings that have suggested ways to foster a patient–therapist alliance (e.g., Hill & O’Brien, 1999; Luborsky, 1984; Safran & Muran, 2000). Although correlational data connecting therapist behaviors to alliance have supported the possibility of such links, the vast majority of studies have failed to rule out reverse causation (i.e., therapists are warm and supportive with patients who positively connect to them but become defensive and less empathic with patients who are hostile and negative about therapy and the therapist).

The current study was designed to provide preliminary data on whether therapists could be trained to enhance the quality of their alliances with patients. For this study, we constructed a treatment model that focused on therapist actions that might help foster the alliance. This treatment approach (alliance-fostering therapy) was developed to be used with patients who have a diagnosis of major depressive disorder (MDD). MDD was chosen for several reasons. First, alliance has been found specifically to predict the outcome of a variety of different treatments for MDD (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Klein et al., 2003; Krupnick et al., 1996). Thus, there is consistent evidence that the alliance is important in the treatment of depression, and maximizing this aspect of process of treatment might yield incremental benefits. Second, existing empirically supported psychotherapies for MDD such as interpersonal therapy and cognitive therapy, although efficacious, have been found to only produce response rates of about 50% (Depression Guideline Panel, 1993), leaving ample room for augmenting existing treatments. Third, given the heterogeneity within the diagnosis of MDD, existing treatments for depression may be too narrow in their focus, limiting change on broader measures of life functioning, interpersonal problems, and quality of life. Fourth, many practitioners in the community primarily implement eclectic therapy or psychodynamic therapy (Jensen, Bergin, & Greaves, 1990), and an empirically supported treatment that is relatively more compatible with their own view of therapy is likely to have greater opportunity for successful dissemination. Although these four reasons provide a clear rationale for developing and testing a treatment for MDD that focuses on the alliance, it should be noted that alliance-fostering therapy, like many psychodynamic and experiential therapies, is not highly specific to a disorder. Whether treatments that are more highly targeted to MDD are more efficacious than treatments that have general techniques has not been adequately answered to date.

However, our current goal in evaluating alliance-fostering therapy was not to propagate a totally new therapy for depression but rather to test whether therapists could be trained to use techniques designed to enhance the alliance. If successful, such techniques could be grafted onto existing empirically supported therapies for depression or other disorders to enhance their effectiveness by maximizing the quality of the alliance. The primary outcome of the study was an examination of changes in alliance scores from before to during and after training in the alliance-fostering treatment model. Secondary outcomes examined changes in patient outcomes as a function of receiving training in alliance-fostering therapy.

### Methods

#### Design

This study assessed alliances formed by five psychotherapists, each of whom treated patients with MDD before, during, and after training in alliance-fostering therapy. During each of the three study phases, each therapist was randomly assigned (schedules permitting) three patients (15 patients in each study phase). The posttraining study phase was designed to determine whether therapists could implement the alliance-fostering techniques on their own without intensive supervision.

The primary hypothesis was that training in alliance-fostering therapy would produce increases in the average alliance for a therapist caseload. Patient outcomes (symptomatic and quality of life) were examined as secondary outcomes. The study was a pilot-feasibility study and was not designed to have high statistical power for testing the significance of differences between therapist alliance scores before versus during and after training. Because the goal of the study was to assess improvements in therapists’ ability to create positive alliances, the primary unit of analysis for detecting changes was the therapist, with patient nested within therapist.
Participants

To be included, participants had to be between the ages of 18–60 years, have a primary diagnosis of MDD, be available for the 16 sessions of study treatment, and provide written, informed consent. Exclusion criteria included any acute, unstable, or severe Axis III medical disorder that might interfere with the safe conduct of the study. Other exclusion criteria included any current or history of schizophrenic disorders, bipolar disorders, or Cluster A Axis II personality disorders (schizoid, schizotypal, or paranoid). Participants were also excluded from the study if, in the past 12 months, they met criteria for alcohol or substance dependence, obsessive–compulsive disorder, eating disorder, or borderline personality disorder. These diagnostic exclusion criteria were based on clinical concerns that patients with these disorders would either need specialized treatment for those disorders or require a greater intensity or length of treatment than was provided in the current study.

Forty-five patients were recruited through the outpatient psychiatric referral system at the Department of Psychiatry at the University of Pennsylvania and through newspaper advertisements. When patients initially contacted the program, they received a 20- to 30-min semistructured telephone screening evaluation to determine likely eligibility. If screening criteria were met, patients were scheduled for a diagnostic evaluation that consisted of a Structured Clinical Interview for DSM-IV for Axis I (SCID-I; First, Spitzer, Gibbon, & Williams, 1994) and Axis II (SCID- II; First, Spitzer, Gibbon, Williams, & Benjamin, 1994), and included a Global Assessment of Functioning (GAF) rating (American Psychiatric Association, 1994). A principal diagnosis of MDD was required for study entry. Principal diagnosis was operationally defined as the disorder associated with the most severe current impairment or distress, rated on a distress/impairment severity scale ranging from 0 to 8.

Five therapists (three women, two men) were trained. All therapists were relatively inexperienced PhD or PsyD psychologists with 1 to 3 years postdegree experience. Relatively inexperienced therapists were selected because of the possibility that experienced therapists would have developed their own ways of achieving high alliances and, therefore, have little room to improve their alliances. Two of the therapists identified themselves as primarily cognitive–behavioral in orientation, two were psychodynamically oriented, and one was primarily trained in family systems therapy. All therapists were currently working as clinicians in the community.

