

The Impact of Collaborative Alliance Feedback and Autonomous Motivation in
Psychotherapy for Depression Symptoms

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The Impact of Collaborative Alliance Feedback and Autonomous Motivation in
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Abstract

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The Impact of Collaborative Alliance Feedback in Psychotherapy for Depression

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Routine outcome monitoring feedback systems have been successfully implemented to track progress in psychotherapy and reduce rates of deterioration. The current study examined autonomy support as a mechanism involved in a novel common factors enhancement (CFE) feedback system in psychotherapy when compared to treatment as usual (TAU). The CFE treatment prominently featured protocols regarding collaborative discussions between clients and therapists on the working alliance in order to promote positive outcome and increase client autonomous motivation. Seventy-nine clients were drawn from a pool of 1,862 undergraduate student sample for depression symptoms using the Beck Depression Inventory-II (BDI-II) as a screening and outcome measure. Clients were randomized to five sessions of CFE or TAU and completed measures of process (along with their therapists), depression symptoms, and wellbeing. Results indicated that there were no significant differences between TAU and CFE on outcome or ratings of the therapeutic alliance. Mediation analyses found that therapist autonomy support emerged as an indirect mediator of positive outcome for CFE only. Results indicate that CFE system may have important, indirect implications for process through strengthening clients' intrinsic motivation for treatment.

Keywords: alliance, autonomous motivation, feedback, psychotherapy process

Table of Contents

	Page
Abstract	3
List of Tables	6
List of Figures	7
The Impact of Collaborative Alliance Feedback in Psychotherapy for Depression	8
Outcome Monitoring and Feedback.....	9
Limitations of Outcome Feedback Systems.....	9
Unknown mechanisms	10
Therapist barriers to implementation	10
Re-thinking Outcome Monitoring: Process-focused Feedback	12
Common Factors Enhancement System	14
Further Investigating Collaborative Alliance Feedback.....	14
Feedback on the Working Alliance.....	15
Client Autonomous Motivation.....	15
Hypotheses	18
Primary Objectives	18
Hypothesis one.....	18
Hypothesis two.....	18
Hypothesis three.....	19
Hypothesis four.....	19
Hypothesis five	19
Methods.....	20
Participants	20
Therapists	22
CFE Training/Adherence	22
Procedures	23
Measures.....	26
Beck Depression Inventory-II.....	26
Health Care Climate Questionnaire-Short	27
Schwartz Outcome Scale-10	28

	5
Working Alliance Inventory-Short Form Revised.....	29
Working Alliance Inventory-Therapist Version	29
Data Analyses.....	30
Analysis one.....	30
Analysis two.....	30
Analysis three.....	31
Analysis four.....	31
Analysis five	31
Results.....	33
Depression and Wellbeing Outcomes	33
Alliance	34
Client and Therapist Alliance Agreement.....	34
Autonomy Support	34
Mediational Model One: Treatment Condition, Autonomy Support, and Depression .	35
Mediational Model Two: Autonomy Support, Alliance, Depression	35
Discussion.....	36
Depression and Wellbeing Outcomes	36
Alliance	38
Autonomy Support	40
General Discussion.....	42
Limitations	42
Clinical Illustration.....	43
Conclusion and Future Directions.....	44
References.....	51
Appendix A: Clinical Support Tools (CFE Manual)	59
Appendix B: Measures.....	74

List of Tables

	Page
Table 1. Overall Means (Standard Deviations) and Correlations among Study Measures.....	46
Table 2. Means (Standard Deviations) among Study Measures at Sessions One and Five by Condition.....	47
Table 3. Results of Mediation Analyses.....	48

List of Figures

	Page
Figure 1. Attrition Flow Chart.....	49
Figure 2. Example of CFE Alliance Data Visualization (at Session Five).....	50

The Impact of Collaborative Alliance Feedback in Psychotherapy for Depression

Outcome monitoring in psychotherapy represents an effective method for significantly reducing rates of clients stagnating or deteriorating over the course of their treatments. However, only a small subset of clients tends to experience a benefit from the inclusion of outcome monitoring. Further, community clinic implementation rates of outcome monitoring systems remain low. The present study tested a novel form of collaborative feedback designed to increase positive outcome for a wide range of clients while potentially being more acceptable to practitioners. To accomplish these aims, the present study examined the potential impact of (and mechanisms underlying) a novel form of collaborative therapeutic feedback based entirely on key elements of psychotherapy process (e.g. the working relationship or working alliance between client and therapist).

Outcome Monitoring and Feedback

For nearly two decades, psychotherapy researchers have worked to design, empirically investigate, and disseminate outcome feedback systems. The results of these investigations show outcome feedback to be an effective and clinically useful addition to psychotherapeutic interventions, most notably within the subset of deteriorating cases (De Jong et al., 2014; Shimokawa et al., 2010). Feedback systems, such as the pioneering Outcome Questionnaire-45 (OQ-45) therapist feedback system (Lambert et al., 2001), have been found to prevent over half of clinical deterioration cases.

Many outcome feedback system studies collect data from clients on symptoms, well-being, and/or functioning (Overington & Ionita, 2012) and provide that aggregate data to therapists. In a few other empirically tested protocols, such as the Partners for Change Outcome Management System (PCOMS; Duncan, 2012), brief outcome and alliance data are also presented to the clients who complete the measures.

Limitations of Outcome Feedback Systems

Despite significant commercialization of empirically supported outcome protocols like the OQ system, the majority of community practitioners in the US have not implemented a standardized feedback system within their practices (Phelps, Eisman, & Kohut, 1998; Zimmerman & McGlinchey, 2008). Even in health care economies that mandate outcome monitoring, routine use of feedback has been inconsistent (Mellor-Clark, Cross, Macdonald, & Skjulsvik, 2016), with some implementation trials showing little therapist behavior change in response to outcome feedback (Lucock et al., 2015). Given the disconnect between aspirational psychotherapeutic practice and current realities of community treatment, the vast majority of mental health care providers have

no feedback on important client data (Zimmerman & McGlinchey, 2008). A recent study of 1,688 registered Canadian psychologists found that two thirds of therapists were unfamiliar with monitoring client progress and only 12% reported using an outcome measure in their clinical work (Ionita & Fitzpatrick, 2014).

Unknown mechanisms. As noted earlier, outcome feedback literature lacks vital insight into the underlying mechanism (or mechanisms) that explain the relationship between client feedback and positive therapeutic outcome (Lambert & Shimokawa, 2011; Lutz, De Jong, & Rubel, 2015). Anecdotal and preliminary research evidence suggests that some clients may feel more autonomously engaged in their therapy when their treatment includes feedback (De Jong et al., 2014; Lambert & Shimokawa, 2011). Another potential hypothesis is that client and therapist feedback promotes a focus on processing within the therapeutic relationship (Unsworth, Cowie, & Green, 2012), which is a critical element of positive therapeutic outcome (Horvath, Del Re, Flückiger, & Symonds, 2011).

Therapist barriers to implementation. Survey research has shown that community clinicians may be hesitant to adopt outcome feedback measures due to fears of performance evaluation/comparison as well as the hassle of translating outcome feedback into useful clinical information (Lucock et al., 2015; Overington, Fitzpatrick, Hunsley, & Drapeau, 2015; Unsworth, Cowie, & Green, 2012). One study of Australian clinicians found that more than half of study therapists reported that they would not implement an outcome feedback system (even if it meant that their patients would see a benefit) due to the perceived untranslatable nature of the outcome data (Walter, Cleary, & Rey, 1998).

This evaluative threat may relate to widespread clinical disinterest in outcome monitoring. Tasca and colleagues (2015) conducted a large-scale survey among practicing clinicians ($N = 1,019$) to determine what information practitioners most wanted from psychotherapy research. Clinicians rated progress or outcome feedback among the least important topics of research for informing their practices. The researchers found that, above all other subjects, clinicians wanted more research to focus on process and mechanisms of change within therapy, primarily in relation to the working alliance.

Re-thinking Outcome Monitoring: Process-focused Feedback

While demonstrably effective for select clients, outcome monitoring systems have met with concerns about acceptability from clinicians, difficulties in implementation (Lucock et al., 2015; Mellor-Clark et al., 2016), and a lack of clear mechanisms. Some therapists may feel evaluated by (De Jong, 2016; Callaly et al., 2006; Overington et al., 2015; Unsworth et al., 2012; Walter et al., 1998) or disinterested in (Tasca et al., 2015) using outcome monitoring in therapeutic practice.

By removing the presence of outcome, the process-focused feedback may reduce evaluation threat as therapists who receive process feedback would have a better sense of how to address process issues (compared to ambiguous off-track outcome feedback). Further, process-feedback may meet with enhanced acceptability (and as a result, greater implementation). All evidence-based treatments feature some level of focus on process which may lead to a relatively straightforward integration of a process-focused system in a wide range of community practices. Given that clinicians are more interested in research on psychotherapeutic process and mechanisms of change (Tasca et al., 2015), a process-focused feedback system may be viewed more favorably than an outcome-focused system. By tailoring feedback to processes like common factors, elements of therapy may be tested as mechanisms. Indeed, common process factors, like the therapeutic relationship, account for up to 50% of the variance in outcome (Cuijpers, Driessen, Hollon, van Oppen, Barth, & Andersson, 2012; Lambert, 2013). These premises form the basis of a new feedback protocol rooted in promoting a strong therapeutic alliance and increasing the client's feelings of autonomy in treatment process decisions. The current study reports on a re-imagined form of feedback called the

common factors enhancement (CFE) feedback system, which is focused around elements of psychotherapeutic process.

Common Factors Enhancement System

Based on Wampold and Imel's (2015) contextual model, the CFE system highlights feedback on outcome expectations (Constantino et al., 2011; Swift & Derthick, 2013), empathy (Bohart & Greenberg, 1997; Dowell & Berman, 2013), and alliance (Hill & O'Brien, 1999; Safran & Muran, 2000; Safran & Muran, 2006). The novel CFE system featured a collaborative presentation of client-generated data and discussion between client and therapist each session about each of these three constructs. Results from the overall CFE have found that the CFE system (compared to TAU) resulted in an increased rate at which empathy and alliance developed throughout the treatment (McClintock, Perlman, McCarrick, Anderson, & Himawan, in press).

