9-2020

The Development of a Therapeutic Alliance Focused Intervention

Amanda L. Mendez

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Psychology

_____

The Development of a Therapeutic Alliance Focused Intervention

by

Amanda L. Mendez

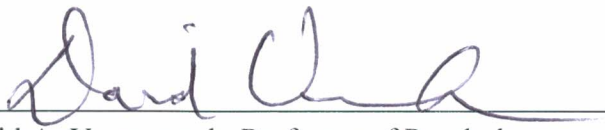
_____

A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology

_____

September 2020

Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.



, Chairperson

David A. Vermeersch, Professor of Psychology

Adam L. Aréchiga, Associate Professor of Psychology

ACKNOWLEDGEMENTS

I must first thank God for providing me with opportunities to serve others in unique and special ways, and equipping me with every gift to succeed (Hebrews 13:21).

I would also like to express my sincere gratitude to Dr. David Vermeersch who never stopped believing in me and advocated for me in pursuing my endeavors. You have been an excellent role model in researching treatment outcomes and patient-centered care. Thank you for being my Chairperson and supporting this project. To Dr. Adam Aréchiga, thank you for agreeing to serve on my committee. Your feedback and honesty helped focus my work. Thank you to Dr. Holly Morrell – you pushed me and supported me through my most difficult parts of graduate training. Your calm steady presence is pure gold. To my mentor, Dr. Mary Eason, and the other family of clinicians who inspired me and were role models in clinical work and evidence-based treatment; thank you for cheering me on and celebrating my successes along the way.

To my family and friends, your love and support through this process have been essential to my success. Thank you for being ever-loving and gracious as I skipped more than one family event and saw you less than desired. I also want to thank my Pastors and church family. Your guidance, prayers, and encouragement meant the world to me.

Last, but certainly not least – to my husband, Kyle Mendez, without whom this endeavor would not have been possible. You supported me from day one, and encouraged me to pursue the work I truly desired. Thank you for being my #1 cheerleader, my best friend, and my partner through each step. Your unwavering support and belief in my abilities inspired me to be my best.

CONTENT

FIGURES

Figures Page

ABBREVIATIONS

NEO-FFI	NEO-Five Factor Inventory
WAI-S	Working Alliance Inventory Short
CRTA	Client Reported Therapeutic Alliance
TA	Therapeutic Alliance
RCT	Randomized Control Trials
ORS	The Outcome Rating Scale
TAFI	Therapeutic Alliance Focused Intervention
MI	Motivational Interviewing

ABSTRACT OF THE DOCTORAL PROJECT

The Development of a Therapeutic Alliance Focused Intervention

by

Amanda L. Mendez

Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2020
Dr. David A. Vermeersch, Chairperson

The therapeutic working alliance is defined as the collaborative relationship between the therapist and the patient. This relationship largely determines whether the patient experiences therapy as helpful or unhelpful in reaching their agreed upon goals. The relationship between the therapeutic alliance and psychotherapy outcome has been well documented in the literature. The therapeutic alliance is considered a “main curative component” in the interpersonal process of therapy, and is the foundation necessary for successful therapy outcomes across various orientations of psychotherapy. Still, far less research has examined the relationship between specific therapist personality characteristics and the quality of the therapeutic alliance. The current study is aimed at examining the relationship between several therapist personality traits and the therapeutic alliance. The study utilizes the Working Alliance Inventory Short-Form (WAI-S) to measure client-reported therapeutic alliance, and the NEO-Five Factor Inventory (NEO-FFI) to measure therapist personality. This project will explore the effect of education on promoting better therapeutic alliance in unlicensed, novice therapists. Program development to educate new therapists on the relationship between personality and therapeutic alliance will be tested through a pilot study. This study is designed to determine the effectiveness of such training in actual clinical settings. We hypothesize

that education on this topic will ameliorate the therapeutic alliance when compared to therapists who have not received the training. We further hypothesize that there will be a relationship between psychotherapist personality (measured by the NEO-FFI) and the client reported therapeutic alliance (CRTA) (measured by the WAI-S).

Keywords: Therapeutic alliance, psychotherapy outcome

CHAPTER ONE

INTRODUCTION

It is important to assess the efficacy and effectiveness of psychotherapy. With higher standards for accountability and insurance reimbursement requirements, tracking patients' progress or change has become crucial. There is a demand for a demonstration that the treatment provided is having a positive outcome. Notwithstanding improved standards, there is also a moral and ethical obligation to ensure the therapist is working in the client's best interest and in a competent and safe manner. Both the patient and the therapist contribute to the therapy environment and the outcome. Therefore, it is imperative for a safe, warm, and collaborative relationship to be present between the patient and the therapist. This is referred to as the therapeutic alliance. "Working alliance," "working therapeutic alliance," or "therapeutic relationship" are also common terms used to describe the same phenomenon, and may be used interchangeably in this paper. The therapeutic alliance (TA) is invariably the highest identified predictor of outcomes in psychotherapy (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Jensen & Kelley, 2016; Lambert & Barley 2001; DHHS 2001). Lambert and Barley (2001) named The Common Factors model, which credits four factors in psychotherapy that influence outcome: expectancy effect, extratherapeutic change, technique, and therapeutic relationship factors (Figure 1). In order to produce positive psychotherapy outcomes, it is important to study and understand the contribution of each factor.

Expectancy Effect

Also known as the placebo effect, the expectancy effect of psychotherapy is a noteworthy contributor to effective treatment. There is extensive literature on the placebo effect in psychotherapy. The definition of a placebo is any health care treatment that is inert for the condition being treated. Unfortunately, the definition of placebo also has an association with deception. Examples of this include sugar pills, saline injections, and sham surgeries. Within the context of psychotherapy, a placebo is somewhat more difficult to define. In the past, some had trouble distinguishing between the placebo effect and psychotherapy, "because both psychotherapy and the placebo effect function primarily through psychological mechanisms," Patterson explains (1985). Jensen and Kelley (2016) define the placebo effect as "a beneficial psychological or physiological change that derives from the treatment context, rather than the specific mechanisms of an active treatment." The authors go on to provide an eloquent explanation that the placebo effect is a paradoxical phenomenon since an actual effect does take place. Therefore, Jensen and Kelley (2016) suggest it be called "the context effect." In summary, it is wise to consider the "placebo" effect as a useful tool and recognize the value in this newly described "context" effect.

This "context" effect has a significant role in psychotherapy since it is psychological in nature. The belief that therapy will be effective is a top-down process (Wampold, 2017) and involves various considerations. When the client has an expectation of benefiting from attending therapy, there is a presumption they are looking for certain qualities within their therapist to be able to deliver these results. Bringing into light the social-psychological variables of the psychotherapy relationship, Patterson (1985) outlines three main therapist variables in psychotherapy as a social influence

process. Perceived expertness (including respect and perceived competence), perceived attractiveness (including therapist-client similarities), and therapist expectancy (including therapist self-confidence leading to the expectation of change or improvement in the client) are non-specific variables which make up approximately 15% of psychotherapy outcome. These expectancy effect processes typically occur from the time the client makes the initial appointment before the first meeting with the therapist. This leads us to explore whether the therapeutic alliance can be defined as specific or non-specific – since it is developed and maintained throughout therapy, beginning upon first interactions between the client and therapist.