Treatment

During the pretraining study phase, each therapist treated three patients using their usual approach to psychotherapy. During the training phase of the study, therapists learned and were supervised in manual-based alliance-fostering therapy (Cris-Christoph et al., 1998); each treated an additional three patients using this treatment. In the posttraining phase of the study, therapists each treated three patients using the alliance-fostering psychotherapy but without intensive supervision. In all three phases of the study, treatment consisted of 16 weekly 50-min individual therapy sessions.

This was the first study using the new alliance-fostering treatment manual. The manual was developed through collaboration between researchers familiar with the alliance literature and a senior clinician–supervisor who had extensive experience in training therapists in manual-guided interpersonal–psychodynamic therapy. The manual is organized around general principles for fostering the alliance, illustrated with examples.

The specific techniques used to enhance the alliance drew from a variety of existing psychotherapies, including client-centered therapy–motivational enhancement therapy (e.g., empathy, positive regard), cognitive–behavioral therapy (e.g., collaborative stance), and particularly the supportive principles of treatment described by Luborsky (1984). These techniques were organized according to the three-component theory (agreement on tasks, agreement on goals, therapeutic bond) of the alliance described by Bordin (1979). For the therapeutic bond, we relied on Orlinsky, Grawe, and Parks’s (1994) presentation of elements of the bond that have been found to successfully predict the outcome of psychotherapy. Thus, the alliance-fostering therapy manual was largely based on techniques that have some empirical basis.

Techniques designed to maximize agreement on goals included establishing explicit goals and regular review of goals in subsequent sessions. To maximize agreement on tasks of therapy, patients were first socialized to the therapy process in the first one to two sessions so that the general tasks of therapy were evident. Subsequent to this, therapists were instructed to review tasks regularly (approximately every other session) and assess whether there was still agreement with the patient about such tasks.

Techniques designed to enhance the patient-therapist bond consisted of a variety of elements described by Orlinsky et al. (1994), including personal role involvement, interactive coordination, communicative contact, and mutual affect. Personal role involvement was addressed by examining the
patient’s motivation for change and using techniques to enhance motivation drawn from the stages of change model (Prochaska & DiClemente, 1984). For example, if a patient is unaware that there is a problem that needs changing, initial sessions of alliance-fostering therapy would focus on empathically reviewing the symptoms and costs of depression to the patient in order to increase motivation for treatment. In addition to motivation for treatment, therapists were instructed to monitor patient involvement in the process of treatment in terms of attentiveness and activity level.

The establishment of a collaborative climate for therapy (interactive coordination) was pursued through the empathic stance of the therapist and use of the word we (or other word describing working together as a team) during sessions or collaborating on a role-play with the patient. Communicative contact is facilitated in alliance-fostering therapy by using a conversational style (i.e., a back-and-forth discussion but avoiding being chatty and unfocused), making repeated acknowledgments that the patient is being heard, and through accurate empathic responding by the therapist (using simple reflective clarifications with relatively high frequency). If communicative contact is ruptured, as evidenced by verbal or nonverbal distancing by the patient, the therapist works to have the patient express the underlying feelings, such as anger or anxiety and the interpersonal issues connected to them, in an empathic and accepting climate, so that the patient no longer feels the need to distance and disrupt communicative contact. For example, if the patient is talking rapidly, the therapist can say, “You’re going at a fast clip today—have you any feelings about my being able to keep up or comment on what you’re saying? Does it feel more comfortable to just have me listen and not comment?” Alternatively, if the patient is not making eye contact, the therapist can say, “You seem to be looking at me less today—how are you feeling about my involvement in what you’re saying? Are any feelings you’re having about me interfering with your sense of our being connected on this material?” Sometimes the patient may appear connected but is not bringing up relevant material. This may be explored by asking how the therapist can help the patient raise more emotionally loaded issues.

Mutual affirmation (a sense of caring, respect, acceptance, warmth, and positive regard) is communicated both indirectly and directly through nonverbal signs like smiling, leaning forward, and facial expressions exhibiting interest and respect as well as tone of voice and verbal content specifically noting positive attributes and changes.

In addition to these techniques that directly attempt to enhance aspects of the alliance, therapists were trained to formulate and address the core conflictual relationship theme (CCRT) patterns (Luborsky & Crits-Christoph, 1998). The CCRT is a way of formulating interpersonal issues in terms of the patient’s main wish or need toward other people, response of other people toward the patient, and subsequent response of patient. We included this interpersonal–psychodynamic expressive technique in the manual for three reasons. First, patients generally experience accurate CCRT interpretations as empathic, supportive statements. Research (Crits-Christoph, Barber, & Kurcias, 1993) has shown that accurate CCRT interpretations are associated with the development of a positive alliance over the course of treatment. Second, inclusion of CCRT interpretations addressed a need to have an agenda for the work of therapy. Other alliance-building techniques (enhancing the bond, reviewing goals and tasks of therapy) in themselves are not likely to present a compelling rationale to patients as an agenda for therapeutic work. Third, CCRT interpretations provided an opportunity to focus on patients’ depressive symptoms directly, because these symptoms (e.g., depressed mood, helplessness, guilt) would often be addressed as part of the response of self component of the CCRT. Because of the inclusion of CCRT-related techniques, the alliance-fostering manual was not markedly dissimilar from other interpersonal–psychodynamic treatment models. It is important to note that, in the treatment of MDD, several studies have found psychodynamic approaches to yield similar outcomes to cognitive–behavioral therapy (Shapiro et al., 1994; Thompson, Gallagher, & Steinmetz Breckenridge, 1987) or medication (Hersen, Bellack, Himmelhoch, & Thase, 1984), and a meta-analysis across six depression studies found no significant differences between short-term dynamic therapy and cognitive–behavior therapy on measures of depressive symptoms, general psychiatric symptomatology, and social functioning (Leichsenring, 2001). Thus, there was a reasonable expectation that patients were receiving a treatment for their MDD that would likely be as efficacious as other available treatments.

