

Different Processes for Different Therapies: Therapist Actions, Therapeutic Bond, and Outcome

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Therapeutic bond, as a component of the alliance, is considered a common factor in psychotherapy; however, it may operate differently in various treatments. This article investigates therapist actions, particularly affect focus, in the formation of the bond and on reduction of symptoms in short-term dynamic psychotherapy (STDP) and cognitive therapy (CT) for cluster C patients. Forty-six cases (23 STDP and 23 CT) were assessed using the Psychotherapy Process Q-Sort, the Helping Alliance Questionnaire, and the Symptom Checklist 90. These scores were used to determine (a) therapist actions that predict formation of the bond, (b) the relation of the bond to symptom reduction, and (c) how therapist actions and bond interacted to reduce symptoms. Multiple regressions were applied to the total sample and to the STDP and CT cases. Psychotherapy Process Q-Sort items describing avoidance of affects were positively related to the bond in the total sample, STDP and CT. However, the relation between therapist actions, bond, and symptom reduction differed for the two treatments. For STDP, avoidance of affect suppressed the relation of bond to symptom reduction and also negatively influenced symptom reduction. On the other hand, in CT, avoidance of affect was positively related to both the formation of the bond and to symptom reduction. Although the bond is a common factor and important component of the alliance, it appears to operate differently in STDP and CT. A focus on affect is important to the benefits of STDP but interferes with the benefits of CT.

Keywords: alliance, therapist actions, cognitive therapy, dynamic therapy, personality disorders

The most recent meta-analysis on the working alliance in individual psychotherapy identified nearly 200 independent studies that investigated the relationship between alliance and outcome (Horvath, Del Re, Flückiger and Symmonds, 2011). The Horvath et al. (2011) meta-analysis reported an aggregate correlation between alliance and outcome of .275, which is a moderate-to-large effect. The interest in the alliance is probably due to its pantheo-

retical nature as well as its well-documented and robust relationship with the outcome of psychotherapy (Norcross, 2011).

The importance of the alliance as a therapeutic factor, despite its robust relationship with outcome, is not firmly established for a number of reasons (see, e.g., DeRubeis, Brotman, Gibbons, 2005). DeRubeis et al. (2005), in a critique of nonspecific factors in psychotherapy, aptly observed that the alliance-outcome relationship may be due to (a) the therapist's ability to form the alliance, (b) the patient's characteristics that are facilitative of forming a relationship (e.g., the patient's social skills and attachment style), (c) an appropriate match of therapist and patient characteristics, or (d) earlier symptom change (i.e., before the alliance was measured). Baldwin, Wampold, and Imel (2007) investigated these various possibilities by disaggregating the total correlation between alliance and outcome into within and between therapist components (as well as the interaction). They found that therapists vary in their ability to form alliances with their patients and that this variability accounted for the correlation between alliance and outcome. Specifically, they found that those therapists who were better able to form strong alliances with their patients had better outcomes than therapists who were less able to form alliances with

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their patients. Moreover, it appeared that the patient's contribution to the alliance did not affect the outcome—that is, those patients who had better alliances with a given therapist did not have better outcomes than other patients of the same therapist who had poorer alliances. Finally, this research did not provide support for a matching effect or that the alliance was a result of early symptom change, although the evidence for the alliance as a consequence of early symptom change is ambiguous (see Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Crits-Christoph, Connolly, Gibbons, Hamilton, Ring-Kurtz, & Gallop., 2011; DeRubeis & Feely, 1990; Feeley, DeRubeis, & Gelfand, 1999; Klein et al., 2003; Tang & DeRubeis, 1999; Webbet al., 2011). Nevertheless, the importance of therapists' ability to form an alliance for the outcome of psychotherapy has been replicated in a variety of settings (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010).

Although some theoretical orientations emphasize the importance of the alliance (e.g., humanistic/experiential therapists and some psychodynamic therapies) more than others (e.g., cognitive-behavioral therapies), the alliance seems to be critically important across therapeutic approaches (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath & Bedi, 2002). Flückiger et al. (2012) investigated moderators of the alliance-outcome relation in a meta-analysis and found that neither research design, use of disorder-specific manuals, type of treatment, or specificity of outcome measures affected alliance-outcome relationship. However, it may well be that the components of the alliance (viz., bond, agreement about goals, agreement about tasks; Bordin, 1979, 1980, 1994) function differently in different therapies. Indeed, Webb et al. (2011) found that agreement about goals and tasks, but not the bond, were related to improvement subsequent to alliance measurements in cognitive therapy. Webb et al. (2011) argued that the relationship between the three components of the alliance might function differently for different types of therapy. Indeed, Bordin (1979) wrote that “some basic level of trust surely marks all variations of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed” and “one bond may not necessarily be stronger than the other, but they do differ in kind” (p 254). Hatcher and Barends (2006) discussed how different therapies put different strains on the therapeutic bond, depending on the activity, commitments, and degree of personal involvement that is expected of the client (e.g., see p. 293).

Despite ambiguities in the literature, it appears that the therapist is critical to making the alliance therapeutic, and thus attention must be paid to what the therapist does to form an alliance that is therapeutic. In 2003, Ackerman and Hilsenroth comprehensively reviewed the therapist characteristics and actions that positively affect the alliance. They noted that little attention has been paid to this question, although they did identify 16 studies that investigated techniques and interventions used by therapists to facilitate the alliance. The literature suggested, according to Ackerman and Hilsenroth (2003), that the following characteristics and actions were related to development of the alliance: exploration, depth, reflection, support, past therapy success, accurate interpretation, facilitation of expression of affect, activity (vs. passivity), affirmation, understanding, and attention to the patient's experience. Hilsenroth and Cromer (2007) identified largely parallel findings when investigating formation of the alliance very early in therapy,

indicating “that it is ‘never too early’ for clinicians to attempt to adopt these attitudes and interventions” (p. 210).