Further Investigating Collaborative Alliance Feedback

This paper was pre-planned as a compliment piece to the study of the overall CFE (McClintock et al., in press) in order to focus more specifically on the alliance component of the overall CFE. Due to the construct's wide appeal with clinicians (Tasca et al., 2015) and the alliance's robust link to outcome (Horvath et al., 2011), the collaborative alliance feedback component of the CFE system merits further attention. Since clinicians are more likely to adopt assessment tools when they see a practical use (Jensen-Doss & Hawkley, 2010), focusing feedback on process may ultimately lead to more widespread community acceptance and utilization of feedback interventions than are currently observed with outcome monitoring.

Feedback on the Working Alliance

The alliance has been found to robustly predict outcome. Horvath and colleagues' (2011) meta-analysis determined that 8% of outcome variance (mean weighted $r = .28$) can be attributed to the working alliance. The working alliance is viewed as an ever evolving collaborative or negotiated relationship between client and therapist that varies significantly through therapy (Safran & Muran, 2006). Further, these rapid fluctuations in the alliance, specifically periods of disconnect or “rupture” followed by corrective “repair” experiences, may serve as powerful mechanisms of personal growth or change through therapy. A meta-analysis conducted by Safran, Muran, and Eubanks-Cater (2011) found that successful rupture-repair processes were significantly predictive of outcome (mean weighted $r = .24$) and accounted for 6% of outcome variance. The fluctuating nature of an alliance relationship could serve as a sound construct for the basis of a routinely administered collaborative feedback element.

Client Autonomous Motivation

Research on mechanisms of change has been noted as a key target of future investigation by psychologists within the feedback community (Lutz, De Jong, & Rubel, 2015) because little is known about what therapeutic processes change as a result of outcome feedback. One hypothesized mechanism involves feedback increasing the client's autonomous motivation for treatment (De Jong et al., 2014). Autonomous (or intrinsic) motivation in psychotherapy can be defined as the degree to which a client willfully internalizes the treatment process (de Charms, 1968; Ryan & Deci, 2008). Within the realm of psychotherapy process, autonomous motivation is implicated as a

potential mechanism of effective therapy, particularly when therapy focuses on process instead of outcome (Ryan & Deci, 2008).

By rooting a collaborative feedback system in the therapeutic alliance, therapists can successfully encourage and support client autonomy (for example, by expressing that they value the client's input) while still firmly basing session work in a familiar set of psychotherapy process constructs. Collaborative alliance feedback creates a foundation in client control and goal setting in the therapeutic process which may help dyads facilitate greater autonomous motivation and ultimately, enhanced therapeutic outcome. The process of working collaboratively on the goals and tasks of session work may most appropriately be couched in interactions concerning the status of the working alliance.

Pelletier, Tuson, and Haddad (1997) found that client autonomy had a significant relationship with positive outcome in 138 outpatient psychotherapy clients with a wide range of diagnoses and psychotherapy treatment modalities. They also found that clients who reported feeling externally motivated for treatment, which anchors the opposing end of the motivation spectrum, reported worse therapeutic outcomes and experienced increased treatment drop-out. Zuroff et al. (2007) expanded on this work and found longitudinal, predictive linkages from therapist autonomy-supportive behavior to client autonomous motivation to post-treatment psychotherapeutic outcome in a sample of 95 depressed clinical outpatients.

Providing clients with feedback on the working alliance within a semi-structured format that encourages further collaborative discussion may influence other client changes. Specifically, when clients receive feedback about the working alliance from their therapist, along with encouragements for discussion/input, clients are also given the

message that they are a full partner in those negotiations. Making those negotiations around the working alliance more manifest (through feedback) gives both clients (and therapists) a forum to raise pertinent psychotherapeutic issues from the data presented, which in turn, offers a unique opportunity to experience meaningful engagement with the treatment process. At the same time, therapists are able to support and build intrinsic motivation in their clients through a number of methods. Reeve, Bolt, and Car (1999) identified a number of these techniques including: expressing awareness of clients' unique points of view, validating clients' feelings, avoiding pressure in directing treatment process, providing as much treatment choice as possible, and giving clients clear and believable rationales for elements of therapy. Using collaborative discussions to negotiate the working alliance may ultimately improve the course of treatments by enhancing clients' autonomous motivation and treatment engagement.

Hypotheses

Primary Objectives

The current study developed and tested a novel common factors enhancement (CFE) feedback protocol, which, at the time of its inception, was a design that no other research protocol had tested. As a preliminary study of a novel process focused feedback system, the alliance feedback component was couched within a larger feedback protocol designed to maximize the effective elements common to all psychotherapies (i.e. Wampold & Imel, 2015). The protocol made use of alliance feedback provided to both therapists and clients in order to facilitate an open, ongoing autonomy-supportive collaboration about the working alliance.

Feedback in the context of this project refers to a collaborative, in-session process data presentation (based on client self-report) along with an alliance-focused discussion between client and therapist on the goals, tasks, and affective bond of the therapy. Besides a focus on the therapeutic relationship, the CFE feedback system also included two other effective therapeutic processes: outcome expectations (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Newman & Fisher, 2010) and empathy (Elliot, Bohart, Watson, & Greenberg, 2011).

Hypothesis one. It was predicted that clients who receive CFE will achieve a significantly greater reduction of depression symptoms and greater enhancement of overall well-being compared to clients in a TAU group.

Hypothesis two. It was predicted that both clients and therapists in the CFE group will report stronger alliances than those in the TAU group by the end of treatment.

Hypothesis three. It was predicted that there will be a stronger overall correlation between client and therapist ratings of the therapeutic alliance in the CFE condition when compared to the correlation of alliance ratings in the TAU group.

Hypothesis four. It was predicted that clients who receive CFE will rate their therapists as more autonomy supportive compared to clients in the TAU group by the end of treatment.

Hypothesis five. It was predicted that the relationship between CFE and reduction in depressive symptoms will be mediated by both the working alliance and by therapist autonomy support.

Methods

Participants

This study drew on a sample of undergraduate psychology students from a large, public university in the Midwestern United States. The final sample ($N = 79$) included students who endorsed a mild (a score of 14-19), moderate (a score of 20-28), or severe (a score of 29-63) level of depressive symptoms on the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) at two time points: 1) a general pre-screening at the beginning of the semester and 2) during a pre-session-one assessment. All participants had to be 18 years or older to participate. Additionally, participants were excluded if they expressed suicidal thoughts or were diagnosed with any of the following conditions: learning disability, bipolar disorder, schizophrenia, or other psychotic disorders. These exclusion criteria were established to ensure that all therapists seeing cases at a developmentally appropriate level according to the therapists' training.

The initial participant pool included 1,862 students. Four hundred and sixty three of these students met depressive symptom criteria for entry into the study during the general pre-screen. Participants were invited to enroll in the study voluntarily, of which 95 were assessed during a pre-session-one screening. Sixteen potential participants did not enter into treatment and were excluded from the final sample used in data analysis. Thirteen of these excluded students had pre-treatment BDI-II scores that were below the pre-established cut score of at least 14 points. Three were excluded for having mental health diagnoses that met exclusion criteria, including one participant who expressed suicidality. This participant was given a brief risk assessment and referred out to

appropriate community mental health resources. See Figure 1 for attrition flow chart (adapted from McClintock, Perlman, McCarrick, Anderson, & Himawan, in press).

The treatment sample of 79 participants was then randomized to the CFE ($n = 35$) or TAU ($n = 44$). Of those allocated to CFE, 29 completed at least two sessions (making them eligible for intent-to-treat [ITT] analyses) and 24 completed all five sessions. For those in TAU, 40 completed at least two sessions while 32 participants completed all five sessions. All participants were awarded course credit for participation while participants who completed all five sessions were offered a 10 dollar bonus.

While not a true, treatment-seeking outpatient sample, the participants of this study can be considered “clients” given that they, 1) reported enduring (i.e. reporting elevated symptoms of depression at multiple time points [assessed somewhere between one to nine weeks] before entering into treatment) levels of psychological distress that are akin to treatment-seeking clients, 2) voluntarily signed up for a treatment study, and 3) received a role induction (to the role of a therapy “client”) as a part of the consent process. Further matching a client sample, a notable subset of participants (13.3%) endorsed receiving concurrent mental health treatment (either psychotherapy, medication, or a combination) for depression (5.00%), co-morbid depression and anxiety (5.00%), anxiety, (1.25%), OCD/ADHD/anxiety (1.25%), or an unspecified mental health concern (1.25%). Most clients identified as female (79.5%), Caucasian (77.1%), and freshman status (57.8%). Clients ranged in age from 18 to 44 years old ($M = 19.3$, $SD = 2.99$). Clients who received concurrent mental health treatment were no more likely to drop out of treatment than those not receiving treatment.

Therapists. All six study therapists were graduate students in clinical psychology who were trained to use and facilitate discussion using the CFE system. Therapists were also trained in identifying, assessing, and properly referring clients who exhibited elevated levels of active suicidality. Therapists had also completed several graduate-level therapy and assessment courses. Prior to the start of treatment, study clinicians averaged 313.16 direct client contact hours ($SD = 261.31$). Three therapists identified as female and all identified as Caucasian. Three of the therapists self-described their theoretical orientation as cognitive-behavioral, two identified as integrative/eclectic, and one reported their primary orientation as humanistic.

CFE Training/Adherence

Pre-study training included a comprehensive CFE manual that featured evidence-based strategies for enhancing outcome expectations (Constantino et al., 2011; Swift & Derthick, 2013), empathy (Bohart & Greenberg, 1997; Dowell & Berman, 2013), and alliance (Hill & O'Brien, 1999; Safran & Muran, 2000; Safran & Muran, 2006) compiled by three of the therapists involved in the project (McClintock, Perlman, & McCarrick, unpublished manuscript; see Appendix A for the CFE manual). All six study therapists read the CFE manual, completed a two hour training seminar on delivering CFE interventions (as outlined within the manual), and practiced interpreting data and utilizing the CFE system in several mock clinical situations. Therapists were crossed between treatments to reduce the potential influence of therapist effects. Additionally, therapists participated in weekly, group supervision to discuss individual cases and treatment protocols for both study conditions. This step helped to maintain CFE adherence and promote an understanding of unique clinical issues related to the study treatments

(particularly the use of the CFE elements like the collaborative alliance feedback). At the end of the project, therapists were provided an anonymous survey using a 5-point Likert (1 = never; 5 = always) to rate the frequency with which they discussed client feedback with CFE treatment clients. Study therapists reported high adherence to treatment protocols ($M = 4.67$; $SD = 0.82$). Therapists were also asked to describe the length of time spent discussing feedback using the following options: 0-1 minute, 1-5 minutes, 5-10 minutes, 10-20 minutes, or >20 minutes. Three therapists reported an average feedback discussion lasting 1-5 minutes while three therapists reported average use lasting 5-10 minutes.