Extratherapeutic Change

A large percentage of client outcome (40%) is attributable to factors that occur outside of therapy, known as extratherapeutic factors (Lambert & Barley 2001). Extratherapeutic factors include spontaneous remission, unplanned social and life events, social support, professional therapeutic networks, community resources, political conditions, and structural and climatic conditions of the treatment environment. Although social support is noted as a paramount extratherapeutic and common factor, the many extratherapeutic factors likely add up and cause exponential effects towards extratherapeutic change and outcome (Roehrle & Strouse, 2008).

More recently, additional extratherapeutic factors have been highlighted. One example is the public encounter with one's therapist, which can have a positive or a negative contribution to outcome, depending on how each party responds. With therapy becoming more prevalent, and social media also increasing the likelihood of two persons having a virtual encounter, it would be beneficial for future studies to continue to explore

this influencing factor in detail. Additionally, there is a potential to enhance the use of community and social support with the use of teletherapy and video-therapy. This will provide exciting and relevant areas for continued research on the effects of extratherapeutic factors and the unique contribution to therapy outcome.

Techniques

According to Lambert and Barley (2001), technique composes approximately 15% variance in psychotherapy outcome (Figure 1). This model shows that technique, or treatment modality, makes up approximately the same amount of variance as the expectancy effect. There is a plethora of research on specific interventions and treatment for various psychological disorders and symptoms. Certainly improving skill and competency is a fundamental and worthy goal for therapy trainees. Still, therapy variables such as diagnosis, severity, family support, and technique are not as crucial to predict outcome compared to monitoring early response (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). In other words, measuring early response and monitoring progress in treatment is one of the very best means to predict a patient's final outcome.

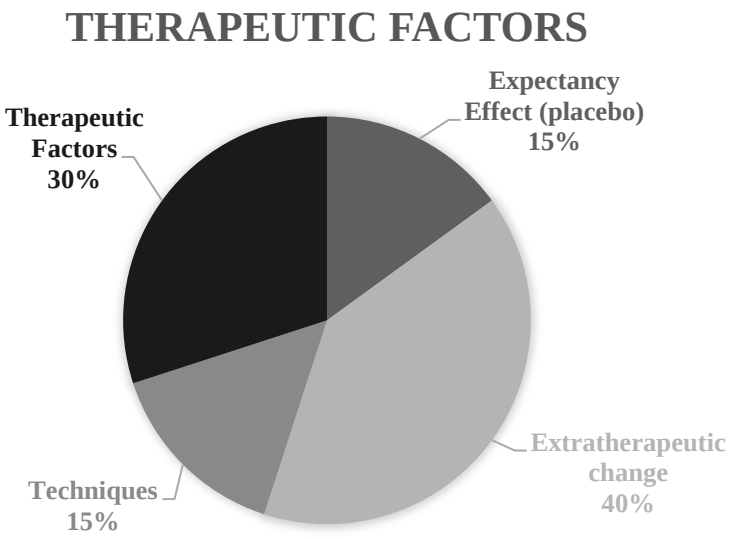


Figure 1. Common Factor Model – The percentage of change in outcome associated with the four primary factors described by Lambert and Barley (2001).

It is important to discuss whether one treatment modality is more effective than another. Lambert and Bergin (1992) summarized that there is relative equivalency "in outcome for a large number of therapies, treatment modalities, and temporal arrangements." Differing thoughts and opinions remain regarding the emphasis on technique over other factors such as therapist factors. Evidence-based practice is a very prominent focus and includes the best available research evidence, clinical expertise, as well as client characteristics, culture, and preferences. Researchers highly value randomized control trials (RCTs) from a methodological standpoint. RCTs are vital to the goal of finding causality since they maximize internal reliability in order to have less susceptibility to confounding variables. Still, RCTs have primarily focused on specific treatment effects for specific conditions, and do not capture the unique contribution of individual therapists (Crits-Christoph & Mintz, 1991). Research evidence other than RCTs may include observations, process research (examining interactions within

sessions), process outcome research (examining the end effects of the intervention delivered), meta-analyses, and others.

Research evidence may tell us what technique or treatment is likely to work for a particular group of people or presentations. Still, this is aggregate data, and it is also crucial to consider the unique contribution of the clinician utilizing their clinical expertise to tailor the treatment for individuals as needed. By considering both, the data and patient-specific details, the therapist can better determine the most suitable treatment modality to use with the patient and their unique symptoms. This method requires knowledge of the best available research evidence as well as clinical expertise. Specific elements of clinical expertise include systematic case conceptualization, treatment planning, treatment implementation, monitoring patient progress, and interpersonal expertise.

While evaluation and use of research evidence are crucial, understanding the influence of cultural contexts, and becoming an expert in interpersonal relationships is dually important. This area is where technique or treatment modality may not make up for a significant amount of variance compared to individual therapist factors. The cultural context of presenting symptoms may alter the course of treatment compared to another population experiencing the same diagnosis. It is vital to provide treatment in a culturally sensitive manner, which may require adapting a manualized treatment or utilizing a different approach rather than what empirical research suggests for a specific diagnosis. Additionally, a therapist who can understand what goes on interpersonally between people, and are masters of their own interpersonal relationships, is going to contribute beneficial individual factors beyond technique. Some go as far as to argue that excessive valuing of technical expertise can hinder the effectiveness of therapy, without proper

attention given to therapeutic factors such as the therapeutic alliance.

Therapeutic Relationship Factors

The therapeutic relationship is considered a “main curative component” in the interpersonal process of therapy and is “the context in which specific technique exert their influence” (Lambert & Barley, 2001). Therapeutic relationship factors are applicable across various orientations of psychotherapy and occur in every therapeutic relationship. An effective client-therapist relationship will include unique therapist variables, favorable conditions that promote growth such as warmth, empathy, agreement, and finally, the therapeutic alliance. Many factors, including the personal characteristics of the therapist, influence the quality of the therapeutic alliance. With these factors occurring congruently, it is almost impossible to consider one without the other. Still, there remains a gap in research on the effect of specific therapist-client variable combinations on the development of the alliance. Therefore, this study will help fill that gap and endeavor to understand the qualities effective therapists bring to the therapeutic relationship.

Therapist Characteristics

Jennings & Skovholt (1999) explored the personal characteristics of effective therapists and found what qualified one as a “master therapist.” One key finding contributes pointedly to our study: “master therapists believe that the foundation for therapeutic change is a strong working alliance.” The therapist contribution accounts for more significance in building the therapeutic alliance. Wampold (2017) concludes, “Effective therapists form strong alliances across a range of patients.” Because the therapeutic alliance is a primary contributing factor of healing and change, it is important

to study variables in this therapeutic relationship – including those which therapists may have a more considerable influence.