The relationships between therapist actions, the alliance, and outcome are unfortunately not straightforward. It may be problematic to assume that therapist characteristics and actions that are associated with the alliance are also important to therapeutic outcome based on the fact that the alliance is related to outcome. It could be, and would be very interesting if it were the case, that some therapist characteristics and actions might predict the alliance but not predict outcome—that is, these characteristics and actions predict a part of the alliance that is not related to outcome. For instance, the therapist might participate in actions that the patient finds agreeable but leads to an avoidance of real work in psychotherapy, as suggested by a case study in which the therapist subtly encouraged storytelling by the patient (Wampold & Kim, 1989). There is a lack of research that has examined therapist actions, alliance, and outcome simultaneously in therapy.

The purpose of the present study was to examine therapist actions that predict the bond and to determine how these actions work with the bond to create the benefits of therapy¹. In this study, we thus examine the relationships between therapist actions, the bond, and outcome, as indicated by symptoms, in two treatments, cognitive therapy (CT) and short-term dynamic psychotherapy (STDP), for cluster C patients. Given previous research that indicates that the bond was not predictive of outcome in CT (Webb et al., 2011), we were interested to determine whether the bond worked differently in a dynamic therapy than it did in a CT. The cluster C patient group is an interesting group on which to study these phenomena, as a defining feature of the diagnosis is the patient's difficulty with experiencing and expressing affect and forming adaptive close interpersonal relationships.

Method

Data Material

Psychotherapy sessions from a previously conducted randomized clinical trial (RCT) that compared CT and STDP for cluster C patients were used in the study (see Svartberg, Stiles & Seltzer, 2004 for more details). In this study, the patient groups showed significant improvement on all measures during treatment, and there were no group differences in outcomes on any measures (Svartberg et al., 2004).

Patients

There were 50 patients in this RCT; 25 in each treatment. All patients met criteria for one or more *Diagnostic and Statistical Manual of Mental Disorders–III–R* cluster C personality disorder, and did not meet criteria for any other axis II disorder. Additional exclusion criteria were current or past psychotic disorder, current substance abuse or dependence, current eating disorder, organic brain disorder and other serious physical illness, active suicidal behavior, refusal to discontinue other active treatments,

¹ Although it would be interesting to examine these relations in all three components of the alliance, the data collected in this clinical trial only contained measurement of the bond.

and refusal to have therapy sessions videotaped. There were no significant differences in the measured patient characteristics between the treatment conditions. Due to one patient missing alliance data and poor quality of video recordings for three patients, 46 patients of the 50 patients in the RCT were included in the present analysis; 23 in each condition. See Table 1 for demographic details.

Therapists and Treatment

The CT and STDP treatments were carried out in accordance with treatment manuals (Beck & Freeman, 1990; McCullough Vaillant, 1997, respectively). Half of the patients received 40 weekly sessions of CT, whereas the other half received the same amount of STDP. All sessions lasted 50 minutes and were videotaped. Treatment adherence and competence were monitored using video-based group supervision. The clinical supervisor gave adequate feedback on how to improve the treatment in accordance with the treatment manual. All therapists treated at least one patient as a training exercise before treating patients who were enrolled in the study. No cases were excluded as a result of low treatment competence or adherence (Svartberg et al., 2004).

Treatment integrity was assessed with the inventory of therapeutic strategies, plus assessment of agenda setting and homework. The two raters were reliable ($r > .65$; range = 0.65–0.83; $M = 0.73$), and two-tailed tests showed the two treatments to differ in emphasis on supportive strategies ($t = 2.2$, $df = 48$, $p < .02$),

agenda setting ($t = 9.9$, $df = 48$, $p < .0001$), and homework ($t = 5.6$, $df = 48$, $p < .0001$) (CT emphasized more), defense work ($t = 4.0$, $df = 48$, $p < .001$), and transference work ($t = 3.33$, $df = 48$, $p = .002$) (STDP emphasized more). For work enhancing strategies, the emphasis was equally strong for the two treatments ($t = 0.03$, $df = 48$, $p = .50$) (Svartberg et al., 2004).

The CT therapists were six clinical psychologists with a mean of 11.2 years of clinical experience ($SD = 4.3$). All CT therapists were trained in the CT model and received supervision and seminars from CT experts such as J. Beck, A. Freeman, and J. Young (Svartberg et al., 2004). The STDP therapists were three psychiatrists and five clinical psychologists with a mean of 9.2 years of clinical experience ($SD = 3.6$). All STDP therapists were trained in the STDP model and received supervision and seminars from L. McCullough (Svartberg et al., 2004).

Instruments

The Helping Alliance Questionnaire. The Helping Alliance Questionnaire (HAQ; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983) was designed to be a pantheoretical measure of the therapeutic alliance. The patients rated the instrument after Session 4. The HAQ consists of 11 questions each rated on a scale with the following scale points: -3 (*strongly disagree*), -2 (*disagree*), -1 (*slightly disagree*), 1 (*slightly agree*), 2 (*agree*), and 3 (*strongly agree*). A total score is calculated, in which a higher score is indicative of a better alliance. The HAQ has been found to be both reliable and related to outcome (Horvath & Symmonds, 1991; Martin, Garske, & Davies, 2000).

The HAQ has been found to include questions that are reflective of early symptom improvement, rather than the alliance, and has appeared in a revised version where these items are excluded (Luborsky, 1996). Using only items 6, 7, 8, 9, 10, the measure used in this study therefore consists only of items considered to represent the therapeutic bond (Luborsky et al., 1996; Cronbach's alpha = .90 in the present study). The bond, as discussed earlier, is a central and defining feature of any alliance, and, as such, only the items that addressed the bond were included in the analysis.