Procedures

Study procedures were approved by university institutional review board and all ethical standards were upheld through the duration of the project (which lasted through the 2015-2016 academic year). To determine study eligibility, students completed a psychology subject pool prescreen instrument that included the BDI-II for the current study. Prescreen respondents who scored above the mild depression cut-off of 14 or higher on the BDI were recruited via email for the final sample to serve as clinical analogs for individuals with high levels of depression symptoms. All eligible participants who registered for a study time slot were provided with a pre-treatment BDI-II to ensure enduring psychological distress. In addition to the baseline measure of depressive symptoms, clients also completed the Schwartz Outcome Scale (SOS-10; Blais et al., 1999) as a baseline measure of overall psychological well-being.

After screening for elevated depressive symptoms, participants met with a study therapist in mock therapy room housed within a psychology research laboratory to review

a research consent form, complete the client role induction, and determine study eligibility.

After the consent and measures, all of the participants were randomized to receive either: 1) an established treatment of the clinician's choosing, labelled treatment as usual (TAU), or 2) TAU in addition to the common factors enhancement (CFE) feedback system. Randomization was completed after consent to avoid unintended experimenter effects during the consent process. Each treatment consisted of five (including the initial visit) weekly sessions that each allot one hour of time to complete brief, pre- and post-session measures and undergo psychotherapy (for 45 to 50 minutes) with a trained clinical psychology graduate student therapist. After each session, clients completed the BDI-II, Schwartz Outcome Scale-10 (SOS-10; a measure of general wellbeing), Health Care Climate Questionnaire – Short (HCCQ-S; measure of autonomy support), and the Working Alliance Inventory – Short Form Revised (WAI-SR; client-rated alliance) while study therapists complete the Working Alliance Inventory – Therapist Version (WAI-TV; therapist-rated alliance).

Within the CFE treatment, sessions two through five began with the implementation of the collaborative feedback by having the clients and therapists discuss their unique working relationships in terms of goals, tasks, and bond as reported by the clients in the session prior (see Figure 2 for an example of the CFE data presentation for the working alliance). Outcome expectations and empathy were also discussed during the feedback. The alliance discussion was accompanied by a visual presentation of the client's self-reported alliance data in a line graph that featured percentile-based “tracks” created from a general outpatient clinical sample. These “tracks” were color-coded green

(the top 33rd percentile of outpatient clients), yellow (the middle 33rd percentile), and red (the bottom 33rd percentile) to help both clients and therapists use a heuristic to determine the current state of their shared therapeutic alliance when compared to an aggregate mean. This normative data was collected from a sample of 238 outpatient clients from the psychology department clinic.

The alliance visualization was accompanied by descriptive information from the study therapist for clients to learn about the therapeutic alliance. Therapists were instructed to place a distinct focus on explaining to clients that successful therapeutic dyads demonstrate a variety of trajectories in alliance development (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004) and that scores presented in session do not reflect the ultimate course or outcome of their treatment. Instead, clients and therapists were encouraged to collaboratively discuss their unique, ipsative therapeutic relationship using the presentation of alliance data as to help facilitate discussion. The normative data was primarily functioning as a starting point for productive conversation between client and therapist (instead of predicting therapeutic outcome). Clients in the TAU group completed the same post-session measures on alliance and autonomy support after each session in the same manner as the CFE group, but this was not presented in session as a feedback protocol for the treatment. Neither therapists nor their clients received data on outcome expectations, empathy, or alliance in the TAU condition.

At the conclusion of the five sessions, participants were fully debriefed on the nature of the experiment. Those in the TAU condition were given the opportunity to participate in the CFE therapy if they elected to do so (none did). Participants who attended all five sessions were offered 10 dollars, in addition to five research credits, as a

bonus for fully participating in the study. All fully completing participants, except for one from the CFE condition who stated that they received more than adequate compensation through the course of their treatment, accepted the 10 dollar bonus.

Participants who partially completed the study received partial course credit prorated to their level of participation.

Measures

This study protocol involved multiple administrations of a variety of measures designed to assess depressive symptomatology, working alliance, therapist autonomy support, and general well-being as rated by participants and study therapist. As a result of the extensive measurement schedule, brief measures (or brief versions of more extensive measures) were used as frequently as possible to maximize enrolled participants' time in psychotherapy sessions to ensure adequate treatment dose.

Beck Depression Inventory-II. The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) is the most widely used measure in the clinical assessment of depressive symptoms. The measure features 21 items on depressive symptoms a 4-point Likert scale per item ranging from zero to three. Item scores are summed to create a total score. The BDI-II focuses primarily on the cognitive aspects of depression with items on “self-dislike” and “suicidal thoughts or wishes.” It also features physiological indicators with items on “changes in sleeping pattern” and “changes in appetite.” The measure can be administered in five to ten minutes and features good sensitivity and moderate specificity in the design of its three cut scores which are used to differentiate between mild, moderate, and severe depression. The measure has demonstrated good internal consistency (Cronbach's $\alpha = .93$) in nonclinical student samples and good one

week test-retest reliability ($r=.93$; Beck, Steer, & Brown, 1996). This measure was used to determine inclusion criteria into the study and served as the primary outcome measure to determine if clients in the CFE condition experience significantly greater improvement in depressive symptoms than the TAU condition. Within the study sample, the BDI-II demonstrated good internal consistency at session one pre-treatment (Cronbach's $\alpha = 0.84$).

Health Care Climate Questionnaire-Short. The Health Care Climate Questionnaire-Short (HCCQ-S; Williams, Grown, Freedman, Ryan, & Deci, 1996) is part of a family of climate measures developed based on the theoretical and empirical research on factors involved in human motivation (Ryan & Deci, 2000). This measure is 6-items with responses rated on a 7-point Likert scale ranging from “strongly disagree” to “strongly agree.” The HCCQ-S is designed to examine to what extent clients feel that their health care provider (therapist) is autonomy supportive (as opposed to controlling). Sample items include “I feel that my therapist has provided me choices and options” and “my therapist encourages me to ask questions.” A subsequent factor analysis supported a one-factor solution on the HCCQ measuring perceived autonomy support from a health care provider. The HCCQ-S was created as a psychometrically comparable short version of the full HCCQ and has been used in published research to assess autonomy support. Prior research by Williams, Freedman, and Deci (1998) used a similar 5-item modified HCCQ and found good internal consistency (Cronbach's $\alpha = 0.80$) and very strong correlation with the full HCCQ ($r = 0.91$). The HCCQ-S is scored by totaling the responses to the items. In the current study, HCCQ-S scores were used to test whether clients in the CFE condition report higher average levels of autonomy support than

clients in TAU. Within the study sample, the HCCQ-S demonstrated good internal consistency at session one (Cronbach's $\alpha = 0.80$).

Schwartz Outcome Scale-10. (SOS-10; Blais, Lenderking, deLorell, Peets, Leahy, & Burns, 1999) The Schwartz Outcome Scale-10 is a 10-item self-report measure that addresses mental health distress and well-being. Designed to help evaluate the effectiveness of mental health treatments, the SOS-10 was developed using classical test theory and Rasch item analysis. Each item features a 7-point Likert scale ranging from “0 – never” to “6 – nearly all of the time” in response to items regarding general feelings that respondents have had over the past seven days about their well-being. Sample items include “I have confidence in my ability to sustain important relationships” and “I am generally satisfied with my psychological health.” Prior research has found excellent internal consistency (Cronbach's $\alpha = .96$) and has been shown to be sensitive to change (Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003), which is a critical element of a treatment evaluation measure. Additionally, the measure has been shown to have good test-retest reliability over one week ($r = .86$) in a non-treatment college student sample (Young et al., 2003). The SOS-10 has found to relate to other measures of adult attachment, interpersonal issues, and facets of the big five personality factors in predictable ways (Haggerty, Blake, Naraine, Siefert, & Blais, 2010). The SOS-10 is scored by summing the scores from each of the 10 items. In the current study, the SOS-10 served as an outcome measure to allow for comparison between the CFE and TAU conditions. Within the study sample, the SOS-10 demonstrated good internal consistency at session one (Cronbach's $\alpha = 0.84$).

Working Alliance Inventory-Short Form Revised. The Working Alliance Inventory-Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006) is a widely-used 12-item measure of the therapeutic alliance. Each item is rated on a 5-point Likert scale ranging from “1 – seldom” to “5 – always” and loads onto one of three factors: goals of therapy, tasks of therapy, and the bond between client and therapist. Taken together, these factors comprise the therapeutic concept of alliance (Bordin, 1979). Sample items include “I believe [my therapist] likes me” and “I feel that the things I do in therapy will help me to accomplish the changes that I want.” The measure has demonstrated excellent reliability (Cronbach’s $\alpha = .92$ for the overall scale and range from .85-.90 for the subscales; Hatcher & Gillaspy, 2006). An overall score is calculated by averaging the score from each of the 12 items. Three subscale scores are also calculated for the goals, tasks, and bond by averaging the items associated with the respective subscales. In the current study, the WAI-SR was used to generate visual feedback for the client and therapist to discuss in session. It was also used to assess the correlation between client and therapist perceptions of the working alliance and test for mediation in the relationship between the presentation of collaborative alliance feedback and positive therapeutic outcome. Within the study sample, the WAI-SR demonstrated good internal consistency at session one (Cronbach’s $\alpha = 0.88$).

Working Alliance Inventory-Therapist Version. Developed directly from the WAI-SR, the Working Alliance Inventory-Therapist Version (WAI-TV) mirrors the 12-item format of the WAI-SR. Each item is rated on a 5-point Likert scale and loads onto one of three factors: goals of therapy, tasks of therapy, and the bond between client and therapist, much like the WAI-SR. However, this measure has been used to assess the

therapist's view of the working alliance. Its item descriptions, Likert scale, and psychometric properties are highly comparable to those of the WAI-SR. In the current study, the WAI-TV was used to assess the correlation between client and therapist perceptions of the working alliance. Within the study sample, the WAI-SR demonstrated excellent internal consistency at session one (Cronbach's $\alpha = 0.95$).

Data Analyses

Medium effects were expected based on a recent treatment study conducted by Connolly Gibbons et al. (2015) in which a novel (clinician only) feedback intervention was tested and a medium effect was found with a sample of 100 clients.