Extensive research exists on external variables that make for a better therapist such as gender, level of education, experience, caseload, or religious position (Bowman, 1993; Chapman, 2009; Lambert et al. 2001, Sanders et al., 2015; Stein & Lambert, 1995). When looking at client reported psychotherapy outcome, psychotherapists were equally as effective, regardless of gender. In other words, patients of both male and female therapists experience a similar amount of change (Bowman 1993). Religious beliefs of the therapist was also a poor predictor of psychotherapy outcome. Sanders et al. (2015) found that while clients improved with the use of spiritual interventions along with various secular treatments, "frequency of use of spiritual interventions was not a significant predictor of differential growth trajectories for clients."

Psychotherapy can include treatment from individuals with a wide range of qualifications, including professional, graduate-level trained individuals, individuals with a high school diploma, bachelor's degree, or paraprofessionals. Paraprofessionals and professionals are better than untrained laypersons at identifying emotional experiences and appropriately providing empathy, as well as handling trauma (O'Brien & Haaga, 2015). Research has found that trained professionals are better equipped to provide therapy; however, there is no significant correlation between psychotherapy outcomes and length of training or amount of experience (O'Brien & Haaga, 2015; Stein & Lambert 1995). For those invested in higher education, this information may be disturbing to hear. Stein & Lambert (1995) report that graduate-trained psychotherapists are more effective at treating severe psychopathology, providing brief therapy, and more time-intensive and complex forms of family therapy. Professionally trained

psychotherapists were also found to have better outcomes with older patients; however, it was noted professionals in this study were on average 10 years older than the paraprofessionals (Berman & Norton 1985).

Additional components of therapist contribution to the therapeutic relationship include factors outside of their characteristics. Caseload and severity of cases have been shown to have an inverse relationship with psychotherapy outcome. When therapists have a high number of cases, including, high severity of cases, they may become overwhelmed. This hinders their ability to form a positive therapeutic alliance (Saxon & Barkham, 2012).

Therapists who carry large caseloads with severe symptoms and high-risk are also vulnerable to experience compassion fatigue. Compassion fatigue is a common phenomenon in all healthcare fields and effects the most empathic individuals. Figley (2003) provides some descriptors of compassion fatigue as the “cost of caring” for others in emotional pain. The helper may suffer secondary or vicarious victimization and secondary traumatic stress. This is important to consider in this study because some personality profiles may be more susceptible to this phenomenon than others.

Additionally, personality profiles of psychotherapists overall tend to reflect a person who is more open and accepting of others. Without any challenging of negative thoughts and behaviors, findings suggest the stereotypical psychotherapist personality profile may not be the most conducive to enhanced psychotherapy outcomes. Part of the program development in this study will include ways to protect oneself against this dilemma in order to continue to form a positive therapeutic alliance and ultimately enhanced therapy outcome.

Client Characteristics

Client characteristics also play a role in the formation of therapeutic alliance and positive therapy outcomes. Readiness for change, strengths, resources, level of functioning before treatment, and life events all influence outcome, and many are outside the therapist and client's control. Additional client characteristics include race and cultural factors, personality traits, symptom severity and risk, and previous levels of functioning. While there is a lack of research on specific client characteristics predicting outcome, narcissism, distrust, and manipulativeness are traits characterized to pose a challenge to various treatment. Helping individuals with higher risk involves advanced skills and techniques. Current level of functioning as well as baseline level of functioning play a considerable role in psychotherapy outcome. A lower level of functioning will likely hinder the patient's ability to actively and consistently participate in therapy. A therapist will need to be flexible and customize the techniques used based on research evidence, experience, and the individual's specific needs and abilities. It is also possible that a patient with a lower level of baseline functioning will lead to difficulty in the formation of the alliance. Further research will help in determining what specific ways therapists can buffer the impact of this variable.

Therapist-Client Interaction

As stated before, the therapeutic relationship between the patient and therapist is crucial to successful treatment. The therapeutic alliance, also known as the working alliance, is the collaborative relationship established from the first encounter between patient and therapist. It is a well-known fact supported by research that "the therapeutic alliance is one of the most powerful predictors of outcome in psychotherapy" (Jensen &

Kelley, 2016). This fact is also true independent of the specific treatment type (Ackerman et al., 2001). Bordin (1979) is one of the leading researchers examining the working alliance. He describes the working alliance between the patient (person seeking change) and the therapist (person offering to be a change agent) as an essential part of the change processes - “The effectiveness of a therapy, is a function, in part, if not entirely, of the strength of the working alliance.” To understand this significant predictor better, we will present information on the history of the therapeutic alliance.

We see early definitions of the therapeutic alliance in Freud’s writing. He described it as positive transference, concluding it was a client-therapist attachment that was grounded in reality and proved beneficial. Additionally, he described the client’s ability to connect with the therapist in this way, is what makes it possible to undertake the task of healing and change. Other theorists (Gitleson 1962; Horwitz 1974; and Bowlby 1988) conceptualize the therapeutic alliance as the essential part of the therapy process in which the client “develops the capacity to form a positive, need-gratifying relationship with the therapist” (Horvath & Luborsky, 1993). In Jennings and Skovholt’s (1999) review, master therapists are quoted on the personal characteristics of effective therapists. These therapists spoke of the therapeutic relationship as therapy itself, acknowledging that healing takes place in the utilization of this relationship.

Research has shown therapeutic alliance accounts for approximately 10-20% of the variance in psychotherapy outcome (Bowman, 1993; Crits-Christoph & Mintz, 1991; Hill, 2009; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins., 2001; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007) and contributes to approximately 30% of positive outcomes (Lambert & Barley 2001). The aspects of the therapeutic alliance are conceptualized into three components: tasks, goals, and bonds. Tasks include the actual

work of therapy such as processes and behaviors within the session. Goals of therapy should be developed collaboratively as a discussion between the patient and therapist. Finally, the bonds have been identified as the "positive interpersonal attachment between therapist and client of mutual trust, confidence and acceptance" (Bordin 1979, Safran & Muran 2000). The ability to measure and define the therapeutic alliance has struck a debate in the field for over three decades. Whether the description of the therapeutic alliance is a nonspecific technique or common factor, may lead to neglecting it during training compared to specific techniques. Still, robust findings show that the formation of a positive therapeutic alliance early on in treatment is correlated with early improvements, which is a good predictor of further improvement. Barber et al. (2000) suggest that by bringing clarity to this relationship, the potential causal mechanisms of change in psychotherapy may be closer to being unraveled.

Further concerns impacted by the therapeutic alliance include therapy dropout rates and deterioration. With the absence of a warm, nonjudgmental, and empathic therapeutic alliance being formed early on, patients are three times more likely to drop out of treatment. This is not only a concern for the patient's outcome – but also that the therapist might be confronted with the resulting financial burden and overcommit to large caseloads. Lambert et al. (2001) conducted a study to determine if providing the therapist feedback regarding patient progress would affect patient outcome and number of sessions attended. They found that for patients who were not progressing, or whose symptoms were getting worse, providing feedback to their therapists resulted in improved outcomes and extended duration of treatment, relative to patients whose therapists were not provided feedback. Lambert's piece of research provides support to the current study to see if providing feedback on therapist personality, may increase therapeutic alliance.