Despite the inclusion of CCRT interpretative work, the alliance-fostering manual differs from Luborsky’s (1984) traditional supportive–expressive psychotherapy in style and emphasis. Stylistically, many therapists practicing supportive–expressive therapy take a traditional, “blank screen” stance that is somewhat distant from the patient. In alliance-fostering therapy, the style is warmer and more active. It was also expected that the attention
given to the alliance through frequent review of goals and tasks, efforts to increase the bond, and managing of alliance ruptures would lead to relatively less expressive work (addressing the CCRT) in alliance-fostering therapy compared with traditional supportive–expressive therapy. Alliance-foster therapy is also not identical to motivational enhancement therapy (MET), another approach that attempts to establish a positive alliance. Although techniques such as affirmation and reflective listening are used in both alliance-fostering therapy and MET, the latter also includes a number of other techniques such as a decisional balance strategy and various strategies for dealing with resistance (amplified reflection; double-sided reflection; shifting focus; agreement with a twist; reframing; and siding with the negative) that are not part of alliance-fostering therapy. In addition, there are techniques in alliance-fostering therapy such as formulating and addressing CCRT patterns and regular review of the goals and tasks of therapy that are not as prominent in MET. MET also is typically administered in three sessions, whereas alliance-fostering therapy was designed as a 16-session treatment.

The basic prototypic structure of the alliance-fostering psychotherapy was as follows: Socialize to therapy, review expectations, review history of treatment, and establish the patient’s goals in Sessions 1 and 2; formulate and address the initial CCRT in Sessions 3 to 5; reformulate, expand, and work through the CCRT in Sessions 6–16; and address impending termination in Sessions 13–16. In almost every session, the therapist should evaluate agreement on goals and tasks, work toward better agreement on goals and tasks, and establish and maintain a bond with the patient.

Training and supervision
Training in alliance-fostering therapy consisted of an initial workshop that was held before the initiation of the training phase of the study to review the alliance-fostering therapy manual, discuss therapists’ reactions to and concerns about the treatment approach, and give examples of how the techniques are implemented. The central part of the training was intensive, weekly individual supervision over the course of three training cases. During this phase of the study, the clinical supervisor listened to audi-tapes of all treatment sessions for all patients and then reviewed the session material with the therapist to facilitate learning of alliance-fostering techniques. In addition, the supervisor reviewed therapist adherence checklists and made recommendations for specific interventions for the next treatment session with each patient.

In the posttraining phase of the study, therapists each treated three patients using the alliance-fostering psychotherapy but without intensive supervision (supervision was provided on a monthly basis during the posttraining phase of the study and was oriented toward significant clinical concerns).

The clinical supervisor—trainer was a highly experienced clinician (not a researcher) with more than 15 years experience in training therapists in manuals-based (interpersonal–psychodynamic) treatments and was a coauthor of the alliance-fostering treatment manual. The supervisor’s style was warm and respectful of the clinical skills of the therapists but also focused on teaching further skills and modifying therapist behavior to conform to the approach in the alliance-fostering manual.

Assessments

Alliance. Measures of the alliance were the primary outcome measures for the study. The therapeutic alliance was measured using two self-report scales: the California Psychotherapy Alliance Scale—patient version (CALPAS; Gaston, 1991) and the Helping Alliance Questionnaire (HAq-II; Luborsky et al., 1996). Two alliance scales were included because of the exploratory nature of the study and the associated desire to broadly measure facets of the alliance to see where training effects might emerge.

The CALPAS consists of 24 items rated on a scale ranging from 1 to 7. It includes four subscales: Patient Commitment, Patient Working Capacity, Therapist Understanding and Involvement, and Working Strategy Consensus, which were derived to capture the definition of the alliance first described by Bordin (1979) and elaborated on by Gaston (1990). The subscales’ internal consistency reliabilities have been reported in the range of .43 to .73 and .83 for the total score (Gaston, 1991). In the current study, internal consistency reliability (selecting Session 4 for all patients) were .93 (CALPAS total), .61 (Patient Working Capacity), .67 (Patient Commitment), .91 (Working Strategy Consensus), and .79 (Therapist Understanding and Involvement). The HAq-II consists of 19 items and has demonstrated excellent internal consistency (.90–.94) and good test–retest reliability over a period of 3 weeks (.79; Luborsky et al., 1996). In the current study, the internal consistency reliability (using Session 4 scores) was .96. Both the CALPAS and HAq-II were administered at the end of every treatment session during all three (before, during, and after training) phases of the study. Alliance forms were collected by the research assistants, and patients were told that the forms would not be seen by the therapists.
Patient outcomes. Assessment of patient symptoms and quality of life were obtained at pretreatment, midway through treatment (8 weeks), posttreatment, 6 months posttermination, and 12 months posttermination. Depressive symptoms were measured by the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) and the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) to capture both interview-based and self-report assessments of depression. A 17-item version of the HRSD was completed by applying the Structured Interview Guide (SIGH-D; Williams, 1988) to enhance reliability. The BDI is a 21-item self-report measure that surveys common symptoms of depression, focusing on cognitions, rated on a 4-point severity scale. Beck et al. (1988) demonstrated good internal consistency as well as concurrent validity for the BDI.