Analysis one. To test the hypothesis that clients who received collaborative alliance feedback achieved a significantly greater reduction of depression symptoms and greater enhancement of overall well-being compared to clients in a TAU group, two mixed-design analyses of covariance (ANCOVAs) were conducted. One ANCOVA examined BDI-II scores and the other examined SOS-10 scores as dependent (outcome) variables. The between-groups variable for both analyses was the CFE intervention (versus TAU control) and the within-subjects variable was session (i.e., two through five). Initial BDI-II score was entered as the covariate for the first ANCOVA while initial SOS-10 score was added as a covariate for the second ANCOVA.

Analysis two. To test the prediction that both clients and therapists rated their alliances as higher after receiving collaborative alliance feedback when compared to their rating of the alliance before receiving feedback, two separate mixed-design ANCOVAs were conducted. The between-groups variable was the CFE intervention (versus TAU control) and the within-subjects variable was session (i.e., one through five). The

dependent variable for the first analysis was client-rated alliance (WAI-SR) and the second ANCOVA used therapist-rated alliance (WAI-TV) as the dependent variable. End of session one alliance was the covariate (as no feedback had been presented yet in either treatment condition during session one).

Analysis three. To test the third hypothesis, the correlation of client-rated and therapist-rated alliances was compared for the CFE treatment versus TAU conditions using Fisher's r -to- z transformation. It was predicted that the correlation will have higher magnitude for the treatment condition and significantly lower magnitude for the TAU group.

Analysis four. To test the predictions that clients who received collaborative alliance feedback rated their therapists as autonomy supportive, two analyses addressed this hypothesis:

Part a. To test if the alliance feedback group had relatively higher HCCQ-scores than the TAU group, an ANCOVA was conducted using the end of treatment HCCQ-S scores. Session one HCCQ-S scores were entered as the covariate.

Part b. Regardless of differences between groups (tested in hypothesis four), a planned comparison was conducted between end-of-treatment (session five) and beginning of treatment (session one) HCCQ-S scores for both conditions. Only the alliance feedback condition was predicted to have a significantly greater HCCQ-S score relative to session one.

Analysis five. Client perception of autonomy support and working alliance were examined as potential mediators for the relationship between collaborative alliance feedback and therapeutic outcome. In the first model, treatment condition was the

independent variable, autonomy support was entered as the mediator, and depressive symptoms at termination served as the dependent variable. Initial depression severity and session one autonomy support were entered as covariates. If autonomy support emerged as a mediator, a second model would test to see if the alliance explained this relationship.

In the second model, autonomy support was the independent variable, client-rated working alliance served as the mediator, and depressive symptoms at termination was the dependent variable. Initial depression severity was entered as a covariate within the model. It was hypothesized that autonomy support mediated the relationship between CFE treatment and depressive symptom outcome and that this relationship would not be explained through the working alliance. To establish that mediation has been found, temporal precedence must be established where the mediator occurs in between the measurement of the independent and dependent variables (Kraemer, Wilson, Fairburn, & Agras, 2002). The constructs measured in this model satisfied temporal criteria for mediation.

Mediation was tested using the PROCESS macro (Hayes, 2014) for SPSS which was designed as a path analysis mediational approach for SPSS when analyzing mediators (alliance [via the WAI-TV and WAI-SR] and autonomy support [via the HCCQ-S]). This macro bootstrap randomly resamples cases within SPSS and provides confidence intervals for the detection of significant mediation effects. If the resulting confidence intervals (set at $\alpha = .05$) from the bootstrapping process do not contain zero, one can say that a significant mediation effect has been found.

Results

Due to variability in recruitment in the present study, the final sample fell short of the 100 participant target ($N = 79$). The sub-samples in each treatment condition were found not to be significantly different in terms of client characteristics, depression severity, or sessions attended (all p 's $> .05$). Overall correlations (r) between study measures are reported in Table 1. Between group (TAU versus CFE) means and standard deviations of all study measures at sessions one and five are reported in Table 2.

Depression and Wellbeing Outcomes

Average pre-session-one assessment BDI-II score was 23.75 ($SD = 8.18$), indicating that the average participant entered into the study with moderate depressive symptom levels (indicated on the BDI-II within the range of 22 to 28). For those who completed treatment in either condition ($n = 56$) overall effect sizes for the intervention were large on both depression (Cohen's $d = 1.21$) and wellbeing (Cohen's $d = 1.13$). Similar large effects were found for the intent-to-treat (ITT) sub-sample of those who completed at least two sessions ($n = 69$) for both depression (Cohen's $d = 1.14$) and wellbeing (Cohen's $d = 1.00$).

The first hypothesis stated that CFE clients would experience a greater reduction in depression and greater overall increase in wellbeing scores than clients in TAU. This hypothesis was not supported as no significant effects were found between TAU and CFE conditions for either depression or overall wellbeing. For depression, a mixed ANCOVA yielded an interaction effect for the length of treatment by initial severity, $F(1, 53) = 7.24$, $p < .05$, $\eta^2 = .14$, indicating that more sessions (in either condition) had a greater effect for participants with a higher initial BDI-II score. For wellbeing, a different

pattern of results emerged where the main effect for length of treatment (in either condition) emerged significant, $F(1, 53) = 9.327, p < .05, \eta^2 = .15$.

Alliance

The second hypothesis stated that CFE clients and therapists would rate their alliances as higher than clients and therapists within the TAU condition. This hypothesis was not supported as there were no significant interactions effects in terms of client-rated or therapist-rated alliance and treatment condition. For the client-rated alliance, a mixed ANCOVA yielded a significant main effect for length of treatment, $F(1, 54) = 9.327, p < .05, \eta^2 = .14$. For the therapist-rated alliance, a different pattern of results emerged as the ANCOVA yielded a significant interaction effect between treatment length and initial WAI-SR score, $F(1, 54) = 15.63, p < .05, \eta^2 = .22$, indicating that number of sessions had a greater effect on alliance scores for therapists reporting a lower alliance at the end of session one.

Client and Therapist Alliance Agreement

The third hypothesis stated that alliance scores between CFE clients and therapists ($r = .23$) will share a stronger correlation than dyads in TAU ($r = .37$). This hypothesis was not supported as a Fischer's r-to-z transformation found no significant differences in the magnitude of these correlations, $z = 1.35, p > .05$.

Autonomy Support

The fourth hypothesis asserted that CFE and TAU clients would differ on the clients' perception of their therapists as autonomy supportive (with CFE clients rating their therapists as more supportive). Clients in CFE rated their therapist as overall significantly more autonomy supportive than those in TAU, $F(1, 53) = 6.36, p < .05, \eta^2$

= .11. This same pattern of results was also found in the planned comparison of session five autonomy support scores between TAU ($M = 36.49$, $SE = 0.38$) and CFE ($M = 38.70$, $SE = 0.48$), $t = 2.21$, $p < .05$.

Mediational Model One: Treatment Condition, Autonomy Support, and Depression

Comparing both TAU and CFE (TAU = 1; CFE = 2), a model was created to examine the influence of these treatment conditions on post-treatment depression scores as mediated by therapist autonomy support. Both pre-treatment depression and session one autonomy support were controlled for. A significant indirect effect emerged such that autonomy support mediated the relationship between the CFE treatment condition (but not TAU) and depression outcome (indirect effect = -1.95 , 95% CI $[-4.93, -0.35]$). See Table 3 for results of the mediational analysis.

Mediational Model Two: Autonomy Support, Alliance, Depression

A second model was created to determine whether the working alliance explained the relationship between autonomy support and depression. Session one autonomy support score was entered as the independent variable, mean client-rated working alliance was entered as the mediator, and depression score was the dependent variable. No significant direct or indirect effects emerged (all confidence intervals contained zero). See Table 3 for results of the mediational analysis.

Discussion

No differences emerged between TAU and CFE for alliance or treatment outcome. Further, there were no differences in the correlations in client and therapist-rated alliance between treatment conditions. However, clients' perception of therapist autonomy support was a mediator to depression outcome in the CFE condition. Autonomy support did not factor significantly into the outcome of TAU. Further analyses found that alliance was not a mediator in the relationship between autonomy support and outcome. Given this pattern of results, it may be that autonomy support is a distinct mechanism, independent of the alliance, but still malleable in the face of relationship-focused process discussions occurring in session.

Depression and Wellbeing Outcomes

No differences were detected between treatments for either outcome measure. It should be noted that both outcome measures shared a significant correlational relationship ($r = 0.71$) which shows there was substantial, shared variance between depression and wellbeing. Prior research has found significant relationships between theoretically different distress measures; for example, Steer, Ball, Ranieri, and Beck (1997) found a similar correlation between the BDI-II and the Symptom Checklist-90 Revised (Derogatis & Savitz, 1999) Anxiety subscale ($r = 0.71$). As such, it was unlikely for one outcome to differ from another in the current research.

Within the feedback literature, some studies have found significant medium effects with smaller treatment samples ($N = 100$; Connolly Gibbons et al., 2015). However, a number of other studies on outcome feedback required substantially larger samples of thousands of clients in order to detect small effects (Shimokawa et al., 2011).

The lack of results in treatment outcome in the current study may be explained by an underpowered sample.

Regardless of condition, the overall effect sizes in levels of symptom reduction were high for a five session treatment. Among meta-analyses, typical effect sizes for psychotherapy fall within the range of 0.75 and 0.85 (Wampold & Imel, 2015), making the results of the current study somewhat atypical, particularly for a five session protocol. Given the significant effects in the current study for depression (Cohen's $d = 1.21$) and wellbeing (Cohen's $d = 1.13$) were abnormally large, from a statistical standpoint, this large overall effect left very little room to detect differences between treatments.

As another potential explanation of the null findings for outcome, a number of direct comparisons of psychological treatments produce equivalent results (Wampold et al., 1997). Even in tests of specific components that are theoretically believed to drive effects, “underpowered” treatments still produce equivalent or even better results compared to gold standard treatments (Ahn & Wampold, 2011; Dimikijian et al., 2006; Jacobson et al., 1996). The results of the current study may also be interpreted as evidence of this general equivalency of treatment outcomes. It is also important to note that, in both treatment conditions, therapists were encouraged to select specific interventions (e.g. cognitive-behavioral, client-centered, mindfulness, etc.) that they believed would best suit their clients' needs and conform to their own theoretical preferences. As such, allegiance effects (Robinson, Berman, & Neimeyer, 1990) may have explained part of the strong effect sizes in this study.