Addressing the contributing factors which foster a positive therapeutic alliance early on, could result in early career, novice therapists learning to appropriately balance caseloads, reduce dropouts, stabilize financial woes, and ultimately improve outcomes for patients.

Contribution of Therapist Personality to Therapeutic Alliance

Psychotherapists attend many years of formal training to become skilled, qualified, and licensed providers. Other professionals in the mental health field prefer to be described as “healers,” “helpers,” or “counselors,” depending on the context or setting in which they work. Clearly, it takes a particular skill and temperament in order to conduct effective psychotherapy. Therapists are described as empathic, intuitive, and having the desire to help others. Research supports there may be a “set of personality traits that are conducive to creating an empathic environment and establishing working alliances with others” (Finlay, 2018; O'Brien & Haaga, 2015). Each therapist brings their own unique personality characteristics to their work in psychotherapy. These personality characteristics impact the quality of the therapeutic alliance in various ways. Research has yet to satisfy naming specific personality factors which significantly contribute to building the therapeutic alliance. It is important to examine which personality profiles are associated with better client reported therapeutic alliance and if this relationship can be modified by education on therapist personality and the therapeutic alliance.

The NEO-Five Factor Inventory (NEO-FFI) is a standardized measure comparing individuals to the general population, and examines five different personality factors; Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. Compared to the general population, therapists are typically lower on Neuroticism, and higher degrees of Openness to Experience, Agreeableness, and

Conscientiousness. Each of these factors contributes to the therapeutic alliance in a particular way. This study is designed to utilize the NEO-FFI to capture personality profiles for each participating therapist. The five factors will be compared to the client reported alliance, to examine patterns and effect of each factor.

Personality differences will also play a critical role in the formation and maintenance of the therapeutic alliance in the area of appropriately handling countertransference. Research performed by Jackson and Thompson (1971) found that effective therapists held more positive attitudes toward themselves, clients, most people, and therapy compared to ineffective therapists. Psychotherapists are generally open and accepting towards others, have effective coping skills, advanced communication skills, and are practiced at being flexible. These are all conducive parts of personality which will also contribute to developing a strong working alliance early on in therapy. Research on the effects of personality on the therapeutic alliance by Chapman et al. (2009), suggests that the stereotypical psychotherapist personality is the most conducive to psychotherapy outcome – openness towards others, the ability to be flexible, and having effective communication skills.

We understand many of the desirable characteristics of therapists as discussed in prior sections. We also understand that personality plays an important role in the development of a collaborative and effective therapeutic alliance. Therefore, this study aims to examine which personality factors may ameliorate or deter a strong alliance conducive to change. Then, by developing a program to educate and provide feedback to newly trained therapists, this intervention can be empirically tested to see if education will modify the relationship between psychotherapist personality and therapeutic alliance. Learning the mechanisms of change and how to foster the therapeutic alliance, while

taking into account therapist personality, will add considerable knowledge and opportunities for further research in the field. For example, there is a foundation for future research on the therapist personality being explored as part of the supervisory relationship to assist in the training of therapeutic alliance skills for new unlicensed therapists.

Specifically, the development of a Therapeutic Alliance Focused Intervention aims to (1) educate therapists on the relationship between several therapy factors and patient outcome, highlighting the central importance of the therapeutic alliance in all treatment approaches; (2) educate therapists on the literature regarding the relationship of therapist personality variables and the therapeutic alliance; and (3) administer and provide feedback regarding therapists personality profile, as measured by constructs assessed on the NEO-FFI, and the potential relationships of the specific variables measured on the NEO-FFI and the therapeutic alliance.

CHAPTER TWO

METHODS

Participants for this study will be graduate-level unlicensed therapists from local outpatient counseling centers. Graduate students pursuing a degree in a clinical field of mental health such as marriage and family therapy, social work, clinical counseling, school psychology, and clinical psychology will be most appropriate for the current study. Exclusion criteria include if the candidate had sat for his or her licensing exam, had more than three years of therapy experience, or did not see the same patients on a weekly basis.

Participants will be randomly assigned to one of two groups, either the intervention or the control group. Both groups will complete the personality assessment, as well as utilize measures of alliance and well-being for their patients. However, the control group will not take part in the intervention, until after data collection. It will be important that the training is given by the same person for fidelity purposes.

Measures include the NEO-Five Factor Inventory (NEO-FFI) to assess personality, the Working Alliance Inventory-Short Form (WAI-S) to measure the client and therapist rating of therapeutic alliance, and the Outcome Rating Scale (ORS) to measure overall well-being. Samples of the measures are included in the appendices.

The NEO-FFI will be administered prior to the intervention. The NEO-FFI is an assessment of personality, which is valid across cultures (Costa & McCrae, 1992) and has also demonstrated as valid for use with children. This 60-item questionnaire uses a five-point Likert scale. The NEO-FFI will provide a comprehensive report of personality profiles on five personality traits; Neuroticism, Extraversion, Openness to experiences, Agreeableness, and Conscientiousness. This study will then examine these five factors as

predictors for therapeutic alliance.

The WAI-S is a repeatable tool that has good overall reliability and validity compared to the extended version, the Working Alliance Inventory, and has acceptable psychometric properties (Horvath & Luborsky, 1993). It has 12 items answered on a seven-point Likert scale, which measures the clients or therapists views on the global level of alliance and the various components of alliance including task, bond, and goals of therapy. This tool will be given as early as possible in the therapeutic relationship, to identify early alliance before crystallization; in other words, to avoid a long history of previous outcomes influencing the therapeutic alliance.

The Outcome Rating Scale (ORS) will be used to measure outcome. The ORS is a tool which captures overall well-being and will be useful to measure the client's perception of change prior to the measurement of therapeutic alliance.

Therapeutic Alliance Focused Intervention

The Therapeutic Alliance Focused Intervention (TAFI) will be held in the format of a one-day seminar. Training objectives will include increasing knowledge on therapy outcomes, the therapeutic alliance, skills to build the therapeutic alliance, how therapist personality contributes to this relationship, provide feedback on their personality profiles, and explore areas of personal growth which may impact the therapeutic alliance. Interactive parts of the seminar will include a PowerPoint presentation, role plays, video clips, group discussions, and question and answer opportunities throughout. Research and evidence-based practices will be discussed as well as personal experiences, questions, and concerns.

During training, it is prudent to give your participants something they can begin

implementing right away. A goal of this intervention is for the participants to gain insight on their abilities and areas of growth, learn something new and feel comfortable adopting new information and techniques, and be able to give an honest reflection on themselves and the trainer at the end of the seminar. In order to address tools they can use right away, Motivational Interviewing (MI) would be a helpful component to facilitate collaborative communication and foster a therapeutic alliance.

MI is an evidence-supported intervention, while not being considered a theoretical orientation – it can be used across modalities. Elements of motivational interviewing naturally invite a therapeutic relationship to form, as you work from a place of openness, alignment, rolling with the resistance, and staying curious with open-ended questions, rather than carrying out your own agenda. Many participants may already have been introduced to MI, and if so, this will help them practice a newly-learned skillset (building therapeutic alliance) with the support and comfort of a more familiar skill (MI).