Psychotherapy Process Q-Sort. Psychotherapy Process Q-Sort (PQS) (Jones, 1985) is an observer-rated broad measure of the psychotherapy process. The PQS was developed pantheoretically to assess therapist actions valued across therapies, making it especially useful for comparing the process of different therapies (Jones, Hall, & Parke, 1991; Lambert & Hill, 1994). The PQS contains 100 clinically relevant items that describe an entire psychotherapy session. Items refer to specific actions, behaviors, and statements by both patient and therapist. The scoring involves the Q-sort method and thus yields ipsative scores. Specifically, each of the 100 items is given a score from 1 (*uncharacteristic of the session*) to 9 (*very characteristic of the session*). In PQS, each score can only be given a fixed amount of times for every session (only 5 items can be given a 1 and a 9, only 8 items can be given a 2 and 8 etc.). This requires the judges to make multiple evaluations among items and thereby avoids halo effects and response sets (Block, 1961) and yields a normal distribution.

Reliability and validity of the PQS has been shown across a number of studies and treatment samples (Jones et al., 1991).

Table 1
Demographic and Clinical Characteristics of Patients Who Received Either CT or STDP

Characteristic ^a	STDP patients (<i>N</i> = 23)	CT patients (<i>N</i> = 23)
Age	33.5 <i>N</i>	34.3 <i>N</i>
Female Sex	13	10
Employed	14	18
Axis I diagnosis		
Major Depression, Current episode	6	11
Major Depression, Previous episode	8	10
Dysthymia	7	2
Panic disorder ^b	2	2
Agoraphobia ^c	2	2
Social phobia	7	12
Obsessive-compulsive disorder	3	4
Generalized anxiety disorder	12	14
Somatization disorder	1	3
No diagnosis	2	1
Axis II disorder ^d		
Avoidant personality disorder	15	15
Obsessive-compulsive personality disorder	8	8
Dependent personality disorder	4	5
Passive-aggressive personality disorder	1	2
Self-defeating personality disorder	1	2
More than one personality disorder	4	7

^a Treatment groups did not differ significantly on any characteristic. ^b With or without agoraphobia. ^c Without history of panic disorder. ^d Patients may have received more than one axis II disorder.

Interrater reliability across all items has repeatedly been shown to be satisfactory (alpha range from 0.83 to 0.89). Computing interrater reliability for single items has also given satisfactory results (alpha range from 0.50 to 0.95). There is also considerable evidence for the construct and discriminant validity of PQS (Jones, Cumming, & Horowitz, 1988, 1991; Jones, Krupnick, & Kerig, 1987; Jones & Pulos, 1993; Lingardi, Colli, Gentile, & Tanzilli, 2011; see also Ablon & Jones, 1999). For the purpose of this study, the mean level of PQS items was calculated over the first four sessions of therapy (i.e., before the alliance was assessed), making a single mean score for each patient.

In this study, the PQS was rated by 25 students, all of whom were enrolled in a clinical master's degree program in psychology at one of three different universities in Norway. They had studied from six months to four years and had little or no clinical experience. The raters attended a 2-day seminar, which included theoretical introduction and practical exercises and which was conducted by two expert raters. After the seminar, the raters practiced on their own using stimulus videotapes that had already been rated by experts. They then sent their scores to expert raters, who provided feedback on the raters' performance. To determine a rater's reliability, a Pearson's r was calculated as a correlation between the rater's score and the expert score. To qualify for the study, raters had to rate five sessions with a Pearson's r of at least .5. Student raters used a mean of 17 hours (range, 10–26) to achieve reliability on PQS. From an initial pool of 50 raters, 25 reached the criterion reliability level and were willing to participate in the study. Based on sample of ratings, the scores produced by the raters were dependable, as determined by a generalizability analysis (G-coefficient of 0.97; see Ulvenes, Berggraf, Wampold, Hoffart, & McCullough, 2012, for more details).

One purpose of the article was to investigate therapist actions that promote the therapeutic bond. The 38 PQS items that focused on therapist actions were therefore selected from the 100 PQS items. The correlations between the items and the bond derived from the HAQ were examined. Of these items, four were significantly correlated with HAQ Bond at the .05 level, namely the following:

1. Therapist draws attention to patient's nonverbal behavior, for example, body posture, gestures, tone of voice ($n = 46$, $df = 44$, $r = -0.516$, $p = .002$)
2. Therapist is sensitive to the patient's feelings, attuned to the patient; empathic ($n = 46$, $df = 44$, $r = -.402$, $p = .017$)
3. Therapist is distant, aloof (vs. responsive and affectively involved) ($n = 46$, $df = 44$, $r = .384$, $p = .023$)
4. Therapist comments on changes in patient's mood or affect that occur during the hour ($n = 46$, $df = 44$, $r = -.377$, $p = .026$)

All these items focused on the therapist either paying attention to affect, or emotional retreat or withdrawal, as illustrated in Table 2. The rating scale for items 1, 2, and 4 were reversed, so that a higher score on these PQS items were positively correlated to the bond. As a result, a higher score on these PQS items reflected avoidance of affect; that is to say, the more affect was avoided, the better the bond. Because the items were scored to indicate avoidance of affect, the average of the four items composed a scale referred to as PQS Affective Avoidance (PQS-AA).² The Cronbach's alpha for the four-item scale for the 46 patients was 0.70.

Symptom Check List 90-R. Symptom Check List 90-R (SCL90) is a broad measure of symptom distress relevant for

psychotherapy. It is a self-report instrument, and produces nine subscales, along with a Global Severity Index (GSI, Derogatis, 1983, 1994). In the analyses for this article, the GSI scores at start and termination of therapy were used. The GSI is often used as a general symptom outcome measure in clinical trials (Derogatis & Savitz, 2000). The mean GSI for a normal population ($n = 974$) is 0.31 ($SD = 0.31$). Derogatis (1983) did not report Cronbach's alpha for the GSI, but across two studies, the subscales from which the GSI is derived had a Cronbach's alpha ranging from 0.77 to 0.90. A more recent validation study found a Cronbach's alpha for the GSI of 0.94 for a nonclinical sample of 1006 persons (Schmitz, Hartkamp, Kiuse, Franke, Reister, & Tress, 2000). In the following analysis in this study, the GSI was reversed, so that a higher score indicate greater symptom relief (i.e., higher scores reflected more positive outcomes and consequently higher correlations with SCL-90 scored in this way indicate that the other variable is positively related to outcome).