Alliance

The results of the study found no effect of treatment condition on working alliance. These null results may be related to the overall strong effects of the treatment in both conditions. As the alliance is well-established as a globally significant predictor of outcome (Horvath et al., 2011), the design of the study (which featured a powerful TAU condition alongside CFE) may have been partially responsible for the formation of strong working alliances in both conditions. In other words, these null results may be explained most parsimoniously as the result of strong alliances that were not directly impacted by a manualized process feedback approach.

One significant criticism of existing feedback protocols (particularly the few existing collaborative designs) is that the focus on presenting self-report data may have introduced researcher effects that might have influenced clients to exaggerate their alliances. This presented a concern for the CFE system as well. However, recent research has suggested that clients may not change their alliance ratings in feedback paradigms, even when informed of therapists receiving their data. Reese et al. (2013) utilized the ultra-brief alliance measure from the PCOMS feedback system, the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) for client self-reported alliance ratings. In this study, the researchers found that there were no statistically significant differences in alliance ratings between the clients who were informed that their therapists would see data versus clients who were told that therapists would not see data. Since the current study featured a similar design, it is likely that clients rated their genuine perception of the alliance without any noticeable effect of social desirability. As a counterpoint, the proposed study's CFE system places an overt emphasis on actively

encouraging and promoting a strong alliance (this was not a feature of the Reese et al. [2013] study) which may play a more significant role in altering client ratings of alliance. It should be noted that the CFE system protocol and training for therapists emphasized overtly communicating to clients that genuine responses on all study measures was encouraged for optimal treatment process and outcome.

Another potential explanation of null findings for between condition alliance ratings is the influence of the alliance measure ceiling effect. For the WAI-SR, the normative outpatient sample of 238 college counseling center patients (used for the creation of the feedback graphs) featured an average overall alliance score of 4.28 out of 5. Average working alliance scores for the current sample (4.08), while slightly lower, reflect significant similarities between alliance scores found in the present sample and typical outpatient clients. The sample used in the study most likely provided a comparable experience to outpatient clients in terms of the process of developing a working alliance.

Typically, clients rate their alliances toward the top 20% of alliance measures (Shick-Tryon, Collins-Blackwell, & Felleman-Hammel, 2008). This pattern of a high average alliance rating characterized the sample of the current study. It also means that there is little variance that could be detected with our final subset of treatment completers ($n = 56$). As such, the study may have been underpowered for that end.

It should also be noted that the alliance ratings in this study may have been influenced by measurement error. Through the course of the study intervention, a significant plurality of client and therapist dyads in the CFE intervention discussed what appeared to be low or “off-track” alliance scores. It came to light that in a number of

these cases, clients did not catch the unique attention check reverse scoring/wording system employed on the WAI-SR. This result is further contaminated due to the fact that dyads in the CFE intervention were allowed to discuss and correct this discrepancy while TAU clients and therapists did not have the ability to see WAI-SR data and correct problematic measure completion. The results of the alliance tests may better reflect a combination of ceiling effects and measurement error than genuine perceptions of the working alliance.

Autonomy Support

Results indicated significant differences between the CFE and TAU groups on therapists' autonomy support, such that clients in the CFE condition rated therapists as significantly more autonomy supportive. Prior literature on intrinsic motivation has found that when therapies focused explicitly on elements of process, it may enhance the client's sense of intrinsic motivation for treatment in accordance with self-determination theory (Ryan & Deci, 2008). As a process-focused feedback system, the CFE protocol demonstrated congruence with self-determination theory by amplifying the importance and focus that therapeutic dyads placed on the role of process. The CFE protocol prominently featured techniques that attribute independence and value to choices that clients make through treatment. For example, if a client and therapist are maligned on the goals of treatment, the CFE protocol recommends that the therapist check in with the client, ask for the client's perspective on treatment goals, and adjust the trajectory of treatment to be more overtly in accordance with the client's perceptions. By facilitating discussions of the working alliance, clients and therapists in the CFE condition may have

been able to collaborate explicitly and routinely on setting and affirming goals while establishing meaningful tasks for therapy.

Further, results of this study found that autonomy support helped to explain the relationship between treatment condition and positive outcome for those in the CFE group. The nature and format of the CFE may have provided an optimal environment for therapists to demonstrate awareness of the client's perspective, provide believable treatment rationales, and encourage the client's input, all of which have been identified as techniques to successfully foster autonomous motivation and engagement in treatment (Reeve, Bolt, & Carr, 1999). Prior research by Zuroff and colleagues (2007) has found similar connections between therapist autonomy supportive behaviors, increases in intrinsic motivation, and outcome.

While autonomous motivation has been linked with outcome in aforementioned extant research (see Zuroff et al., 2007), a number of key limitations to the current study may have prevented similar conclusions. One such limitation is that the CFE protocol lasted five sessions. Since autonomous motivation increased throughout treatment in the study by Zuroff and colleagues (2007), it may be that longer, more robust treatments (such as a 16 session protocol) are needed for therapist autonomy support to truly develop as an enhancer of outcome. Further, the present study relied on a clinical analog population that may have been less intrinsically motivated to improve than a willfully presenting outpatient sample. Finally, it may be that therapist autonomy supportive behaviors are better explained by larger differences between therapists in their overall interpersonal acuity. Prior research has found that therapists uniquely and robustly impact therapeutic outcome based on their interactional skills (Anderson, Ogles,

Patterson, Lambert, & Vermeersch, 2009; Laska, Smith, Wislocki, Minami, & Wampold, 2013).

General Discussion

The CFE did not significantly alter the therapeutic alliance or treatment outcome. In some ways, the CFE was designed as a more flexible approach when compared to alliance rupture-repair treatments like brief relational therapy (Safran & Muran, 2000). However, it appears as though the scaffolding provided by the CFE may have been too aligned with the antiquated paradigm of common versus specific factors, which prior theorists have eloquently described as a false dichotomy (Butler & Strupp, 1986). Further, the notion of adding “specificity” to or “manualization” of interventions on common factors (like the working alliance) may be antithetical to the process of enhancing them, as treatment manuals may constrain the typically significant contributions of therapist effects (Strupp & Anderson, 1997). Thinking of the dichotomy of common versus specific may inhibit direct enhancements to process as interventions (such as the CFE) attempt to break down the interpersonal context of therapy into actionable components (e.g. facets of the working alliance) and apply specified techniques to enhance it.

Limitations

The combination of collaborative alliance feedback within the overall CFE has the benefit of more comprehensive feedback of common factors, but the system also comes with some costs. Due to the intertwined nature of the three components of feedback, it is impossible to attribute meaningful clinical results to the specific effects of the alliance feedback (outside of the other two components: outcome expectations and

empathy). Given the limitations in attributing causality, the results examined the impactful elements related to alliance feedback instead of directly attributing meaningful improvements in outcome to the alliance feedback. To answer the question of causality, a new RCT would have to be developed. While this may be a topic of investigation in the future, the overall study was more broadly focused on exploring effects of a process-focused feedback system.

Another key component of the design, crossing therapists between conditions, also created the potential for another study limitation: therapists participated in both conditions and thereby were not blind to the experimental condition. Therapists, when working with clients in the TAU condition, were not prevented from employing any techniques or protocols in order to maximize both the dose and external validity of the TAU. Given the extensive training and reinforcement of CFE skills, it stands to reason that study therapists may have applied the process techniques across both conditions, reducing statistical effects. It should be noted that there has not yet been any independent coding of session audio data to rule out the possibility of these bleed-over effects.

Clinical Illustration

While the overall use of the CFE system did not significantly alter the outcome of a brief therapy intervention, the results speak towards the importance of the relationship between intrinsic motivation for treatment and outcome. As an example, in one CFE case, a participant (a 19 year-old Caribbean-American woman) and her therapist (a 24 year old Caucasian man) utilized data of relatively low bond scores from working alliance in session one (that fell within the “yellow” or moderate range) to foster a discussion of differences in the way that the pair identified themselves. The therapist

took an inquisitive, open approach with the subject, asking the participant if she would like to make this a focus of therapy after she indicated that the therapist may not have a complete sense of her personal culture and development. Through the course of treatment, the participant described her experience navigating sociocultural adjustment concerns between her country of origin and the United States (after moving to attend school in her teens). The dyad routinely discussed their improving bond score at each session as a way to process feelings of growing comfort with cultural identity in the relationship (ending in a maximum bond score of “5”). This translated into the participant reporting a more comfortable sense of self by termination. She also indicated that she was pleasantly surprised with the direction of therapy, noting that treatment moved in an unexpected direction set at the client’s pace.

Conclusion and Future Directions

Future studies within the realm of process feedback may advance the literature by accounting for therapist behaviors between treatment conditions. By understanding how therapists differentially utilize a framework or scaffold such as the CFE, we may be able to learn more about mechanisms than through a more rigorous isolation of techniques expressed through the CFE system. Future studies may also move away from a focus on feedback of working alliance “data,” and instead build interventions into the CFE protocol for building therapists’ “autonomy-giving” behaviors as a means of building autonomous motivation within the working alliance. The results of this study imply that, while using the CFE as a starting point for conversations that encouraged autonomous motivation, alliance was largely unaffected. Future research on process feedback interventions may benefit from pursuing a better, more nuanced integration of alliance-

focused treatments, such as alliance focused therapy (Muran, Safran, Samstag, & Winston, 2005). Core components of the CFE, such as the collaborative discussion of the working alliance may be useful across a multitude of theoretically distinct psychotherapies in order to better generate a sense of intrinsic motivation in clients through autonomy supportive behaviors of the therapist.

Table 1

Overall Means (Standard Deviations) and Correlations among Study Measures
N = 79

Measures	<i>M (SD)</i>	1	2	3	4	5
1. BDI-II	18.38 (10.12)	-				
2. HCCQ-S	36.85 (4.31)	-.26**	-			
3. SOS-10	35.53 (10.02)	-.71**	.44**	-		
4. WAI-TV	3.7805 (0.79)	-.13*	.27**	.24**	-	
5. WAI-SR	4.08 (0.67)	-.34**	.79**	.53**	.32**	-

Note: BDI-II = Beck Depression Inventory-II; HCCQ-S = Health Care Climate Questionnaire- Short; SOS-10 = Schwartz Outcome Scale-10; WAI-TV = Working Alliance Inventory- Therapist Version; WAI-SR = Working Alliance Inventory- Short Form Revised.