Another immediate benefit will be the feedback received on their NEO-FFI. The intervention will provide validation and affirmation when discussing various personality profiles which may be more conducive to certain elements of the therapeutic alliance. Additionally, we will empower the clinicians to be a stakeholder in this research and assist with empirically testing the effectiveness of this intervention through administering the ORS measures to their patients consistently, for the duration of the study.

It will be important to keep in contact with clinicians in the intervention and control groups regularly during data collection and administer the intervention to the control group after data collection has completed. Please refer to the attached program outline for the TAFI in the appendices.

CHAPTER THREE

DISCUSSION

While there is abundant research on the personality of the patient and outcomes of psychotherapy, little exists on the personality of the therapist and contributions to the therapeutic alliance. This project fits into the context of a larger research project (pilot study by Michael Finlay) and informs the applied portion of the research. Mr. Finlay conducted initial research finding the relevance and need for heightened studies on therapist personality and therapeutic alliance. A previous study by Crits-Christopher et al. (2006) explored if training focusing on the therapeutic alliance would result in significant improvement in psychotherapy outcomes. This study was limited by a low sample size and did not develop significant findings. Discovering a deficiency of literature on the specific area of therapist personality and contributions to the therapeutic alliance, I joined in a partnership with the role of program development to complete his study. Empirical testing is required to determine what can further ameliorate the therapeutic alliance. This intervention will focus on exploring if feedback on personality profiles and education on improving the therapeutic alliance will impact therapeutic alliance and therapy outcome.

Recommendations for Further Research

Due to possible ceiling effects on current face-valid measures, it will be necessary to create less face-valid tools to measure the therapeutic alliance. Additionally, focusing on measuring collaboration rather than therapist “performance” may assist in capturing essential components of therapeutic alliance skills.

Chow et al. (2015) found that when therapists spent an increased amount of time improving targeted therapeutic skills outside of therapy, it significantly impacted their

outcomes with patients. Furthermore, many participants recruited for this intervention communicated an increased desire to learn skills to improve therapeutic alliance. Therefore, it would be prudent in future directions to provide therapists in training with a support tool to accomplish this, such as a binder or repository with articles related to the therapeutic alliance including contributing factors, techniques to build and repair the therapeutic alliance, and how to develop personality traits identified to facilitate a strong alliance with patients. An additional suggestion to provide this support may come in the form of implementing a focus of therapeutic alliance during supervision – exploring ruptures, transference, and measuring outcomes.

REFERENCES

Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., … Rainer, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 495–497. https://doi.org/10.1037/0033-3204.38.4.495

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology*, *68*(6), 1027–1032. https://doi.org/10.1037/1949-2715.S.1.80

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, *16*(3), 252–260. https://doi.org/http://dx.doi.org/10.1037/h0085885

Bowman, D. O. (1993). Effects of therapist sex on the outcome of therapy. *Psychotherapy: Theory, Research, Practice, Training*, *30*(4), 678–684. https://doi.org/10.1037/0033-3204.30.4.678

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, *52*(3), 337.

Crits-Christoph, P., Gibbons, M. B. C., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research*, *16*(03), 268-281.

Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology*, *59*(1), 20–26. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2002139

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. American Psychological Association.

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology*, *46*(1), 3–11. https://doi.org/10.1037/0022-0167.46.1.3

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of consulting and clinical psychology*, *61*(4), 561.

Jensen, K., & Kelley, J. M. (2016). The therapeutic relationship in psychological and physical treatments, and their placebo controls. *Pyschology of Conciousness: Theory, Research and Practice*, *3*(2), 132–145.

Lambert, M., & Barley, D. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research and Practice*, *38*(4), 357–361. https://doi.org/10.1037//0033-3204.38.4.357

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Hawkins, E. J., & Al, L. E. T. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: are outcomes enhanced? *Psychotherapy Research*, *11*(1), 49–68. https://doi.org/10.1080/713663852

Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing, Real-time Assessment Feasible. *Journal of Brief Therapy*, *5*(1).

Miller, S. D., Hubble, M. A., & Duncan, B. L. (2007). Supershrinks. *Psychotherapy Networker*, *31*(6), 26-35.

O'Brien, J. L., & Haaga, D. A. (2015). Empathic accuracy and compassion fatigue among therapist trainees. *Professional Psychology: Research and Practice*, *46*(6), 414.

Patterson, C. H. (1985). What is the placebo in psychotherapy?. *Psychotherapy: Theory, Research, Practice, Training*, *22*(2), 163. Pearson, M., O'Brien, P., & Bulsara, C. (2015). A multiple intelligences approach to counseling: Enhancing alliances with a focus on strengths. *Journal of Psychotherapy Integration*, *25*(2), 128.

Roehrle, B., & Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *45*(4), 464–476. https://doi.org/10.1037/a0014333

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy*, *27*(2), 154-165.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

Sanders, P. W., Richards, P. S., McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality In Clinical Practice*, *2*(3), 180-190. doi:10.1037/scp0000083

Saxon, D., & Barkham, M. (2012). Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk. *Journal of Consulting and Clinical Psychology*, *80*(4), 535.

Scaturo, D. J. (2001). The evolution of psychotherapy and the concept of manualization: An integrative perspective. *Professional Psychology: Research and Practice*, *32*(5), 522.

Schumacher, J. A., Madson, M. B., & Nilsen, P. (2014). Barriers to learning motivational interviewing: A survey of motivational interviewing trainers' perceptions. *Journal of Addictions & Offender Counseling*, *35*(2), 81-96.

Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced?. *Journal of Consulting and Clinical Psychology*, *63*(2), 182-196.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the alliance Inventory. *Psychological Assessment, 1*, 207-210.

U.S. Department of Health and Human Services (DHHS). (2001). *Mental health: Culture, race and ethnicity—A supplement to men0tal health: A report of the Surgeon General*. Rockville, MD: U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Wampold, B. E. (2017). What should we practice. *T., Rousmaniere, RK, Goodyear, SD, Miller, BE Wampold,(Eds.), The cycle of excellence*, 49-65.

Wampold, B. E., & Imel, Z. E. (2015). The great psychotherapy debate: The evidence for what makes psychotherapy work. New York, NY: Routledge.

APPENDIX A

INFORMED CONSENT FOR THERAPIST

TITLE: THE RELATIONSHIP BETWEEN PSYCHOTHERAPIST PERSONALITY AND CLIENT REPORTED THERAPEUTIC ALLIANCE

PRINCIPAL INVESTIGATOR: David Vermeersch, Ph.D.
Department of Psychology
11130 Anderson Street, Suite 106
Loma Linda, CA 92350
(909) 558-7116

INVESTIGATORS: Michael Finlay, Ph.D.
Amanda Mendez, M.A.
Department of Psychology
11130 Anderson Street, Suite 106
Loma Linda, CA 92350

1. WHY IS THIS STUDY BEING DONE?

The purpose of the study is to identify if there is a relationship between psychotherapist personality and client reported therapeutic alliance.