Analysis. The analysis involved a number of regression analyses. The first model predicted the SCL90 from the bond, accounting for the pretest. We expected a positive relationship between bond and reduction in symptoms. In the second regression, we predicted the bond from the PQS-AA and we knew this relationship would be positive and significant, as the PQS-AA items were selected because of their significant relationship with the bond. The third model predicted the SCL90 from the PQS-AA, accounting for the pretest. We were interested in the degree to which the PQS-AA was related to symptom reduction. The final model predicted the SCL90, accounting for the pretest, from both the bond and the PQS-AA in order to determine how these two variables work together to produce outcome. Because of the exploratory nature of the study, we used two-tailed tests with a liberal alpha level of 0.10. We also tested to see whether the models for the two treatments differed.

Results

The means and standard deviations for each of the instruments used in the study are presented in Table 3, and pairwise correlations for residual gain score for SCL90, PQS-AA, and bond are presented in Table 4.

Because the alliance is thought to operate similarly across different types of therapy and because there were no difference in changes in symptoms between CT and STDP, the first analysis included the total sample, notwithstanding Webb et al.'s (2011) suggestion that the alliance may work differently for CT than for other treatments. However, as will be seen, there were indeed differences between the two treatments and those results are presented subsequently.

² For one session, a therapist might receive a score of 7 for drawing attention to patient's non-verbal behavior, a score of 6 for being sensitive to the patient's feelings, attuned to the patient; empathic, a 2 for being distant and aloof, and 5 for commenting on changes in the patients mood or affect. Reversion was done by the formula: reverse score (x) = $((\text{Max } x) + 1) - x$. After reversion the mean score for the four items would be $(9+1-7) + (9+1-6) + 2 + (9+1-5)/4 = 2.8$. This is a low score, indicating that affect avoidance was not dominant in the session. A mean score for the first four sessions was computed to create the PQS-AA.

Table 2
Examples of Therapist Behavior From the PQS-AA

PQS-AA item description	Example of therapist behavior
Therapist draws attention to patient's nonverbal behavior, e.g. body posture, gestures, tone of voice	Do you notice how your voice becomes softer, and it is hard for you to meet my eyes when we talk about this? Why do you think that is?
Therapist is sensitive to the patient's feelings, attuned to the patient; empathic	There seems to be a lot of feelings attached to this for you. It seems really hard, but I am here with you, and these are only feelings, you know.
Therapist is distant, aloof (vs. responsive and affectively involved)	So there is a lot of feeling about what happened after last session. Is there anything else we should talk about?
Therapist comments on changes in patient's mood or affect that occur during the hour	Did you notice what just happened? We were talking about your day, and you were sitting upright, looking at me. But the moment we started talking about you standing up to your boss, you seem anxious, you have your neck bent down as in shame, and your voice is low. What do you think happened here?

Total Sample

The results of the regression analyses examining the relationship of the bond, therapist actions related to affective avoidance (i.e., PQS-AA), and change in symptoms (i.e. SCL90) are presented in Table 5. As expected, the bond was positively related to a reduction in symptoms (i.e., in a regression with the SCL90-Post test as the dependent variable and the SCL90 at pretest as an independent variable) (Std Beta = 0.233, $p = .059$). Also, as was surely the case given the way in which the PQS items were selected, PQS-AA was positively related to the bond (Std Beta = 0.471, $p = .004$); that is, the more the therapist avoided eliciting or commenting on affective material, the higher the patient's rating of the bond.

As discussed previously, certain therapist actions are associated with the alliance and (here the bond) and does not necessarily imply that these therapist actions are predictive of outcome. Consequently, the next analysis examined the association of PQS-AA and reduction in symptoms. For this sample, PQS-AA was not significantly related to SCL90 (after accounting for pretest, Std Beta = 0.081, $p = .591$). That is to say, although certain therapist actions (viz., avoiding affect) were related to the bond, they were not related to outcome. This suggests that PQS-AA was either related to an aspect of the bond that is not relevant to outcome, or the PQS-AA actually was related to a part of the bond that was *not therapeutic*. The latter option would represent an instance of *suppression* (Cohen & Cohen, 1983; Conger, 1974; MacKinnon, Krull & Lockwood,

2000; Tzelgov & Henik, 1991), which refers to "a variable which *increases* the predictive validity of another variable (or set of variables) by its inclusion in a regression equation" (emphasis added, Conger, 1974, pp. 36–37).

The final step of the analysis therefore included both PQS-AA and bond in the analysis, as shown in Table 5. In this analysis, it is clear that PQS-AA indeed does suppress the importance of the bond, as the coefficient for the bond *increased* when PQS-AA was included in the model (i.e., the Std Beta for bond increased from 0.233 to 0.327). That is, focusing on affect reduces the bond, but not the aspects of the bond that lead to better outcomes.

These results are not consistent with Webb et al. (2011), who found that the bond was not related to a reduction in symptoms for CT. Consequently, we were interested to know whether the results were applicable to both treatments. To see if there were treatment differences, two general linear models using maximum likelihood estimators were assessed. The first model included SCL90 at the two time points, the PQS-AA and the bond. The second model included all the previous variables, plus treatment condition. The difference between the log likelihoods for model fit was significantly greater than the critical value (viz., 22.276 compared with a chi square distribution with 1 *df*, $p < .001$, indicating the model for CT was different from the model for STDP, and therefore we investigated each treatment separately.