Quality of life was measured using the Quality of Life Inventory (QOLI; Frisch, Cornell, Villanueva, & Retzlaff, 1992). The QOLI consists of 17 items relevant to overall life satisfaction, including items related to work, love relationships, friendships, self-regard, recreation, community, home, and so on. Respondents rate each item on its importance to overall happiness and satisfaction. Test–retest reliability coefficients have ranged from .80 to .91 and internal consistency coefficients from .77 to .89 across three clinical and three nonclinical samples. Validity of the QOLI was demonstrated by significant positive correlations with seven related measures of well-being and significant negative correlations with measures of general psychopathology, but in all cases the QOLI was not redundant with these other measures (Frisch et al., 1992).

Adherence. At the end of each treatment session during the training and posttraining phases of the study, therapists completed an adherence checklist that listed 12 of the key therapist behaviors that the alliance-fostering treatment manual was designed to encourage. During the training phase of the study, this form was reviewed by the clinical supervisor in supervision sessions. A total score was created from this checklist that represented the total number of alliance-fostered techniques (range =0–12) used by the therapist during a session.

Results

Characteristics of sample

For the full sample of 45 patients who participated in either the pretraining, training, or posttraining phases, about half (56%) were women, 47% had completed college or postgraduate training, 51% were employed full time, 42% were married, and about 25% were members of a minority racial–ethnic group (7% African American; 2% Latino; 2% Native American; 4% Asian; 9% other). The average age was 42.8 years (range =20–59). Comorbid diagnoses were common; 69% of patients had a concurrent Axis I diagnosis and 58% a concurrent Axis II diagnosis. The most common additional Axis I diagnoses were dysthymia (20%), social anxiety disorder (16%), posttraumatic stress disorder (13%), and generalized anxiety disorder (13%). The average HRSD score at baseline was 17.2 (SD =4.4; N =45); the average BDI score, 35.1 (SD =7.7; N =45); and the average GAF score, 55.4 (SD =9.1, N =45). There were no significant differences at baseline on these characteristics among the patients before, during training, and after training. No patients were in any concurrent psychosocial treatment. Two patients in the pretraining phase, two in the training phase, and one in the posttraining phase were taking antidepressant medication, all of whom remained on a stable dose throughout the study.

Treatment retention

The average number of treatment sessions (of 16) attended was 14.7 (SD =1.6; range =10–16) for the pretraining phase, 15.5 (SD =1.1; range =13–16) for the training phase, and 14.7 (SD =3.3; range =6–16) for the posttraining phase, F(2, 42) =0.6, p =.52. The percentage of patients who completed treatment (i.e., finished all 16 treatment sessions) was similar across the three study phases (pretraining, 93%; training, 93%; posttraining, 87%), χ² (2, N =45) =0.55, p =.76.

Changes in alliance across study phases

As mentioned, in the current preliminary study, statistical power was limited to detect anything other than very large effects on the primary outcome measures (alliance). However, to explore whether any such large effects might be present, we implemented a general mixed-model analysis of variance (using PROC MIXED in SAS) that compared average alliance scores across the three study phases. In these models, sessions (up to 16 levels) were nested within patient (three levels per therapist), which was nested within therapist (five levels), which was crossed with study phase (three levels). We fit an autoregressive covariance structure, which allows each time point to have the same variability but assessments closer in time are more correlated than assessments further in time. All nonmissing observations were retained in the analysis.
No significant effects resulting from study phase were evident for the CALPAS total, $F(2, 38) = 1.0$, $p = .39$, Patient Working Capacity, $F(2, 38) = 2.2$, $p = .12$, Patient Commitment, $F(2, 38) = 0.1$, $p = .90$, Working Strategy Consensus, $F(2, 38) = 1.2$, $p = .32$, and Therapist Understanding and Involvement, $F(2, 38) = 2.0$, $p = .15$, or for HAq-II total, $F(2, 38) = 0.7$, $p = .50$. Table I gives the overall means per study phase (averaging alliance scores over all sessions for each patient, then averaging over the three patients per therapist, and then averaging over the five therapists).

As with all training and educational programs, it is possible that some of the trainees learned the method and others did not. This would be evident as a Therapist × Study Phase interaction in the general mixed-model analysis. A significant Therapist × Study Phase interaction effect was indeed evident for the CALPAS Patient Working Capacity, $F(8, 30) = 2.4$, $p = .039$, but not the other alliance scores: CALPAS total, $F(8, 30) = 1.0$, $p = .44$, Patient Commitment, $F(8, 30) = 1.3$, $p = .27$, Working Strategy Consensus, $F(8, 30) = 0.9$, $p = .50$, and Therapist Understanding and Involvement, $F(8, 30) = 1.1$, $p = .42$, and HAq-II total score, $F(8, 30) = 0.7$, $p = .71$.

Although with the small sample of therapists the statistical analysis failed to reveal any significant effects by study phase, the overall trends (see Table I) were for the alliance to increase over study phases. The effect size (Cohen’s $d$) for improvement comparing the average alliance scores pretraining to the average alliance scores posttraining was 0.48 for the CALPAS (average improvement $= 0.20$, SD of difference scores $= 0.42$) and 0.77 for the HAq-II (average improvement $= 0.23$, SD $= 0.30$), suggesting moderate to large effects.