You are invited to participate in this research study because you represent the population of psychotherapist that are currently in training either as a trainee or an intern.

2. HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

Approximately 100 subjects will participate in this study various counseling centers in Southern California.

3. HOW LONG WILL THE STUDY GO ON?

Your participation in this study may last up to 4 months. There will be various phases of the study where you will not be required to take any action. Majority of the study will be the collection of surveys from your clients and making them available for pick-up by the researchers. You will be required to complete a survey that will take approximately 1-2 hours and attend a workshop that will last for approximately 8 hours.

4. HOW WILL I BE INVOLVED?

You must meet the following requirements to be in the study:
Inclusion Requirements
You can participate in this study if you are a psychotherapy trainee or intern, currently providing therapy to outpatient adults with mild to moderate mental illness. You must be under the supervision of a licensed mental health professional while providing psychotherapy. You must be willing to provided de-identified copies of the Working Alliance Inventory (WAI) and the Outcome Rating Scale (ORS) that were collected during the specified window. While not a requirement, we request you provide a WAI and ORS for between 7 and 10 clients. You must have the ability to attend a seminar that will be offered during the study. There will be between 2 and 4 seminars that will be available, you are required to attend one.
If you meet the screening requirements and you choose to take part in the study, then the following procedures will take place: You will complete an NEO Five Factory Personality Inventory. You will be provided the Working Alliance Inventory (WAI) to be given to your client to fill out.

Participation in this study involves the following:

Phase 1: All psychotherapist will complete a FFI. The FFI will take approximately 1 hour to complete. The FFI consist of 150 questions that the participant will rate on a 5 point scale ranging from strongly disagree to strongly agree.
Phase 2: All psychotherapist will be randomly assigned to complete a training seminar. The training seminars will be identical and will provide feedback on the FFI, research on the effects of therapeutic alliance on outcome, and techniques to improve therapeutic alliance.
Phase 3: Psychotherapist will administer the WAI and the Outcome Rating Scale (ORS) to their clients as part of normal clinical practice. The psychotherapist will only write their unique ID, session number, and gender of the client on the WAI and ORS. There will be a collection period where the clients that complete the therapist will provide the researchers a copy of the WAI and ORS prior to recording any identifying information regarding the client on the survey. Once the copy has been made, the therapist can record the identifying information regarding the client and place it in the client's chart per normal operating procedures for the center.

If you agree to participate, you will be responsible for completing the NEO FFI, administering, collecting, and returning the WAI to the investigator.

5. WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

Psychological discomforts: Some of the questions the researchers ask you may be upsetting or make you uncomfortable. If you do not wish to answer a question, you can skip it and go to the next question. If you do not wish to continue to participate you can stop with no penalty. For many of the activities, tests and questionnaires we are evaluating, there is no right or wrong answers. You may experience negative feelings

about your FFI profile. Remember that there are no good or bad profiles and difference combinations can be beneficial in different settings.

6. WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Although you may not benefit from this study, the scientific information we learn from the study may help us improve training on therapeutic alliances.
The possible benefits you may experience from the procedures described in this study include learning factors that contribute to therapeutic alliance. This may increases your effectiveness in establishing a strong therapeutic alliance.

7. WHAT ARE MY RIGHTS AS A SUBJECT?

Participation in this study is voluntary. Your decision whether or not to participate or withdraw at any time from the study will not involve any penalty or loss of benefits to which you are otherwise entitled.

8. WHAT HAPPENS IF I WANT TO STOP TAKING PART IN THIS STUDY?

You are free to withdraw from this study at any time.

9. HOW WILL INFORMATION ABOUT ME BE KEPT CONFIDENTIAL?

Efforts will be made to keep your personal information confidential. Documents will be coded and the key will be maintained in a double locked filing cabinet in the psychology department. Documents that contain the participant ID code and the corresponding name will be maintained on a printed document within the filing cabinet. No names will be entered into any computers or data processing software. You will not be identified by name in any publications describing the results of this study.

10. WHAT COSTS ARE INVOLVED?

There is no cost to you for participating in this study.

11. WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this research study.

12. WHO DO I CALL IF I HAVE QUESTIONS?

If you wish to contact a party from this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact Dr. David Vermeersch, phone (909) 558-7116, email dvermeersch@llu.edu. You may also contact Michael Finlay, phone (951) 444-0596, mfinlay@llu.edu.

If you wish to contact an impartial third party not associated with this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, e-mail patientrelations@llu.edu for information and assistance.

13. SUBJECT'S STATEMENT OF CONSENT

- I have read the contents of the consent form and have addressed any questions or concerns with the investigators.
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities.
- I hereby give voluntary consent to participate in this study.

I understand I will be given a copy of this consent form after signing it.

Signature of Subject	Printed Name of Subject
Date	

14. INVESTIGATOR'S STATEMENT

I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator	Printed Name of Investigator
Date	

APPENDIX B

WORKING ALLIANCE INVENTORY SHORT (WAI-S)

1. _____ and I agree about the things I will need to do in counseling to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in counseling gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ does not understand what I am trying to accomplish in counseling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in _____ 's ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX C

OUTCOME RATING SCALE

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Gender_____
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

ATTENTION CLINICIAN: TO INSURE SCORING ACCURACY PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

International Center for Clinical Excellence

www.scottdmiller.com

APPENDIX D

INTERVENTION PROGRAM OUTLINE

Therapeutic Alliance Focused Intervention (TAFI)

Presented by: Michael Finlay, M.S. and Amanda Mendez M.A.

Loma Linda University School of Behavioral Health, Department of Psychology

Housekeeping Items.

- Questions- ask questions at any time, this is an interactive presentation.
- Phones- silent, and if you need to take a call step outside.
- Restrooms/stepping outside- be respectful of your neighbors when leaving the room.
- Breaks- we will take breaks during the presentation and a break for lunch.

"Therapeutic Alliance and Therapy Outcomes"

Training Objectives

- Identify factors that contribute to positive therapy outcomes.
- Identify the elements of the therapeutic relationship.
- Learn how to incorporate practices to build therapeutic alliance.
- Explore personal areas of growth that may impact the therapeutic alliance.
- Implement skills learning into everyday practice.

Exercise #1

- Think about all the factors you think contribute to success in therapy.

Handout titled "Exercise 1" - 5 minutes to create list and then we will discuss as a group.

List all the factors you think are important to a successful outcome of therapy with your client.

Exercise #2

- 70% of professionals in mental health have participated in therapy at some point

Handout titled "Exercise 2" -Take 5 minutes and we will discuss as a group.

List all the things that made your personal therapy successful/enjoyable or unsuccessful/difficult.

- If you are part of the 30% that has not ever participated in therapy, think about a relationship with a supervisor or professor.