Table 3
Means and Standard Deviations for Instruments Used in Analysis, Combined and by Treatment

Measure	Total sample ($n = 46$)		STDP ($n = 23$)		CT ($n = 23$)	
	Mean	SD	Mean	SD	Mean	SD
SCL90 Pre	3.79	0.66	3.87	0.61	3.71	0.71
SCL90 Post	4.2	0.57	4.24	0.50	4.15	0.64
PQS-AA	3.96	0.72	3.92	0.83	3.99	0.58
HAQ	9.44	4.90	9.35	3.14	9.52	6.26

Note. Because of reverse scoring of the SCL, a higher score indicates less symptom distress. For PQS-AA, a higher score means the therapist is more avoidant of affect. For HAQ, a higher score is indicative of a stronger bond.

Table 4
Pair-Wise Correlation for SCL90 Residual Gain Score, PQS, and Bond

	SCL 90 residual	PQS-AA	Bond
SCL 90 Residual			
Total sample	1.0	.091	.274
STDP	1.0	-.246	.135
CT	1.0	.569*	.340
PQS-AA			
Total sample	.091	1.0	.456**
STDP	-.246	1.0	.463*
CT	.569*	1.0	.479*
Bond			
Total	.274	.456**	1.0
STDP	.135	.463*	1.0
CT	.340	.479*	1.0

* Two-tailed test, significant at the 0.05 level. ** Two-tailed test, significant at the 0.01 level.

Table 5
Regression Analyses For Bond, PQS-AA, and SCL90, by Treatment

Dependent	Independent	Total sample (<i>n</i> = 46)				STDP (<i>n</i> = 23)				CT (<i>n</i> = 23)			
		Std Beta	β	SE_{β}	<i>p</i>	Std Beta	β	SE_{β}	<i>p</i>	Std Beta	β	SE_{β}	<i>p</i>
SCL90-Post	SCL90 Pre	0.617	0.520	0.103	.000	0.558	0.451	0.558	.006	0.644	0.577	0.153	.001
	Bond	0.233	0.033	0.017	.059	0.119	0.021	0.032	.525	0.303	0.039	0.022	.091
Bond	PQS-AA	0.471	1.973	0.644	.004	0.480	1.657	0.734	.037	0.498	2.402	1.119	.050
	SCL90-Post	SCL90 Pre	0.515	0.430	0.124	.001	0.677	0.602	0.154	.001	0.303	0.239	0.162
SCL90-Post	PQS-AA*	0.081	0.057	0.105	.591	-0.185	-0.116	0.109	.302	0.582	0.518	0.183	.014
	SCL90 Pre	0.512	0.426	0.121	.001	0.638	0.563	0.147	.002	0.305	0.241	0.166	.173
	PQS-AA*	-0.083	-0.059	0.117	.619	-0.379	-0.239	0.120	.065	0.507	0.452	0.216	.058
	Bond	0.327	0.056	0.028	.055	0.357	0.065	0.035	.081	0.150	0.028	0.045	.547

Note. The difference between the log likelihoods for model fit for a model with treatment versus a model without treatment was significantly greater than the critical value (viz., 22.276 compared to a chi square distribution with 1 df, $p < .001$, indicating the model for CT was different from the model for STDP. * Because of reverse scoring of PQS-AA and SCL, negative values of PQS-AA (therapist being affect avoidant) leads to lower values on SCL (patients reporting more distress).

Short-Term Dynamic Psychotherapy

The results for STDP parallel those of the total sample, except that the suppression effect was more pronounced. By itself, the bond was *not* associated with a reduction in symptoms (Std Beta = 0.119, $p = .525$), which would be a surprising result. As in the total sample, PQS-AA was unrelated to outcome (Std Beta = -0.185, $p = .302$), although the direction was opposite to that of the total sample. When both the PQS-AA and bond are in the model, the bond is now a significant predictor of the reduction in symptoms (Std Beta = 0.357, $p = .081$). This is the classic suppressor in that bond was only significant when the portion related to affect was removed. Keeping in mind that if variable X suppresses Y, then Y also suppresses X (Cohen & Cohen, 1983), we see that bond has suppressed PQS-AA as PQS-AA is now associated with a reduction in symptoms, that is less avoidance of affect predicted symptom improvement (Std Beta = -0.379, $p = .065$). Said in another way, in STDP, in the context of the bond, a focus on affect is related to a reduction in symptoms, even if such actions decrease the bond.

Cognitive Therapy

The results for CT are quite different from those of STDP. Although bond was not related to a reduction of symptoms in STDP (without considering PQS-AA), it was for CT (Std Beta = 0.303, $p = .091$). However, when both PQS-AA and bond are considered, a different pattern emerges. PQS-AA was now positively related to a reduction in symptoms (Std Beta = 0.507, $p = .058$); that is, in the context of the bond, avoiding affective material in CT led to better outcomes, which is the opposite of what was found in STDP. Interestingly, in the context of the PQS-AA, the bond is no longer associated with a reduction in symptoms (Std Beta = 0.150, $p = .547$).

Discussion

The results of the present study paint a complex picture of therapist actions that create a bond and how the bond is then related to outcomes in the psychotherapy of cluster C personality disorder patients. First, we found that the relationship

among therapist actions, bond, and outcomes in psychotherapy differs depending on the therapeutic approach. Therapist avoidance of affect was found to be positively related to formation of the bond, as rated by the patient, in both STDP and CT. That is, patients in this study found the focus on affect to be problematic in terms of feeling bonded to their therapist. However, the avoidance of affect (or alternatively, the focus on affect) functioned very differently in the two treatments. In STDP, although a focus on affect detracted from the bond, this focus resulted in a reduction of symptoms, and, as well, the part of the bond not related to a focus on affect was predictive of outcome. However, in CT, the portion of the bond not related to a focus on affect was unrelated to outcome and a therapist focus on affect was counterproductive.