Moreover, there appeared to be moderately large differences between therapists across study phases. For the CALPAS Working Capacity, Therapist 2 improved from pretraining to during training by about 1.5 SD, Therapist 5 improved 1.3 SD from pre- to posttraining, and Therapist 1 improved from pretraining to during training by about 0.66 SD. In contrast, Therapist 4 decreased from pretraining to during training (by about 0.66 SD) and continued to decrease during the posttraining phase. Therapist 3 decreased (by about 1.5 SD) from pretraining to during training but then posttraining recovered to a level about 0.50 SD above pretraining levels.

It should also be noted that there was a strong tendency for different therapists to form relatively positive or less positive alliances regardless of training. The correlation between the CALPAS total score for the therapists’ average alliance scores pretraining versus posttraining was 0.56. The comparable correlation for the HAq-II total score was 0.82.

### Table I. Mean alliance scores before, during, and after training.

| Alliance Scale                     | Pretraining | | Training | | Posttraining |
|------------------------------------|-------------|-------------|----------|-------------|
|                                    | $M$         | $SD$        | $M$      | $SD$        | $M$         |
| **CALPAS**                         |             |             |          |             |             |
| Total                              | 5.76        | 0.43        | 5.91     | 0.38        | 5.96        | 0.44        |
| Working Capacity                   | 5.54        | 0.49        | 5.60     | 0.31        | 5.84        | 0.33        |
| Patient Commitment                | 5.89        | 0.41        | 5.99     | 0.42        | 5.90        | 0.28        |
| Working Strategy Consensus        | 5.77        | 0.52        | 5.96     | 0.45        | 5.99        | 0.67        |
| Therapist Understanding/Involvement| 5.85        | 0.42        | 6.11     | 0.41        | 6.11        | 0.59        |
| HAq-II total                       | 4.95        | 0.47        | 5.13     | 0.33        | 5.18        | 0.52        |

**Note.** Alliance scores are averaged over up to 16 sessions for each patient, then averaged over three patients for each therapist in each phase, and then averaged over five therapists within each phase. CALPAS = California Psychotherapy Alliance Scale; HAq = Helping Alliance Questionnaire.
therapy to facilitate agreement on the tasks of therapy” in 68%. Techniques used less frequently included “Made an attempt to connect to the patient in regard to the patient’s interests” (18%), “Noticed and explored verbal distancing” (19%), and “Noticed and explored nonverbal distancing” (11%).

We examined the relation between adherence and alliance across all treatment sessions using hierarchical linear modeling (HLM). The HLM included a Level 1 model that examined patient-specific linear changes for adherence in relation to alliance modeled as a linear regression within subjects. At Level 2, the individual patients’ intercepts and slopes from Level 1 were viewed as varying randomly across patients as a function of patients’ therapist assignment. Combining the Level 1 and Level 2 models results in a mixed linear model with fixed and random coefficients. A therapist effect is included in the model to adjust for therapist differences in adherence and outcome. Our main interest was the pooled slope effect, which represents the relation between change in adherence and change in alliance (Byrk & Raudenbush, 1996).

To test for the potential causal impact of adherence on alliance, we fit an HLM model that examined the relation between adherence at the current session and alliance at the subsequent session. The reverse direction (alliance at the current session and adherence at the subsequent session) was also examined as a comparison. A correlation coefficient between adherence and alliance can be estimated by multiplying the pooled slope coefficient by the ratio of the estimated pooled standard deviation for alliance divided by the estimated pooled standard deviation for adherence, which is extending the simple linear regression formulation to the longitudinal data, as discussed by Lipsitz, Leong, Ibrahim, and Lipshultz (2001). Estimates of the pooled standard deviation of each measure were through a linear mixed-model structure that took into account the repeated observations per patient. During the training phase of the study, a statistically significant relation between adherence at the current session and HAq-II scores at the subsequent session was detected (estimated \( r = .24, p = .02 \)). A similar relation was found for the CALPAS total score (estimated \( r = .26, p = .04 \)). However, alliance at the current session was unrelated to adherence at the subsequent session (HAq-II: estimated \( r = -.04 \); CALPAS: estimated \( r = -.05 \)). During the post-training phase, adherence at the current session was found to be marginally significantly related to CALPAS total scores at the subsequent session (estimated \( r = .39, p = .098 \)), but not to HAq-II scores (estimated \( r = .12 \)). Neither HAq-II (estimated \( r = -.05 \)) nor CALPAS (estimated \( r = .06 \)) total scores were related to next-session adherence scores during the posttraining phase.

**Patient outcomes**

Patient outcome data during the 16-week treatment period was analyzed using an analysis of covariance model that examined termination (Week 16) scores, adjusting for baseline and therapist, with Week 8 scores used when termination scores were not available. Adjusted (for baseline values) means for the pre-, during, and postraining phases are given in Table II, along with the pooled standard deviations from the model. For the follow-up period, we used a general mixed model that incorporated both the 6- and 12-month follow-up assessments and estimated the adjusted (for baseline) means (also shown in Table II) as an average over the follow-up period.