* $p < .05$; ** $p < .01$

Table 2

Means (Standard Deviations) among Study Measures at Sessions One and Five by Condition
N = 79

Measures	<i>M (SD)</i>			
	TAU		CFE	
	Session One	Session Five	Session One	Session Five
1. BDI-II	23.23 (8.17)	12.94 (9.26)	24.40 (8.26)	13.04 (10.99)
2. HCCQ-S	35.16 (4.19)	37.91 (3.86)	34.97 (4.66)	39.54 (3.65)
3. SOS-10	31.25 (7.72)	40.97 (10.74)	31.09 (9.10)	41.76 (11.01)
4. WAI-TV	3.49 (0.70)	4.07 (0.88)	3.51 (0.70)	4.06 (0.74)
5. WAI-SR	3.68 (0.63)	4.29 (0.64)	3.64 (0.68)	4.55 (0.58)

Note: BDI-II = Beck Depression Inventory-II (before first session); HCCQ-S = Health Care Climate Questionnaire- Short (after first session); SOS-10 = Schwartz Outcome Scale-10 (before first session); WAI-TV = Working Alliance Inventory- Therapist Version (after first session); WAI-SR = Working Alliance Inventory- Short Form Revised (after first session).

Table 3

*Results of Mediation Analyses**N* = 56

Models	<u><i>b</i> (95% CI)</u>	
	Indirect Effect in Mediation Model	Direct Effect in Mediation Model
Model One	-1.95 (-4.93, -0.35)*	-0.37 (-5.03, 4.29)
Model Two	-0.49 (-0.96, 0.19)	0.26 (-.32, 0.86)

Note. * = significance (i.e., $p < .05$ or CI interval does not straddle zero).

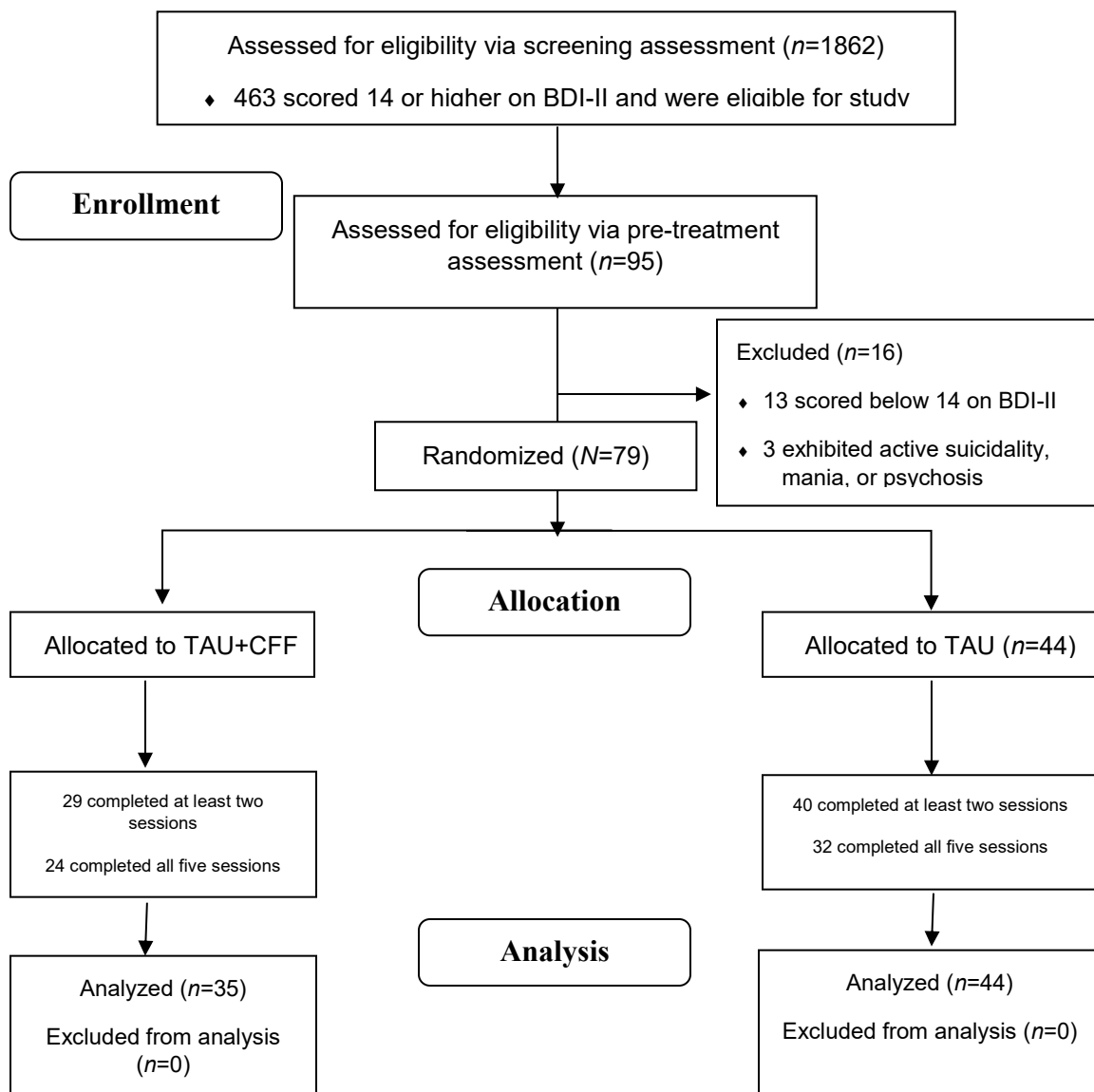


Figure 1. Attrition Flow Chart (adapted from McClintock, Perlman, McCarrick, Anderson, & Himawan, in press).

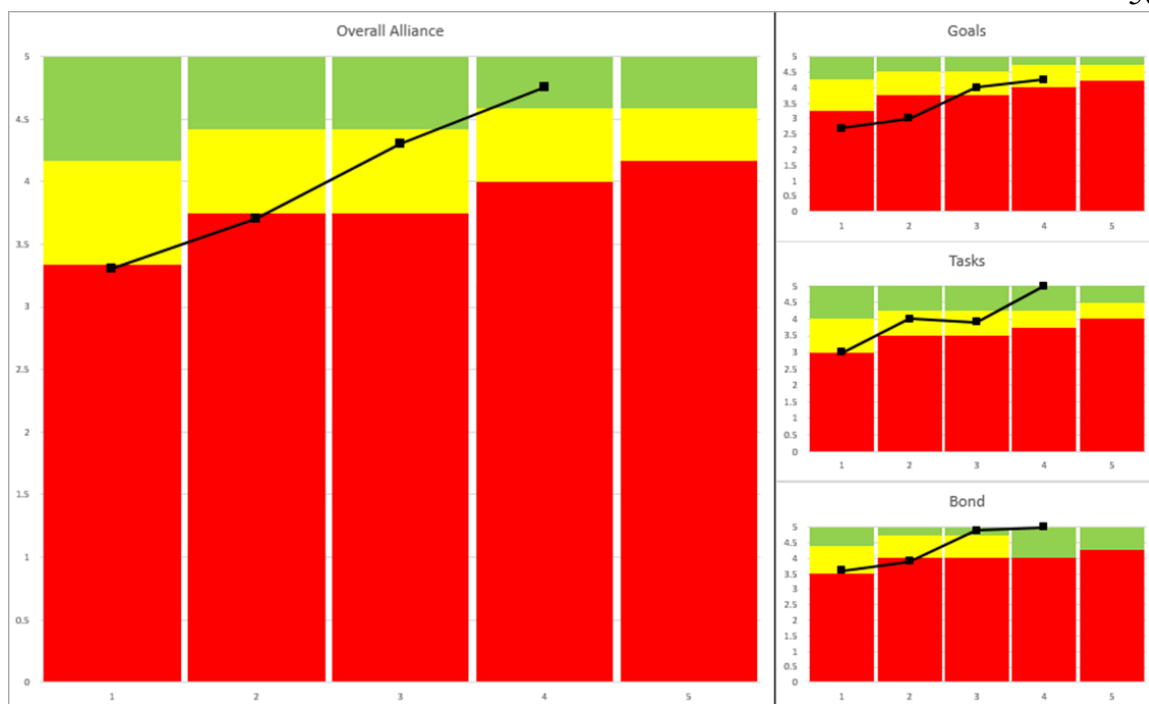


Figure 2. Example of CFE Alliance Data Visualization (at Session Five).

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Appendix A: Clinical Support Tools (CFE Manual)

Clinical Support Tools: Introduction

This manual is integral to the Common Factors Enhancement (CFE) system and details the therapeutic strategies that should be used for enhancing three common factors: outcome expectations, empathy, and the therapeutic alliance. Each of these factors is robustly linked with treatment success (e.g., see Norcross, 2011; Wampold & Imel, 2015), and so it stands to reason that by maximizing these factors in psychotherapy, the effectiveness of psychotherapy will be maximized as well.

There are three practical guidelines that therapists should adhere to when delivering the CFE system. These three guidelines are outlined below.

- Therapists will receive a report that contains client ratings that were made at end of previous session(s). In total, clients will rate three common factors as they exist in that course of psychotherapy: outcome expectations (i.e., clients' expectations about how much improvement they will make in therapy), therapeutic empathy (i.e., the degree to which the therapist is empathically attuned to and expresses appropriate understanding of the client's experience), and the therapeutic alliance (i.e., the collaborative working relationship between client and therapist).
- Client ratings of common factors will be depicted relative to available norms on a longitudinal graph. Specifically, the client's ratings will fall either in the bottom third, middle third, or top third. Therapists are encouraged to discuss ratings that fall in the middle third and top third, and are strongly encouraged to discuss ratings that fall in the bottom third. If more than one factor is suboptimal (i.e., in middle third or bottom third), the therapist and client should strategically identify which factor should be discussed first, second, etc.
- In the first two sessions of psychotherapy, there should be an exclusive (or nearly exclusive) focus on outcome expectations and empathy. This is because the therapeutic alliance takes at least two sessions to develop.

There are six general principles that provide a foundation for processing the common factors ratings and ultimately for enhancing these factors in psychotherapy. These six principles are outlined below.