A Brief History of Therapy Outcome Research

- Compare the two lists that you created.
  - How similar are they? Is what you think your clients need different than what you enjoyed about therapy?
- Research has spent a significant amount of time looking at what contributes to therapy outcomes.
  - Therapist's traits
  - Theory and approach
  - Treatment fidelity
- Therapist's traits and therapy outcomes.
  - Level of education
  - Gender
  - Length of training
  - Professional discipline
- Researchers attempted to match clients based on gender, race, appropriate theoretical orientation, etc.
- Researchers have found that these factors do not contribute to psychotherapy outcomes (Beutler et al., 2004; Miller, Hubble, & Duncan, 2007).
- Researchers have spent a significant amount of time researching the best treatment approaches for specific conditions.
  - CBT vs Psychodynamic
  - Psychotherapy vs Medication
  - Placebo vs Psychotherapy
  - Manualized treatment vs "generic treatment"
- Majority of research has focused on the **best treatment** for **specific conditions**.
- Recent research has found that the theoretical model used accounts for **less than 10%** of outcomes (Wampold and Imel, 2015).

A Note on Manualized Treatment

- Researchers have found manualized treatment to be successful in clinical trials (Scaturo, 2001).
  - Clinical trials generally have strict criteria for participants and are rarely representative of individuals that present for psychotherapy.
  - When researchers have investigated the effects of adherence to specific treatment protocols, they often find that **strict adherence results in decreased benefits** from therapy (Berman & Norton, 1985; Falkenström et al., 2013; Laska, Smith, Wislocki, Manami, & Wampold, 2013; Scaturo, 2001).
  - ***This research highlights the importance of the therapist themselves***.

The Medical Model of Treatment

- Mental Health has often looked to the medical field as an example
    - Consumers often compare to the two disciplines.

- The Medical Model proposes that every diagnosis should have specific treatment.
    - The intervention is more important than the person providing it.

Problems with the Medical Model – VIDEO (*ineffective practitioner*)

Group Discussion

- What problems do you see with the medical model?
- What is your experience with manualized treatment?
- What are some of the challenges as a novice therapist when entering a therapeutic relationship?

~EXERCISE~

Group Discussion

- How was it to speak to a person you don't know or know well?
- How did you manage to continue talking for the duration of the time?
- How is process similar to therapy?
- What factors do you think contribute to therapy outcome now? And how is that different than your first list?

5 min Break

The Common Factor Model

- Early psychologists began questioning whether it was the school of therapy that led to change or the characteristics of the therapist.
- Research looking at whether one therapist can be naturally better at therapy than another.
- What are the components that span all treatment modalities?

The Common Factor Model of Therapy

- The Common Factor Model developed in the 1930's and has been a fixture in research.
- The Common Factor Model suggests 4 general factors that contribute to outcome;
    - Extratherapeutic Factors
    - Expectancy Effects
    - Therapeutic Relationship
    - Treatment Modality

A Look at The Common Factor Model – ***THERAPEUTIC FACTORS PIE***

CHART

What Can Therapists Control?

- Therapists have limited to no ability to control for about 55% of the factors associated with change.
- Therapists get to choose their theoretical orientation, but that is unlikely to change much.
- It's important to understand how a therapist can improve outcomes above and beyond their approach.

Extratherapeutic Factors

- These are events that happen outside of therapy, and are not a direct result of anything occurring in therapy.
- What are some reasons that people come to therapy?
    - Loss of a job, conflict with spouse, trouble with a class.
- What happens when those stressors resolve on their own?
- Spontaneous recovery
    - The cathartic effect of a first session.
- Community Resources
    - NAMI Groups
    - Church Support Groups
- Social Media
    - Support Groups online

Expectancy Effects

- Placebo- An inert treatment that causes changes with no biological effects
    - Psychotherapy could be considered inert.
    - Long-term biological changes
    - APA call for research on placebo effects
- Individuals generally expect to get better when going to therapy
    - Accounts for 15% of outcome
    - Individuals that expect to get better improve the most
- Placebo generally believed to be negative
    - Research into positive use of placebo
- Providing a prognosis at the beginning of therapy can lead to improvement.
    - Telling people that their condition is treatable can make a difference.

Expectancy Effects in Practice

- There are expectations of a stereotypical psychotherapist
    - Three key factors

        - Expertness- Do they appear to be an expert in the practice
        - Trustworthiness- Are they safe to talk to about difficult things
        - Attractiveness- Not necessarily physically, but similar characteristics

Therapist Factors

- Gender
    - Bowman (1993) meta-analysis found no difference in outcome based on gender
        - Earlier studies found that female therapist rate client change higher than males
- Education
    - Paraprofessionals and Professionals are better than lay people at psychotherapy.
    - No difference between paraprofessionals and professionals in mild to moderate cases
    - No research on the effectiveness of graduate training
- Religion
    - No main effect for therapist religion on outcomes
    - No difference in outcome when religion is included in treatment plan compared to completely secular
        - Based completely on client desire
    - Therapist should not include religion in treatment plan if they are not familiar with religion or receiving supervision
- Case load
    - High case load or large number of difficult cases can reduce outcomes
    - Burnout and secondary trauma are a problem
- Experience
    - Professional therapist generally equally effective at identifying emotions and applying empathy.
    - Experience is more important in complex cases

Client Characteristics

- Not extensively researched
- Race
    - Race is generally considered a poor predictor of outcome
    - Race congruent and race incongruent relationships are not significant predictors
    - Clients identify shared race as a factor prior to therapy but not once therapy begins
- Severity of symptoms
    - Severe symptoms and chronic problems show lower outcomes in general
- Client Personality

    - Low self-worth and self-esteem are associated with poorer outcomes
- Baseline functioning
    - Poor previous functioning results in lower outcome scores. Talk/insight therapy may not be appropriate.

What Can We Control

- We can control the **methods** that we use
    - Not every theory or intervention is appropriate for every condition.
        - Example
- We can control the way **we interact with the client**

Techniques

- Most frequently researched topic-Division 12 of APA
- Threatens the therapeutic alliance
- No one evidenced-based treatment is better than any other
- Accounts for 15% of outcome regardless of technique used
- Strict adherence to protocol results in poor outcomes- Paradoxical effect; rigidly

Therapeutic Alliance

- Therapist have the ability to control how we interact with our clients
- Accounts for between 10-20% of outcome variance
- Is the relationship between therapist and client
    - Represented by the relationship between Task, Goals and Bond
- Consistent effects regardless of orientation used
- Predictor of dropout, no shows, and treatment compliance
- Involves accurately identifying emotions, creating empathic environment and listening skills
- Emphasized by every evidenced-based psychotherapy

Therapeutic Alliance Evolution - **VIDEO**

The Working Alliance

- The working alliance is a collaborative agreement between the tasks and goals of therapy.
- An agreement on the task and goals leads to a bond between the therapist and client.
- The bond is generally not addressed directly.

IMAGE- of WORKING ALLIANCE (Upside-down triangle)

People are generally better persuaded by the reasons which they have themselves discovered than by those which have come in to the minds of others -Blaise Pascal

LUNCH- 45 min

Alliance Ruptures and Breaks

- Define a **rupture** as a breakdown of the collaboration between the therapist and the client
  - These can range from mild to severe intensity
  - Occur frequently in therapy
- Define a **break** as a loss in confidence that the therapist and client are working towards the same goals.
  - Generally result in the termination of treatment.