There were no statistically significant differences between the study phases. Effect size comparisons of the study phases revealed a small to moderate effect (Cohen’s \( d = 0.41 \)) on the BDI from pretraining to training/posttraining on termination scores and a small to moderate effect \( (d = 0.39) \) comparing the posttraining phase to the pretraining phase at follow-up. A large effect \( (d = 0.76) \) was evident on the QOLI at follow-up comparing the training phase to

| Table II. Adjusted mean patient outcome scores at termination and follow-up. |
|----------------|----------------|----------------|----------------|----------------|
| **Outcome measure** | **Pretraining** | **Training** | **Posttraining** | **Pooled SD** |
| Hamilton Rating Scale for Depression | 9.1 | 9.6 | 9.6 | 6.4 |
| Follow-up | 10.8 | 11.7 | 7.4 | 8.4 |
| Beck Depression Inventory | 19.1 | 15.7 | 14.0 | 12.4 |
| Follow-up | 16.3 | 20.6 | 11.7 | 11.7 |
| Quality of Life Inventory | 0.10 | 0.19 | -0.02 | 1.3 |
| Follow-up | 0.24 | 1.46 | -0.28 | 1.6 |

*Note.* Means are adjusted for intake values. \( N = 15 \) patients for each of three phases (before, during, and after training).
the pretraining phase. However, this effect was not present comparing pretraining to after training and was not evident at termination.

Moderate differences in the QOLI were apparent at termination for those patients whose therapists displayed higher adherence to the alliance-fostering therapy model compared with the pretraining cases. Adjusted means at termination were 0.58 for training and 0.93 for posttraining compared with 0.24 pretraining (pooled SD = 0.63). Thus, the effect size for the comparison of postraining to pretraining was 0.55.

**Discussion**

The overall findings from this preliminary study were mixed, with some initial evidence that alliance-fostering therapy may successfully improve alliances. In particular, a relatively large effect ($d = 0.77$) was evident from pre- to postraining on the HAq-II. However, the results were not consistent across therapists and were not statistically significant and must be understood in the context of a number of important methodological limitations (discussed later). In addition, there were only small improvements from pretraining to training and postraining in measures of depressive symptoms. Some impact of the treatment on quality of life was evident, especially at follow-up during training and when high adherence cases were examined. No impact of alliance-fostering therapy on treatment retention was observed, but retention was very high in all phases of the study.

A statistically significant difference between therapists in the improvement in their alliances was found for the Working Capacity scale of the CALPAS but not the other alliance scales. It may be that certain alliance techniques are relatively easy to learn, and all therapists mastered these. For example, techniques to increase the aspect of the alliance captured by the Working Strategy Consensus subscale involved a simple review of the tasks of therapy. Other components of the alliance may be relatively resistant to change no matter how skilled the therapist becomes (e.g., the Patient Commitment scale changed very little). The subtle skills involved in improving a patient's working capacity may be difficult to learn and, therefore, only mastered by some of the therapists.

One of the major limitations of the study is sampling error because of the small number of therapists. With a small sample, we do not know if the one therapist who deteriorated in average alliance scores is unusual or not. It is unclear as to whether the poor results for this one therapist are a limitation of the treatment model, a failure of the supervision-training process, or a function of aspects of that therapist. We note that the training background of this therapist was only in cognitive-behavioral treatment, and she may have been less comfortable with the interpersonal-psychodynamic component of alliance-fostering therapy. It was clear that this therapist was less invested in the project than other therapists, as evidenced by her missing more supervision sessions. Thus, our impression was that this therapist had a weaker alliance with the clinical supervisor. It should also be noted that the small number of therapists severely limits statistical power, increasing the possibility of Type II errors (failing to reject the null hypothesis when it is false).

A second limitation is that the number of patients per therapist may not have been adequate. Previous research has documented that patient variables such as expectations and interpersonal issues—problems predict the alliance (Connolly Gibbons et al., 2003; Mallinckrodt et al., 1995; Muran et al., 1994; Piper et al., 1991). If, during the training or postraining phases, a therapist by chance received two or three patients prone to not form positive alliances, this may have hindered the detection of training effects. To have a highly reliable estimate of a therapist's typical level of alliance or outcome, a relatively large number of patients per therapist might be needed.

The use of therapists with 1 to 3 postdoctoral years of experience may also have limited our ability to detect training effects. Our assumption was that highly experienced therapists would have already evolved their own ways of successfully fostering the alliance and may be less open to training than relatively less experienced therapists. In fact, previous studies that examined the effects of training experienced therapists in an interpersonally oriented treatment method that was highly compatible with the form of treatment they typically practiced failed to detect training effects (Crits-Christoph & Crits-Christoph, 1998; Rounsaville, Chevron, Weissman, Prusoff, & Frank, 1986). Within a sample of graduate student therapists, cumulative clinical hours has been found to predict alliance ratings, suggesting that training does affect the alliance for beginning-level therapists (Davenport & Ratliff, 2001). Once therapists have had a clinical internship and 1 to 3 years postdoctoral experience, they may be relatively skilled at forming positive alliances, and it may be difficult to alter their individual style at fostering the alliance. The average Session 2 CALPAS total score in the pretraining phase was 5.6 ($SD = 0.52$) for the five therapists in the current project, which is very comparable to the average Session 2 CALPAS total score for four highly experienced therapists participating in a study of generalized anxiety disorder in our research center ($M = 5.5, SD = 0.78$). Thus, in
the current project a ceiling effect may have made detecting such improvements in the alliance difficult. To achieve a stronger training effect, it may be necessary to conduct a study with inexperienced therapists (i.e., preinternship graduate students) or to begin with a large pool of therapists and only select for training those who have average alliance scores at the lower end of the distribution. Alternatively, it may be necessary to develop more sensitive measures of the alliance that can detect more subtle changes at the upper ranges of the alliance. The current study was limited to patient report of alliance; observer ratings of the alliance might capture more fine-grained distinctions and, therefore, pick up on potential training effects.