- First, client ratings of the common factors should be viewed for what they are: imperfect data points that were collected at one moment in time. Although these data are informative, they should ultimately be used as a jumping-off point for exploring the client's experiences and perceptions of what is transpiring inside (and outside) of psychotherapy.
- Second, explorations of common factors ratings should be done with curiosity and a sense of collaboration. The implicit message should always be one of inviting the client to join the therapist in an attempt to understand what is taking place, rather than one of conveying information with an objective, authoritarian status. By framing therapeutic difficulties as a shared experience, the therapist begins the process of transforming the difficulty by recognizing that the therapist and client are stuck together.
- Third, the therapist should validate the client's perceptions of the common factors; this does not mean that the therapist needs to agree with the client's perceptions, but rather that the therapist sees the client's perceptions as important, understandable, and worthy of respect.
- Fourth, the therapist should always accept responsibility for their contributions to therapeutic difficulties. Therapists play a substantial role in the process of psychotherapy, and so when clients are off-track, the therapists should openly and non-defensively acknowledge their contributions to these difficulties. It should be noted that explicitly acknowledging one's contribution to the client can be a particularly potent intervention in-and-of-itself.
- Fifth, the therapist is encouraged to self-disclose about their perceptions of the common factors. However, these perceptions should only be shared after investigating the client's perceptions. When self-disclosing, the therapist should use "I feel" statements and should link these statements to specific events that

occur in psychotherapy. Self-disclosures should always be done in a nonjudgmental fashion.

- Fifth, the focus of these explorations should be as concrete and specific as possible. Questions, observations, and comments should focus on concrete instances, which will help to facilitate discussion and ultimately resolution of the problem.
- Sixth, the therapist and client should develop solutions (or possible solutions) for improving the process of psychotherapy. After developing a solution, the therapist should check-in with the client to ensure that the solution is understandable and acceptable to the client. What is important here is that the client and therapist have a shared understanding about the difficulty, the solution to the difficulty, and are working together to overcome it.

Clinical Support Tools: Outcome Expectations

Armed with data on client's outcome expectations, the therapist can responsively work to foster, clarify, or shape these beliefs so as to promote more adaptive treatment process (e.g., therapeutic alliance) and treatment outcome.

- Validate client's ratings/outcome expectations
 - If applicable, empathize with current demoralization
 - Should adopt an affiliative, supportive, and autonomous-granting stance
 - E.g., "I can appreciate how difficult this must be for you, and how change might not seem possible at this time. As I certainly want to align with you to help, can you help me understand what this expectation is like for you?"
 - Embedded in this communication is both warm and friendly affiliation/understanding ("I can appreciate..."), as well as autonomy-granting ("Can you help me understand...").
- When applicable, therapist should assume responsibility.
 - E.g., in the context of expressed ineffectiveness of a homework assignment, a therapist might say, "I can see that the homework upset you, and it must have been frustrating to engage in a task that did not seem relevant to your most immediate problem (empathy and validation). I think that the homework was poorly timed on my part, as I think that I misread your most pressing needs. I apologize for this (Accepting responsibility). Can you help me understand how you are feeling right now? (autonomy granting, exploring current experiences)."
- Initiate discussion of outcome expectations using exploratory questions
- Present a convincing treatment rationale
 - A causal explanation for the problem
 - Description of how specific techniques will help in overcoming those problems
 - Tailor rationale to client's strengths
- Theory-base language regarding change processes

- Clinicians can personalize expectancy-enhancing or hope-inspiring statements to match the client's specific situation. "This treatment targets and can be quite effective for anxiety problems like the one's you've described to me." Or the therapist might say, "Your anxiety is likely to respond to treatment, and I believe that your prognosis is good."
 - Tie expectancy-enhancing statements to client's personal strengths. For example, therapist might say, "This is just my opinion of course, and you might disagree, but from my perspective it seems that you have several qualities that make you a good candidate for this treatment."
- Clinicians can also try to foster clients' sense that they are powerful agents in the change process and that they have control over the process (i.e., increased self-efficacy/autonomy). For example, the therapist might say, "I believe that you have the power to produce change in your life, and during this course of therapy you will build skills to help facilitate this goal."
- Observed progress should be validated and used to enhance outcome expectations.
 - E.g., "I see that you did... Great job. I anticipate you being able to continue this trend, which should have a powerful influence on..."
- Provide hope-inspiring statements
 - E.g., "Your problems are exactly the type for which this therapy can be of assistance."
 - "I am confident that working together we can deal effectively with your problems."
- Personalize expectancy- statements that are based on client experiences or strengths. For example, a therapist can state, "You have already overcome a major hurdle in confronting your problem and talking about it openly today, which is not easy to do. This suggests a motivation and desire to change."
- Or a therapist might convey, "You strike me as someone who can really accomplish things that you put your mind to."
- Express confidence in treatment efficacy

- Convey empirical support for treatment
 - Offer a nontechnical review of the research findings on psychotherapy/given treatment. E.g., research has shown that people in this treatment tend to get significantly better than people who simply try to deal with problems on their own.” Or “About 70% of clients experience improvements in psychotherapy.”
- Assess and discuss how outcome expectations might be affecting relational process. For example, with a client who reveals early low-outcome expectations, a therapist might say, “I would expect that we will occasionally have different ideas about our work, and there might even be times when I disappoint or upset you not only do I invite you to share these experiences if they occur, but I believe that openly discussing them—in the service of collaborating toward your treatment goals—may be a very useful therapy experience. Has anything like this happened yet, or is it happening now?”
- Identify and address ambivalence
- Is the client motivated/ready to change?
- Is the treatment plan acceptable to client?
- Does the treatment plan make sense to the client?

Clinical Support Tools: Empathy

Therapists may vary in the degree to which they can accurately empathize with clients' experiences. The following clinical support tools are intended to enhance the degree to which that empathy is *expressed* in session.

- Listen empathically
 - Be present in the room with clients and listen attentively
 - Attempt to minimize note-taking, planning what to say next, etc.
 - Engage in non-verbal behavior that communicates listening and understanding (e.g. body oriented toward the client, head nods, eye contact, trunk leaning, facial expressions should match the client's)
- Identify the “real” concern from the overall session dialogue
 - Sometimes clients will deliver a narrative with many extraneous details – it is the therapist's job to discern the pressing issue at hand and to gently redirect clients when they deviate to a tangential issue (note: this is often due to avoidance of discussing the real issue)
 - Attend to instances when the client mentions a potentially emotionally charged event and quickly moves on to a tangential topic by saying something like, “A few moments ago you mentioned (X experience), can you tell me a bit more about how you were feeling when (X) happened?”
- Pay attention to changes in the client's affect during session (including nonverbal indications)
 - E.g. The client begins crying when describing a recent fight with her partner. The therapist says “I can see that this is painful for you to talk about.”
 - E.g. The therapist notices a shift in the client's affect in response to something the therapist has said. Therapist says “I'm noticing that what I just said seems to have bothered you.”
- Use reflection to communicate that you have heard and understood the client's emotional experience

- E.g. The client reports that she feels left out when her roommates don't invite her out with them. The therapist responds "It hurts when your roommates don't include you."
- Communicate warmth and acceptance towards the client by offering validating and nonjudgmental responses.
 - It is particularly important to validate the client's experiences of negative emotions, e.g. "Most people would feel angry if they were treated that way at work."
- Affirm clients for making progress in therapy, and acknowledge any obstacles they have had to overcome.
 - Look for opportunities to commend clients for *not* engaging in maladaptive behaviors, e.g. "It might have been tempting to stay home from work when you felt depressed yesterday, but you were able to take care of all your responsibilities despite low mood."
- Look for discrepancies between what the client says and their affect or contradictions between past and present statements and gently point these out to the client
 - E.g. The therapist might say, "I'm noticing an inconsistency between what you said a moment ago about --- and the way your responding to --- now."
- Ask open-ended questions to explore and understand the client's experience
 - E.g. "How did you feel when ---?"
 - "What was going through your mind when...?"
- To the extent that it is appropriate, voice your genuine reaction to something the client has said, especially if you believe your reaction will be therapeutic or illuminating for the client
 - E.g. "I'm finding that I feel --- when you say ---, and I wonder whether --- may be happening with your (relevant interpersonal relationships)."
- Demonstrate cultural competency through an appreciation of how clients' cultural contexts have influenced their life experience

- Awareness of how age, gender, race/ethnicity, sexual orientation, SES, family environment, etc. has impacted the client's presenting concerns and overall experience
 - If unfamiliar with a particular relevant cultural issue, consult the literature or another professional with expertise in that area – talk to the supervisor about obtaining the appropriate resources to educate yourself on the subject
- To the extent practical, use the client's own language to refer to events in the client's life
 - E.g. The client says they felt miserable, and the therapist later uses the word "miserable" when referring to the client's emotional state.
 - Note: It is still important to elicit specific emotion words when clients report general emotions such as "I felt bad."
- Demonstrate care and concern by making an effort to remember details about the client's life
 - Review notes prior to session
 - When appropriate, use names to refer to important people, places, events in the client's life

Clinical Support Tools: Therapeutic Alliance

Using data relating to the therapeutic alliance offers therapists a straightforward, natural way of discussing the goals, tasks, and bond of therapy within session. Using the feedback data, it may be helpful to discuss trends (increases, decreases, or plateaus) in a client's ratings of the alliance. Below are some potential relational discussions that a therapist may facilitate through the collaborative alliance feedback. Remember, a strong working alliance entails *agreement* between client and therapist on the goals, task, and bond of treatment.