How to Address Ruptures

- Cause
- Address
- Break in rupture?

Repairing Therapeutic Alliance

Show clip from In Treatment Season 3- Jesse (Mature Scenes)

- Therapeutic Alliance can be fractured and repaired multiple times.
- Degree of rupture varies - Intensity, duration, frequency.
- Can be so significant pt. ends therapy prematurely, or so slight therapist easily misses it.
- Most therapy cases will experience at least one rupture over course of treatment.

  *This MUST be attended to!

  1. Bone Analogy – Makes it stronger
  2. It is also Modeling – what it looks like to have healthy conflict in relationships. – (site research on effective conflict resolution.)

- Research: Foreman & Marmar 1985 small study on outcomes and those who had pos. Outcomes had there who addressed ruptures (i.e. “when you begin to feel angry with me, you withdraw and become silent”) VS. Those with neg. Outcomes had therapists who ignored or avoided it.
- Alliance ruptures provide opportunity for therapist to explore and review goals, expectations, emotions and beliefs, which play role in dysfunctional relational patterns with others in pts. Life. Which in turn allows therapist to disconfirm their neg. belief/schema.

- Need to adequately and empathically understand nature and function of pts. Negative and dysfunctional beliefs about self and others.
- Alliance Rupture markers:
    - Overt expression of negative sentiments towards therapist
    - Indirect communication of negative sentiments or hostility
    - Disagreement about the goals and tasks in therapy
    - Hasty Compliance or Acquiescing
    - Self-Esteem – enhancing operations when feeling criticized
        - Sullivan (1953) security operations- to reduce or avoid anxiety resulting in deflated self-esteem of pt.
    - Non-responsiveness to intervention –
        - may be preexisting problem in alliance or just poorly timed, unempathic intervention.
        - Failed intervention can lead to better understanding of pt. interpersonal schema, (Safran et el., 1990).
    - Avoidance *Safran Article*

<u>Avoidance</u>

- Signs from pt.
- Reaction of therapist (having mindful self-awareness)
- Functions of Avoidance
    - Something so scary, we push it off at <u>all</u> cost!
    - Reduce anxiety, protect self from sense of threat
- Options- What can we do?
    - Slow down voice – helps pt. slow down, and <u>really feel</u> their emotions.
    - Clarify/ make it simple – not giving overly complex interventions.
    - Redirect – Bring attention. to their distractions. Repeating this practice will help them eventually see it too.

Role Playing – Practicing Slowing Down and Redirecting Avoidance

Discussion

<u>Feedback-Informed Treatment</u>

- Treatment using measurements and feedback on therapeutic alliance and outcomes.

    - Use of tools such as the ORS and SRS to provide feedback to clients
    - Found to be evidenced-based practice by SAMHSA
- Improves outcomes, reduces dropouts, decreases the number of required sessions for improvement
- Emphasis on positive therapeutic alliance, client preferences, and growth.

What Builds Therapeutic Alliance

- Empathy
    - The therapist's ability to understand the client's thoughts, feelings, experiences from the client's perspective.
    - A large part of research has focused on empathy
- Positive Regard
    - Similar to the concept of Rogers
    - A warm acceptance of the client without any exceptions. The ability to see the client as a person worth helping despite their problems.
- Collaboration on goals and purpose.
    - The client is invested in what they see as the problem.
    - It is important to remember that therapy is not for the therapist, it is to help the client achieve their goals.
- Ruptures often occur when the client and therapist fail to agree on the goal.
    - Example; bring a homework assignment for the client on a topic they stated they were not interested in.
- Feedback
    - Providing feedback to the client and soliciting feedback from the client. What do they think is working, how do they think therapy is working.
- Genuineness
    - Be yourself, because a client will know when you are being fake.
- Self-Disclosure
- Managing Countertransference

What is Likely to Damage the Alliance

- Confrontation
- Assumptions
- Rigidity/Scripted Therapy
- Focusing on what the therapist wants

Exercise 3

- Meet someone new?
- Look around the room and find someone you don't know or don't know well.
- Pair up with a person.
- Spend a few minutes talking to the new person.

Group Reflection

- How did you communicate?
- How did you know what to talk about?
- What would you have done if it didn't go well?

Implementing Skills into Practice –

How to incorporate all these concepts into my therapeutic approach.

Borrowing From Motivational Interviewing

- Motivational Interviewing is an evidence-based intervention. It is a unique communication skill, focused on meeting the client where they are. Can be used in almost any context, with any modality or orientation, and with different populations.
- Motivational Interviewing is not a theory, but it does provide skills to improve the alliance.
- Refer to the video of the doctor from earlier - what basic skills could improve the therapeutic alliance.

Practical Skills that Make a Difference

- At the beginning of treatment and then throughout treatment, focus on the individual's needs . - OARS
    - **O**pen-ended questions
    - **A**ffirmations
    - **R**eflections
        - Repeat, rephrase, paraphrase, reflection
    - **S**ummarize
- A Motivational Interviewing Skill - RULE
    - **R**esist the Righting Effect
    - **U**nderstand and Explore the person's motivation
    - **L**isten with empathy
    - **E**mpower the person, encourage hope, and optimism

Understanding Communication Styles & Purpose

- Communication styles – *Insert Bar Graph*
    - Directing
    - Guiding
    - Following
- Do These Skills Fit Your Orientation?

Something to Consider After Training

- Professionals have a difficult time "unlearning" old styles of communication. (Schumacher, Madson, & Nilsen, 2014)
    - Professionals in the **corrections field had the most difficulty** implementing new skills, followed by **general health doctors**.
        - What's in common here? – What personality factors may apply here?
    - Mental health professionals also struggled with **asking too many questions, confrontation,** and **having their own agenda.**

Personality and Psychotherapy

- Personality type is a better predictor than education
- Personality traits can predict compassion fatigue
- Psychotherapist tend to have similar personalities that differ from the general public

~BIG FIVE IMAGE~

Typical Therapist Profile

- Lower Neuroticism
- Higher Scores on Openness, and Agreeableness
- What are the implications for therapy?
    - Are some people naturally better at building at therapeutic alliance?

~NEO-FFI PERSONALITY PROFILE IMAGE~

The Perfect Therapist

- There is no such thing. Every therapist has strengths and weaknesses.
- We frequently look at how to sharpen our tools in therapy.
    - The alliance is a tool in therapy and understanding our personality traits can help us sharpen our skills.
- Awareness provides an opportunity for growth.

<u>Final Thoughts</u>

- Personality is consistent but not constant.
- The genuine you, is the best thing you can offer your client.
- **Like any skill, therapeutic alliance can always be improved** if it is measured, evaluated, and addressed in training and supervision.
- Don't be afraid to ask questions. It's just as important to own what you don't know.

Afterwards – what worked well (Administration details, etc.)

Discussion – If we find a result, what would that mean?

“This program will be in collaboration with future publications”

- Questions
- Follow up contact
- References