Another possible explanation of our findings is that the relationship aspect of psychotherapy is not easily “manualized.” The interpersonal and emotional aspects of the process of psychotherapy have been contrasted with the technique approaches to therapy that have lent themselves to the treatment manual format (Norcross, 2002). Indeed, it may be that the capacity to form good alliances cannot be taught at all. Although therapists can be taught certain scripts to say or instructed to give more praise, patients may be able to pick up on the true “inner person” of the therapist, and that may not be trainable.

The nature of the patient sample may have also influenced the findings obtained. The restrictive inclusion–exclusion criteria, although typical for efficacy studies with MDD, reduced the number of difficult patients within the sample. Alliance-building skills and repairing of alliance ruptures may be much more of a concern in the types of patients who were excluded from the trial, such as those with borderline personality disorder. This is not to say, however, that the sample consisted of only easy patients. There was a high degree of comorbidity (69% had an additional Axis I disorder, 58% had an Axis II disorder), and the therapists’ and supervisor’s impressions were that these were relatively difficult, complicated cases. Moreover, variations in the alliance have been found to be related to outcome within MDD samples that had similar inclusion–exclusion criteria (e.g., Krupnick et al., 1996), so it was reasonable to assume that such samples would include patients who needed alliance work. Future research can examine the success of alliance-building work within other patient populations.

Another explanation of our findings relates to the nature and quality of the training and supervision process. Improving therapists’ alliances might be more a function of the nature of the training and trainer rather than anything to do with the treatment model, the therapists, or the patients. In fact, previous research on training in brief dynamic therapy suggests that differences resulting from trainers can occur (Henry, Schacht, Strupp, Butler, & Binder, 1993). A number of aspects of the supervision process, including supervisor style, supervision alliance, and supervisor interventions, may have affected the supervision and the treatments (Bernard & Goodyear, 2004). The adherence measure, in particular, may have been influenced by the style of the supervisor. Because the adherence measure was therapist report, subtle or explicit messages from the supervisor may have influenced therapists to distort their reporting of use of techniques. However, the fact that all sessions were tape-recorded and reviewed by the supervisor likely minimized therapist distortions, because they knew the use of alliance-fostering techniques would be directly examined by the supervisor by listening to the tape. Whether or not alternative ways of training and supervising might have achieved larger changes in adherence, and alliance, remains an agenda for further research.

A question can be raised as to the decision to integrate alliance-fostering techniques into a predominantly interpersonally oriented psychotherapy. The alliance-building techniques such as empathy, mutual affect, communicative contact, and other supportive techniques may be largely already present in interpersonally oriented therapies, again leading to little opportunity to improve on alliances. However, almost all major forms of psychotherapy endorse the use of these techniques; therefore, no other form of therapy would have been likely have been a better choice. An alternative approach would have been to attempt to teach alliance-fostering skills to therapists within the context of each therapist’s own preferred model of therapy. This would have controlled for therapist allegiance to their preferred mode of therapy and the potential impact of such allegiance on outcome (Wampold, 2001). However, as an initial attempt to determine whether the alliance could be fostered, our goal was to control the mode of therapy, because varying therapy mode might introduce some variation in outcomes and would have required several supervisors–trainers, each familiar with the different therapy modes and how best to incorporate alliance techniques into them. In future studies with a larger number of therapists, testing the addition of alliance-fostering techniques to the therapist’s preferred therapy modality might be a more fruitful and clinically generalizable approach.

In the current study, there was some evidence that training in alliance-fostering therapy, compared with treatment-as-usual during the pretraining phase, led to relatively greater improvements in quality of life,
especially for cases that contained higher levels of alliance-fostering techniques. However, there was less evidence that training in the treatment model led to improvements in depressive symptoms. The lack of a more specific focus on depressive symptoms in alliance-fostering therapy, other than the possibility that such symptoms could be addressed as part of a CCRT, may have limited the training effects on depression outcomes. Nevertheless, it is somewhat unusual for a treatment to evidence effects on a broad outcome like quality of life but smaller effects on the specific symptom for which treatment was sought. This is not to say that patients did not improve in their depressive symptoms. The termination scores on the HRSD across all three phases in the current study \((M = 9.4)\) were not dissimilar to the termination means scores on this scale from the National Institute of Mental Health Treatment for Depression Collaborative Research Program (TDCRP; cognitive–behavioral therapy \(= 10.7\); interpersonal psychotherapy \(= 9.8\); imipramine \(= 9.8\); Elkin et al., 1989), although the current study did not have a minimum HRSD for inclusion, and, therefore, the baseline score was somewhat lower \((17.2)\) here compared with the TDCRP \((19.5)\).

In addition to the limitations mentioned previously (small sample size, high initial alliance levels, small number of patients per therapist), a number of others need to be considered in understanding the data. One is that the study was a within-subjects design, with therapists as subjects (no control group). Changes from pretraining to training or posttraining might be due to passage of time or general experience that the therapists obtained in working with depressed patients over time rather than the specific training in alliance-fostering therapy. Thus, the current study was not designed to test the efficacy of alliance-fostering therapy; therefore, we do not advocate the clinical use of this treatment approach for patients with MDD or other disorders.