Goals

- Open questions about goals allow for clients to freely express their opinions without being influenced by the therapist. Here are some examples:
 - “What are your thoughts on the overarching goals of our therapy?”
 - “What are you hoping to get out of this treatment?”
 - If the client's response is not in agreement with your views, share this with the client
 - You may wish to process further and gather the client's reaction to your disagreement on therapeutic goals
 - If the client's response is in line with your perception of the therapy's goals, share this with the client, expressing positivity for being “on the same page”
- Once a discrepancy in goals has been detected, the therapist and client can work collaboratively to reach an agreement that both parties find satisfactory
 - It is often effective in these situations to ask a client how they would like to proceed with the treatment. In these situations, it may be helpful to:
 - Provide clients with choice on the therapy's goals (i.e. letting the client take lead)
 - Avoid pressuring clients to choose a particular treatment goal
 - Express awareness of the client's perception of the therapy's goals (E.g. validating the client's feelings about the goals of therapy)
 - Provide clear rationales for varying treatment elements

Tasks

- Much like facilitating discussion on goals, asking the client about therapeutic tasks allow for clients to freely express their opinions without being overtly influenced by the therapist. In the case of tasks, the therapist has much more control over specific techniques and intervention strategies. Task-related questions should focus on the extent to which clients find the therapy's tasks to be useful for their unique issues. Here are some examples:
 - “What are your thoughts on the tasks we’ve used in treatment so far?”
 - “Do you feel like our time in session will help you achieve your treatment goals?”
 - If the client’s response expresses some level of negativity, pessimism, or ambivalence, share your reaction with the client
 - If the client’s response is in line with your perception of the therapy’s tasks, share this with the client, expressing positivity for being “on the same page” and instilling hope that the techniques used in treatment can be very effective therapeutic tools
- Once a discrepancy in tasks has been detected, the therapist and client can work collaboratively to reach an agreement that both parties find satisfactory
 - It is often effective in these situations to ask a client how they would like to proceed with the treatment. In these situations, it may be helpful to:
 - Provide clients with choice
 - E.g. “So far in therapy, we’ve been focusing on [cognitions, emotions, relationships, etc.], do you think it would be helpful to change direction and focus our work in a different way?”
 - Avoid pressuring clients to choose a particular treatment modality
 - It is important to remember that many therapists feel most comfortable working from a particular orientation/subset of

orientations. This may influence an open discussion on tasks with a client as the therapist feels less comfortable with a client's desired perspective. In these instances, it is helpful to draw on the support and experience of your supervision group in modifying in-session tasks

- Express awareness of the client's perception of the therapy's tasks (E.g. validating a client's feelings about the in-session tasks)
- Provide clear rationales for varying treatment elements

Bond

For general relational issues in the therapeutic relationship, please refer to the enhancement tools section on empathy above as a first-line intervention. For acute relational issues that do not seem to fall under the umbrella of successful empathic communication, you may wish to use the following information about alliance ruptures and repairs.

Some therapeutic alliances fail to develop adequately while others undergo periods of destabilization— otherwise known as alliance ruptures (Safran & Muran, 2000). Alliance ruptures manifest in one of two forms: confrontation or withdrawal. Confrontation ruptures entail an active assertion of an alliance disruption by the client. These are typically straightforward in terms of detection, which allows therapists to engage with clients about any tensions within the working relationship. Withdrawals are more subtle breakdowns in alliance where clients may disengage from therapy or acquiesce to a therapist's directives without truly believing in them. Withdrawals can either increase or decrease the apparent therapeutic "distance" between client and therapist. Increased distance can be seen in cold, tense interactions where the client and therapist are not working together collaboratively and productively. When there is a withdrawal of increasing distance both client and therapist appear to be friendly and in agreement on the surface, but there is the sense that the agreement is superficial and larger issues are not being discussed. These types of ruptures are often more difficult to

understand and require therapists to demonstrate strong attunement to the present moment to detect and repair these ruptures (Safran & Muran, 2006).

Client expression of confrontation ruptures:

- Complaints/concerns about the therapist
- Client rejects therapist's intervention
- Complaints/concerns about the activities of therapy
- Complaints/concerns about the parameters of therapy
- Complaints/concerns about progress in therapy
- Client defends self against therapist
- Efforts to control/pressure therapist

Client expression of withdrawal ruptures:

- Denial
- Minimal response
- Abstract, intellectualized communication (can also be expressed by therapist)
- Avoidant storytelling and/or shifting topic
- Deferential and appeasing the therapist
 - E.g. seeing the therapist as an expert
- Content/affect split
- Self-criticism and/or hopelessness

Therapist alliance-rupture-repair techniques:

- Therapist clarifies a surface-level misunderstanding
 - a. E.g. If a client admits to having a negative reaction to a therapist's statement in a session, the therapist may find it helpful to:
 - i. Take the client's perspective
 - ii. Understand how their words may be perceived negatively by the client
 - iii. Re-explain their statement



- b. This technique uses a focus on the here-and-now to bring awareness to clients of their current emotional, cognitive, and behavioral reactions to relational transactions
- Therapist changes tasks or goals as the therapy evolves
 - a. Allows client and therapists to find agreement on the overarching goals of therapy
 - b. Check to see that both parties are on the same page
 - c. Therapist must be well attuned to avoid the tasks that brought about the initial rupture
 - d. This technique uses a focus on the here-and-now to bring awareness to clients of their current emotional, cognitive, and behavioral reactions to relational transactions
- Therapist illustrates in-session tasks or provides a clear rationale for treatment
- Therapist invites the client to discuss thoughts or feelings with respect to the therapist or some aspect of therapy
 - a. This process involves validating the client's perspective
- Therapist acknowledges his/her contribution to a rupture
 - a. Solidifies the alliance as a shared construct between client and therapist
 - b. Helps clients to feel less "at fault" for a rupture
- Therapist discloses his/her internal experience of the client-therapist interaction
 - a. Immediate process work related to the therapeutic relationship is also known as "meta-communication"
 - i. For more information on meta-communication, please see Matt to watch the Alliance Focused Training (AFT) video series by Chris Muran
- Exploring the underlying relational themes or interpersonal patterns that exist within that client's life
 - a. E.g. linking elements of the therapeutic relationship to outside relationships
 - b. This technique should be used cautiously/sparingly

c. Client must be in agreement that exploring the potential link has merit for their therapy

- Therapist validates the client's defensive posture
- Therapist responds to a rupture by redirecting or refocusing the client
- Some ruptures to be repairable by acting in a novel way, without explicit discussion, to provide the client with a new type of interpersonal experience that differs from prior patterns

Appendix B: Measures


Beck Depression Inventory-II

	Beck Depression Inventory	Baseline
V 0477	CRTN: _____ CRF number: _____	Page 14 patient initials: _____
		Date: _____

Name: _____ Marital Status: _____ Age: _____ Sex: _____
Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

<p>1. Sadness</p> <p>0 I do not feel sad.</p> <p>1 I feel sad much of the time.</p> <p>2 I am sad all the time.</p> <p>3 I am so sad or unhappy that I can't stand it.</p> <p>2. Pessimism</p> <p>0 I am not discouraged about my future.</p> <p>1 I feel more discouraged about my future than I used to be.</p> <p>2 I do not expect things to work out for me.</p> <p>3 I feel my future is hopeless and will only get worse.</p> <p>3. Past Failure</p> <p>0 I do not feel like a failure.</p> <p>1 I have failed more than I should have.</p> <p>2 As I look back, I see a lot of failures.</p> <p>3 I feel I am a total failure as a person.</p> <p>4. Loss of Pleasure</p> <p>0 I get as much pleasure as I ever did from the things I enjoy.</p> <p>1 I don't enjoy things as much as I used to.</p> <p>2 I get very little pleasure from the things I used to enjoy.</p> <p>3 I can't get any pleasure from the things I used to enjoy.</p> <p>5. Guilty Feelings</p> <p>0 I don't feel particularly guilty.</p> <p>1 I feel guilty over many things I have done or should have done.</p> <p>2 I feel quite guilty most of the time.</p> <p>3 I feel guilty all of the time.</p>	<p>6. Punishment Feelings</p> <p>0 I don't feel I am being punished.</p> <p>1 I feel I may be punished.</p> <p>2 I expect to be punished.</p> <p>3 I feel I am being punished.</p> <p>7. Self-Dislike</p> <p>0 I feel the same about myself as ever.</p> <p>1 I have lost confidence in myself.</p> <p>2 I am disappointed in myself.</p> <p>3 I dislike myself.</p> <p>8. Self-Criticalness</p> <p>0 I don't criticize or blame myself more than usual.</p> <p>1 I am more critical of myself than I used to be.</p> <p>2 I criticize myself for all of my faults.</p> <p>3 I blame myself for everything bad that happens.</p> <p>9. Suicidal Thoughts or Wishes</p> <p>0 I don't have any thoughts of killing myself.</p> <p>1 I have thoughts of killing myself, but I would not carry them out.</p> <p>2 I would like to kill myself.</p> <p>3 I would kill myself if I had the chance.</p> <p>10. Crying</p> <p>0 I don't cry anymore than I used to.</p> <p>1 I cry more than I used to.</p> <p>2 I cry over every little thing.</p> <p>3 I feel like crying, but I can't.</p>
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 THE PSYCHOLOGICAL CORPORATION*
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Subtotal Page 1

Continued on Back

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Note: Full BDI-II not included due to copyright.

Health Care Climate Questionnaire – Short

This questionnaire contains items that are related to your visits with your therapist. Therapists have different styles in dealing with patients, and we would like to know more about how you have felt about your encounters with your therapist. Your responses are confidential. Please be honest and candid.

1. I feel that my therapist has provided me choices and options.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

2. I feel understood by my therapist.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

3. My therapist conveys confidence in my ability to make changes.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

4. My therapist encourages me to ask questions.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

5. My therapist listens to how I would like to do things.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

6. My therapist tries to understand how I see things before suggesting a new way to do things.

1	2	3	4	5	6	7
strongly			neutral			strongly
disagree						agree

Schwartz Outcome Scale-10 (Blais et al., 1999)

Instructions: Please respond to each statement by circling the number that best fits how you have generally felt over the last 7 days. There are no right or wrong responses. Often the first answer that comes to mind is best.

Scale: 0 (Never) – 6 (Nearly all of the time)

1. Given my current physical condition, I am satisfied with what I can do.

0 1 2 3 4 5 6

2. I have confidence in my ability to sustain important relationships.

0 1 2 3 4 5 6

3. I feel hopeful about my future.

0 1 2 3 4 5 6

4. I am often interested and excited about things in my life

0 1 2 3 4 5 6

5. I am able to have fun.

0 1 2 3 4 5 6

6. I am generally satisfied with my psychological health.

0 1 2 3 4 5 6

7. I am able to forgive myself for my failures.

0 1 2 3 4 5 6

8. My life is progressing according to my expectations.

0 1 2 3 4 5 6

9. I am able to handle conflicts with others.

0 1 2 3 4 5 6

10. I have peace of mind.

0

1

2

3

4

5

6

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

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

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe____likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ____and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ____and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ____and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that____appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

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

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

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

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Working Alliance Inventory – Therapist Version

Instructions: Below is a list of statements about experiences people might have with their client. Some items refer directly to your client with an underlined space -- as you read the sentences, mentally insert the name of your client in place of ___ in the text.

IMPORTANT!!! Please take your time to consider each question carefully.

1. ___ and I agree about the steps to be taken to improve his/her situation.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. I am genuinely concerned for ___'s welfare.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. We are working towards mutually agreed upon goals.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___ and I both feel confident about the usefulness of our current activity in therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. I appreciate ___ as a person.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. We have established a good understanding of the kind of changes that would be good for ___.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. ___ and I respect each other.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. ___ and I have a common perception of his/her goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I respect ___ even when he/she does things that I do not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. We agree on what is important for ___ to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom



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