The differences between STDP and CT found in this study were consistent with theoretical conjectures (Bordin, 1979, 1980, 1994; Hatcher & Barends, 2006; Wampold & Budge, 2012) and empirical findings (Webb et al., 2011, see also Blagys & Hilsenroth, 2000 for a review of empirical differences between STDP and CT in affect focus). That is to say, the bond, and most likely the alliance more generally, may well function differently in different therapies, particularly with cluster C patients. So, reference to the alliance as a *common factor* may be misleading in the sense that although the importance of the alliance may be common, the manner in which it interacts with the specific treatment to achieve benefits may not be common (see, e.g., Hoffart, Borge, Sexton, Clark, & Wampold, 2012). In Tables 6 and 7 transcripts of an interaction between an STDP therapist and a patient, and a CT therapist and a patient are presented. The transcripts are intended to describe all four therapist actions included in this study. To achieve this, the transcripts were developed from typical interactions in the two treatment orientations, at Session 4.

The analysis for STDP shows that the bond predicts outcome, and that the bond is also related to the therapist being distant or avoiding affect, but that the therapist being distant and avoidant of affective material is not predictive of the outcome. Affect phobia therapy, the short-term dynamic therapy used in this RCT, views psychopathology as a consequence of a conflict between activating and inhibitory feelings. This conflict blocks the patients' adaptive

Table 6

Transcript^a of a Part of Session Four in Psychodynamic Therapy, Illustrating Therapist Actions Investigated in the Current Study

	Verbatim material	Comment
Therapist	Last session we worked a lot with the feelings you are struggling with. How have you been, we were working hard? How does it feel being here, what are your expectations for today?	
Patient	It's been tough, I've been feeling sad. I think this is important for me, but it costs a lot. It's important to do this, but I'm not looking forward to the session. I don't want to fall as deep as I did last time. I have things I need to get done, I have responsibilities. It is hard. (<i>Looks away, stiff and unmoving body, voice somewhat trembling</i>)	
Therapist	It sounds tough. It is something important in what we do, but it costs a lot. (<i>Moves body forward, low and soothing voice</i>)	Therapist is sensitive to the patient's feelings, attuned and affectively involved.
Patient	I'm afraid I won't get back up again. I'm afraid to go deep into my mess.	
Therapist	What's hard about going deep in your mess?	Therapist searches for feeling.
Patient	It's hard to tolerate the feelings. It's like when I was 16 and no one was there for me. I feel the same all over again. I feel locked in and I can't relate to people. (<i>Looks down and away</i>)	
Therapist	What you are saying is important. You feel afraid and locked up, and the feelings come back to you again. There was a wave of sadness in your face just then. Will you be alone with the feeling, or will someone be there with you? (<i>Searches for eye-contact, voice still soft and low</i>)	Therapist draws attention to the patient's non-verbal behavior and comments on change in mood. Therapist is sensitive to the patient's feelings and affectively involved. Therapist is exposing for affect.
Patient	I won't be alone in this session . . . But when the door closes I feel lost. (<i>Faces therapist</i>)	
Therapist	What do you feel in your body when you say that you are alone and lost? (<i>Maintains eye contact and mirrors the patients body posture</i>)	Therapist encourages affect experiencing. Therapist is attuned and empathic.
Patient	It sinks into me. In my stomach. It's in knots. And like some heavy weights on my shoulders. (<i>Sinks down in the chair, diverts eye contact again</i>)	
Therapist	Your stomach is in knots. (<i>Mirrors patients body posture</i>)	Validates the patients feelings, is attuned and responsive. Draws attention to non-verbal behavior.
Patient	Creepy, uncomfortable feeling. And a heavy weight on my shoulders.	
Therapist	That sounds exhausting. For how long have you felt like this? (<i>Empathic voice</i>)	Therapist is attuned and empathic.
Patient	16	
Therapist	What do you feel like you need?	Therapist is attuned and empathic. Therapist is exposing for feeling.
	Weights—stomach—alone . . .	
	What do you need, what do you wish for? (<i>Modulates voice, leans body towards patient</i>)	
Patient	Hard . . . (<i>Looks away, upper body leaning forward</i>)	
Therapist	What do you need? (<i>Looks up, leans back in chair</i>)	Therapist is attuned, empathic, affectively involved and responsive.
Patient	I know what I don't need . . .	
Therapist	That's safer.	Therapist validates the patient's experience.
Patient	That question makes me feel insecure. I wish someone was there, I don't feel safe with other people. (<i>Looks at therapist</i>)	
Therapist	It has been tough opening up here.	Therapist validates the patient's experience.
Patient	All of a sudden people can be gone. (<i>Soft voice</i>)	
Therapist	And maybe it has been like that for you. Letting people get close has not been a good experience for you. You are in a dilemma here. (<i>Soft voice</i>)	Therapist is attuned and empathic.
Patient	That's why it's so hard to get into this. (<i>Eye-contact with therapist</i>)	
Therapist	There's a lot that is scary about this. I want to go back to what you need or wish for?	Therapist is attuned and empathic. Continues to expose for affect.
Patient	Accept me like I am. [Short pause]	
Therapist	How would that be?	Continues to expose for affect.
Patient	Don't have to fake, pull my self together.	
Therapist	Perform?	Continues to expose for affect.
	How is it to feel that it is good to be accepted?	
Patient	Relief. The thought makes me happy. It would have been nice. (<i>Brief smile</i>)	

(table continues)

Table 6 (continued)

	Verbatim material	Comment
Therapist	And now you were able to feel a little of it also, and you felt that it was good. You did it, and it felt good. How is that for you?	Comments on changes in patient's mood, is empathic, and continues exposure.
Patient	I get moved. (<i>Brief smile and quickly tears up</i>)	
Therapist	This was important for you. Breathe a little. How does it feel with me now, still a bit scary?	Therapist is responsive and affectively involved.
Patient	Not as scary now, I liked the questions on what I needed. It felt easier when you helped me. (<i>Faces therapist</i>)	
Therapist	I way to challenge you some more. What do you think I wish for you?	Therapist exposes for affect.
Patient	That's hard. You hope that I get better?	
Therapist	What do I feel for you? That's hard to think about. Alone, weight on your shoulders, afraid. What do you think I feel for you? (<i>Leans forward towards patient, soft voice</i>)	Therapist is empathic and responsive. Continues to expose for affect.
Patient	You want me to feel good about myself. But you think that it's a long way before I get there. (<i>Faces therapist but diverts eye-contact</i>)	
Therapist	But you think you're going to need a lot of time. What does it feel like that I have those feelings towards you?	Therapist is empathic and responsive. Continues to expose for affect.
Patient	[Silent] (<i>Looks down and away</i>)	
Therapist	Did it get hard for you when we came this close?	Therapist is empathic and responsive.