A second limitation is that the adherence measure used was a therapist-report measure. Therapist adherence checklists have been shown to be moderately related to observer ratings of adherence (Carroll, Nich, & Rounsaville, 1998). The scale used in the current study demonstrated validity in terms of prediction of changes in alliance from session to session. However, the extent to which this scale is associated with independent ratings of adherence is not known. Moreover, the scale only assesses whether or not the therapist implemented certain techniques (adherence), not how well such techniques were implemented (competence). Competent delivery of techniques may relate more to outcome than adherence to a treatment manual (Barber, Crits-Christoph, & Luborsky, 1996). An additional potential limitation is that the alliance measures were collected at a higher frequency (every session) than typically done in other studies. This high frequency of assessment may have reduced the validity of the alliance scores. It is also worth noting that some of the CALPAS subscales had marginal reliabilities, particularly the Patient Commitment and Patient Working Capacity subscales, and this marginal reliability may have limited effects on those scales.

Another limitation is that the analyses were exploratory, and two measures of alliance were examined (one with four subscales). As is typical for a preliminary–pilot study, no correction for multiple significance tests was performed, thereby increasing the possibility of Type I errors (rejecting the null hypothesis when it is true). Another limitation is that the study was not designed to isolate which component of the alliance-fostering manual is most useful for enhancing the alliance. It may be that certain elements (e.g., CCRT focus, frequent review of goals) are not essential. Further research can attempt to identify the most efficient and effective ways to enhance the alliance. Finally, although a relatively large effect size was evident comparing pre- to posttraining on the HAIq-II, this effect size was Cohen's \(d\) statistic. Whether this effect size translates into a clinically meaningful effect is not clear because there is no clear standard for clinically meaningful improvement on alliance scales.

We have undertaken a full discussion of the limitations of this pilot investigation more typical of a confirmatory study in the hope that the presentation of these issues will serve to stimulate progress in this area of research. Despite the limitations mentioned, the results of the current study provide some preliminary evidence that, at least for some therapists, alliances can be improved with training. Future studies need to assess the robustness and generalizability of these effects with larger samples of patients and therapists.

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**References**


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Zusammenfassung

Können Therapeuten trainiert werden, ihre Allianz zu verbessern? Eine vorläufige Studie zu allianzfördernder Therapie


Résumé

Peut-on former des thérapeutes pour améliorer leurs alliances? Une étude préliminaire d’une psychothérapie favorisant l’alliance

La recherche a documenté de façon consistante que la qualité de l’alliance thérapeutique est liée aux résultats de diverses psychothérapies. Dans cette étude préliminaire, les auteurs ont investigué si des thérapeutes pouvaient apprendre à améliorer leur alliance avec les patients. Les thérapeutes étaient formés en thérapie favorisant l’alliance, un traitement en 16 séances pour la dépression majeure qui combine des interventions interpersonnelles – psychodynamiques avec des techniques favorisant l’alliance, basées sur le modèle de Bordin de l’alliance. Cinq thérapeutes avec 1 à 3 ans d’expérience clinique post-graduée ont traité 3 patients dans chacune des trois phases de l’étude : avant, pendant et après la formation. Entre la première et la dernière phase, des augmentations modérées à larges de l’alliance ont apparu, mais ces effets n’étaient pas significatifs statistiquement. Il y avait aussi de la variabilité entre les thérapeutes. La formation a produit des améliorations faibles des symptômes dépressifs mais plus larges de la qualité de vie, en particulier à la catamnèse et chez des cas qui profitaient de plus de techniques favorisant l’alliance. Des limitations de l’étude sont discutées, notamment le petit échantillon, les niveaux relativement hauts d’alliance initiale, et l’absence d’un groupe de contrôle, et des futures directions potentielles sont discutées.
fases de un estudio, durante y después del entrenamiento. Desde el entrenamiento previo al posterior surgieron aumentos entre moderados y amplios en la alianza, si bien estos efectos no fueron estadísticamente significativos. La variabilidad entre los terapeutas también fue evidente. El entrenamiento produjo pequeñas mejorías en los síntomas depresivos pero gran mejoria en la calidad de vida, particularmente en el seguimiento y en los casos que tenían niveles relativamente altos de técnicas estimulantes de la alianza. Se debate sobre las limitaciones del estudio incluyendo el pequeño tamaño de la muestra, los niveles iniciales relativamente altos de alianza y la falta de grupo de control. Se señalan las potenciales direcciones futuras de investigación.

Resumo
Podem os terapeutas ser treinados para melhorarem as suas alianças? Um estudo preliminar sobre a psicoterapia de promoção da aliança terapêutica

A investigação tem persistentemente demonstrado que a qualidade da aliança terapêutica está relacionada com os resultados de diversas psicoterapias. Neste estudo preliminar, os autores analisam se os terapeutas podem aprender a melhorar as suas alianças com os pacientes. Os terapeutas foram treinados na terapia de Promoção da Aliança, um tratamento de 16 sessões para a perturbação de depressão major que combina intervenções psicodinâmicas-interpessoais com técnicas para intensificar a aliança baseadas no modelo da aliança de Bordin. Cinco terapeutas com 1 a 3 anos de experiência clínica pós-doutoral trataram três pacientes em cada uma das três fases do estudo: antes, durante e após o treino. Foram evidentes melhorias moderadas a elevadas na aliança entre o pré e o pós-treino, porém estes efeitos não foram estatisticamente significativos. Foi visível a variabilidade entre os terapeutas. O treino produziu pequenas melhorias nos sintomas depressivos, mas bastante mais melhorias na qualidade de vida, especialmente na fase de follow-up e nos casos que tiveram níveis relativamente elevados de técnicas de promoção da aliança. São discutidas as limitações do estudo, incluindo o tamanho reduzido da amostra, os níveis iniciais relativamente elevados da aliança terapêutica e a ausência de grupo de controlo e identificadas potenciais direcções para estudos futuros.