^a In order to include all therapist actions investigated, the transcript is developed from typical interactions observed in short-term dynamic therapy at session 4.

expression of affect and can be thought of as a phobia for feeling the conflicted affect. Affects are treated as primary motivational forces in the treatment (Tomkins, 1962, 1963, 1991, 1992). Affect phobia treatment capitalizes on understanding the complex dynamic between affective motivational forces and exposing the patient to the experience of the conflicted feeling. This exposure process leads to desensitizing the activating affect, allowing it to be used more adaptively (see, e.g., McCullough-Vaillant, 1997; McCullough et al., 2004). The primacy of affect focus in psychodynamic therapies has also been investigated in several studies, and it appears that in these treatments, affective work leads to positive outcomes (see, e.g., Diener, Hilsenroth & Weinberger, 2007 for a meta-analysis on affect in psychodynamic psychotherapy; as well as Diener & Hilsenroth, 2009 and McCullough & Magill, 2009).

Because of the emphasis on affect as a change mechanism in the dynamic treatment, it is logical that the therapist avoidance of affect was not productive of outcome. This can be interpreted as the therapist avoiding affect may help the patient *like* the therapist or therapy better, but it does not help the patient *get* better. The puzzling part of the findings is that this kind of therapist behavior is predictive of the bond and the bond is predictive of outcome. This has two central implications: The bond is important in STDP, and the bond has to form despite the therapist focusing on affect. The first discussion of the alliance construct is often traced back to Freud (see, e.g., Horvath, 2001), who noted the apparent paradox that patients remained in therapy despite the often painful and troublesome feelings they had to experience with the therapist. Another way to understand the findings is that the bond might consist of several parts, one that is predicted by the therapist avoidance of affect (i.e., avoiding what is needed in STDP), and at least one part that is not. Other therapist interventions, not captured by the therapist behaviors included in the PQS-AA, might be predictive of both the outcome and of other aspects of the bond.

In the segment of STDP presented in Table 6, the short-term dynamic therapist is investigating and exposing the patient to feelings. The segment starts out with the patient being reluctant to go into affect. The therapist focuses on feelings of closeness and compassion toward the self, and does so in a very attuned and empathic way. She is affectively involved and stays close to the patient's experiences in the session. The therapist is both drawing attention to nonverbal behavior and comments on changes in mood that occur in the session. Still, the bond in the dyad is strong. The therapist has managed to create a bond despite the focus on affect and, therefore, is able to do work that has been found to be associated with a favorable outcome (see, e.g., Diener, Hilsenroth & Weinberger, 2007). Blagys and Hilsenroth (2000, 2002) also identified several therapist behaviors that separate dynamic therapy from CT. Among these were a focus on affect and expression of emotions, and exploration of the patient's attempts to avoid topics or divert from activities that promoted therapy progress. Related to the importance of our findings here, in a study of therapist actions and treatment outcome in depression, Hilsenroth, Ackerman, Blagys, Baity, and Mooney (2003) identified two specific dynamic interventions, "the therapist encourages the patient to experience and express feelings in the session" and "the therapist addresses the patient's avoidance of important topics and shifts in mood" that were significantly related to symptom improvement in depression.

The results related to CT are complex but appear to be consistent with previous research. CT focuses on cognitions and attributions and therefore a focus on affective states could, as the present results suggest, interfere with the specific ingredients of CT. At first glance, it appears that the bond is important for CT, a result contradictory to Webb et al. (2011); however, the relationship between the bond and reduction in symptoms may have been an artifact of the focus on affect. In CT, at least in this study, it appears that a focus on affect by the therapist creates a weaker

Table 7
Transcript^a of a Part of Session Four in Cognitive Therapy, Illustrating Therapist Actions Investigated in the Current Study

	Verbatim Material	Comment
Therapist	Last time we ended after we discussed how you typically think about yourself.	
Patient	Yes, I think of my self as weak, I can't do anything, I feel like withdrawing. (<i>Patient looks down and away from therapist</i>).	Mentions a core belief
Therapist	So what are you thinking about yourself then?	Therapist investigates thoughts about belief
Patient	I'm not good enough, I can't do anything, I'm not smart enough. I can't express myself, I'm not social. I can't concentrate, my head is just one big buzz. (<i>Patient continues to look away, but is not looking down anymore</i>)	
Therapist	It takes control over you. Now, you've said a few things, but how do you feel?	Validates the patient's experiences. Asks for feelings.
Patient	Fatigued and powerless. Sad. Everyone else can do this, I get paralyzed. (<i>Patient looks sad, lowers head again, voice gets lower</i>)	
Therapist	You feel sad, and compare yourself to other people. If we look closer at what you said, how much fatigue and powerlessness do you feel for each of these things on a 1–100 scale?	Sums up the patients feelings. Asks for more information, but does not go into deep emotions.
	Lets start with "I'm weak". How much do you feel then? (<i>Therapist modulates voice for a short while, resembles that of patient</i>)	
Patient	It's a very general thing, in some situations I'm weak, . . . (<i>Patient looks up again, more animated than earlier</i>)	
Therapist	(Interrupts) It gets tricky to say, but how about right now? How much do you feel? (<i>Therapist moves upper body towards patient, is pointing with his hand towards patient</i>)	Refocuses and challenges the patient to give more information on emotions. Is investigating descriptions of feelings, does not go into experiencing feelings.
Patient	It's about 70–80. (<i>Patient keeps looking up, has eye-contact with therapist for a short while. Patient seems more at ease</i>).	
Therapist	If you think about "I'm not good enough" how much from 1–100? (<i>Therapist is still facing patient, and is taking notes in between looking at the patient</i>)	Gets more descriptions, continues to follow the affect theme on a cognitive level.
Patient	Frightening, lots of powerlessness, close to 90. It's hard to put on a scale, the feelings become scary. (<i>Patient looks momentarily down and away, before looking up again</i>)	
Therapist	Strong feelings. How much powerlessness do you feel with "I can't do it"?	Validates patients experience, continues to investigate descriptions of feelings.
	(Still facing patient and taking notes)	
Patient	We are touching on 90 to 100. This locks me completely down. (<i>Looks up, but not at therapist</i>)	
Therapist	Which thought carries the most meaning for you? (<i>Still facing patient and taking notes</i>)	Identifies the core belief to focus on.
Patient	They are very interconnected, "I'm not good enough" . . . (<i>Looks up, but not at therapist</i>)	
Therapist	That's the central one, "I'm not good enough". Lets focus on that one. (<i>Facing the patient, but no eye contact</i>).	

^a In order to include all therapist actions investigated, the transcript is developed from typical interactions observed in cognitive therapy at session 4.

bond and less benefit. Webb et al. (2011) found that the bond was marginally important but that when considered in conjunction with agreement on tasks and goals contributed very little to the reduction of symptoms. However, in the Webb et al. study and in the current study, the interplay between bond and agreements dimensions was not studied. As Hatcher and Barends (2006) commented, "Successful collaboration is based on a level of trust and attachment (bond) that is commensurate with the task" (p. 293). That is, in CT particularly, there may be a need for a strong bond *before* there can be agreement on goals and tasks (Wampold & Budge, 2012). By the time the alliance is measured, even at Session 3 or 4, the collaboration may well have moved beyond building trust and forming an agreement about what will happen in therapy so that the importance of the bond, particularly over and above agreement on tasks and goals, is not as critical as it was in the first few moments of the therapeutic engagement (see

Wampold & Budge, 2012). Indeed, there is experimental evidence that judgments of trust are made in less than one second (Benedetti, 2011). Clearly, longitudinal efforts are needed to determine how the bond, agreement about goals and tasks, and symptom reduction develop interactively over time, in CT and in other therapies.

Throughout the segment of CT presented in Table 7, the cognitive therapist is investigating core beliefs that are tied to feelings. The focus is on descriptions of feelings. The therapist is attuned to and empathic toward the patient. The therapist is, however, not affectively involved, although he is responsive. The therapist does not draw attention to the patient's nonverbal behavior and does not comment on changes in the patient's mood. All these therapists' behaviors were predictive of a good alliance in CT in the study. The behaviors were, however, not predictive of outcome.

It is interesting to compare the results of the present study with those of Lingiardi et al. (2011), who examined PQS items and the working alliance, as well as session depth. Lingiardi found that several PQS items were associated with the alliance and session depth and concluded that their results “indicate the importance of therapist interventions that focus on the patient’s affects, relational patterns, and the “here and now” of the relationship in the increase of the Depth of elaboration and therapeutic alliance” (p. 391). In our study, interventions that focused on affect attenuated the bond and were positively related to outcome only in dynamic therapy. Unfortunately, Lingiardi et al., who used material from independent practice, were not able to investigate the theoretical approach or the outcome of the psychotherapy. These contrasting results suggest the importance of specifying the nature of the treatment being delivered and assessing outcomes.

There are a number of limitations to the present study. First, the patients in this trial were diagnosed with cluster C personality disorders and were thus avoidant of affective material. Therefore, the results of the present study, particularly with regard to the therapist actions related to affect, may be specific to this population. That is to say, the role of the bond in therapy may well depend on the type of treatment *and* characteristics of the patient. Second, the reduction in symptoms was assessed by comparing symptoms at the end of treatment to that at the beginning of treatment. Webb et al. (2011) appropriately used the change of symptoms subsequent to measurement of the alliance, but we could not do that unfortunately. However, previous research has demonstrated that the alliance measured early in therapy is not simply a function of early symptom change and continues to predict treatment outcome even when these early changes are controlled for (Barber et al., 2000). Third, the PQS items were selected based on their relationship to the bond, which may capitalize on chance findings, although one of the purposes of this article was to explore which therapist actions lead to formation of the bond. The properties of these items have not been investigated extensively. Moreover, there may be, and likely are, many therapist actions not captured by the PQS that are related to alliance formation. Fourth, this research, as well as Webb et al. (2011), focused on symptom reduction, which may well overemphasize an agreement about tasks focused on particular problems, particularly in CT. It could be that the bond has a different role in benefits of psychotherapy other than symptoms, such as general well being and role functioning (Wampold & Budge, 2012). Finally, only two treatments were examined and a general theory of the role of the bond across a range of therapies is needed.

The present investigation is distinguished by identifying therapist actions in the first four sessions that affected subsequent ratings of the bond, and the effect of the actions and the bond on outcome. As such it begins to illuminate how therapist actions and the bond work together to produce the benefits of psychotherapy in two different treatments. The results of this study have demonstrated that simple conclusions about the pantheoretical nature of the alliance may be misleading—the alliance seems to be important for all therapies but may well interact with the specific treatment components differently. As such, this research is an effort in understanding what makes psychotherapy work, but

clearly additional research on the mechanisms of change in various therapies is needed.

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