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Therapeutic alliance in short-term supportive and psychodynamic psychotherapies: A necessary but not sufficient condition for outcome?

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ABSTRACT

The therapeutic alliance is considered as one of the active relational factors to improve the outcome of patients engaged in a psychotherapeutic process. Our objective was to examine the role played by the therapeutic alliance in psychodynamic versus supportive psychotherapy. We examined data from a previously published randomized controlled study. Outpatients suffering from depression ($n = 74$) received the same antidepressant (clomipramine) and were randomized into two groups, receiving either psychodynamic or supportive psychotherapy. Subjects were assessed at inclusion (Structured Clinical Interview for DSM-IV Disorders, SCID), during treatment and at discharge (Global Assessment Scale, Hamilton Depression Rating Scale, Helping Alliance questionnaire). Over time, the therapeutic alliance improved regardless of condition, and the relationship between alliance and outcome strengthened. This relationship was significant only among patients assigned to the supportive therapy condition. These data suggest that although the therapeutic alliance is an important factor in psychodynamic treatment, additional ingredients may be involved in its superiority compared to supportive therapy.

1. Introduction

Over the last decades, research in psychotherapy has tended to distinguish specific and nonspecific factors related to improvement. The former refer to the elements that are characteristic of a particular type of therapy. The latter, on the contrary, include factors common to all types of therapy such as expectations of improvement, therapist skills, and the therapeutic alliance (Castonguay, 1993). Regarding nonspecific factors, a substantial body of work has focused on the therapeutic alliance. There is increasing evidence of a relationship between improvements concerning patients' psychiatric status and the therapeutic alliance (Fava and Sonino, 2000), which has been described as one of the most efficient curative factors in psychotherapy (Luborsky, 1990). Furthermore, various controlled studies have shown different theoretical approaches to be equally effective in some controlled studies, particularly among depressed patients (Marks, 1999), suggesting their action might be mainly related to the nonspecific ingredients.

The concept of working alliance, introduced by Greenson (1965), can be assessed in research using a number of instruments. Luborsky (1976, 2000) in particular created several scales that can be completed from the perspective of an observer, the patient or the therapist. These scales aim to assess two dimensions: firstly the extent to which the therapist is perceived as supportive, and secondly the sense of collaboration between patient and therapist.

The concept of the therapeutic alliance is of particular interest in the field of research as it appears to be a predictive index of outcome (Summers and Barber, 2003; Petry and Bickel, 1999). Indeed, two previous meta-analyses have shown the existence of a correlation between alliance and outcome (Horvath and Symonds, 1991; Martin et al., 2000). Although the overall effect sizes reported in these studies were relatively low, the relationship has been described as a robust one (Castonguay, 2006). Nevertheless, the correlation design of most of these studies is an important limitation not to be overlooked. Furthermore, the therapeutic alliance has been reported to be associated with other patient variables, in particular expectations of treatment (Castonguay, 2006). Similarly, measures of early alliance, a frequently used assessment point, might be confounded by improvement (Crits-Christoph et al., 2006). These are considerations that should not be neglected when interpreting the relationship between alliance and outcome. However, one study reported a significant relationship even after controlling for these variables (Klein et al., 2003).

Another interesting issue to consider is the variation in the relationship between treatment and outcome across a spectrum of

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types of psychotherapy. In their study, although type of treatment varied (psychodynamic, cognitive, gestalt and eclectic integrative therapies), Horvath and Symonds (1991) reported no variation of the effect size. A strong alliance seems to contribute to a favorable outcome for patients regardless of type of treatment (Horvath and Luborsky, 1993). One study, however, reported that alliance was associated with outcome for the control but not for the active psychotherapeutic modality (Carroll et al., 1997).

The objective of our study is to examine the role of the therapeutic alliance scores in psychodynamic psychotherapy versus supportive psychotherapy, among a population of patients suffering from depression. For this purpose, we used the data collected in a previously published randomized, controlled study (Burnand et al., 2002). To our knowledge, this is the first study to use a randomized and controlled design to explore the relationship between therapeutic alliance and outcome among patients receiving supportive psychotherapy or psychodynamic therapy.

2. Methods

2.1. Design

As a full account of this randomized controlled study was presented in a previous publication (Burnand et al., 2002), this article will describe the method only insofar as it is relevant to the present study. The study was approved by the ethical committee of the Geneva University Hospitals.

2.2. Participants

A total of 390 patients were screened, of whom 95 aged between 20 and 65 years were assigned to a 10-week (mean = 86.6 days, S.D. = 19.9) acute outpatient treatment for major depression. All participants provided written informed consent. A specific treatment manual was created for each type of therapy, and two psychologists controlled adherence to the manual.

Bipolar disorder, psychotic symptoms, severe substance dependence, organic disorders, past intolerance to clomipramine, mental retardation, poor command of the French language and insurance coverage outside the Geneva canton were all criteria for exclusion. Inclusion criteria were: aged 20–65, a diagnosis of major depressive episode and a score of at least 20 on the Hamilton Depression Rating Scale. The complete Structured Clinical Interview for DSM-IV Disorders (SCID) (Spitzer et al., 1992) was used to screen for all the axis I clinical disorders and the International Personality Disorder Examination (Loranger et al., 1994) for all the axis II diagnoses. The interviews were performed by well-trained psychologists from a specialized center (kappa = 0.89).

2.3. Procedure

We compared two 10-week acute treatment programs for major depression: clomipramine combined with psychodynamic psychotherapy ($N = 35$) and clomipramine plus supportive psychotherapy ($N = 39$). Consent was obtained before the first assessment. Data were collected by four psychologists at baseline and discharge.

We used randomization blocks stratifying for gender, presence of SCID-defined past depressive syndrome and presence of DSM-IV personality disorder. Although raters were blind to treatment conditions insofar as it was possible, the size of the research team allowed no guarantees on this point up until discharge. From that moment on, raters were completely unaware of initial protocol.

2.4. Treatments

Treatment was conducted in an outpatient crisis center. Both the clomipramine protocol and the psychodynamic psychotherapy technique were extensively described in Burnand et al. (2002).

The psychodynamic protocol was implemented by experienced nurse–therapists with psychodynamic background knowledge who were trained over a 6-month period using a manual and had weekly supervision sessions with a psychoanalyst. The treatment focuses upon the development of an empathic relationship between patient and therapist who, together, investigate interpersonal difficulties in relation to past life-events. Present relationships are explored and the investigation of the patient's social environment is encouraged. The therapy aims to "work-out" the unconscious pathological mourning process that is posited to be at the basis of the patient's depression. Transference phenomena per se were not interpreted. To control for treatment fidelity, two clinical psychologists having reached a consensus rated adherence to treatment.

The supportive treatment was again delivered by experienced nurses having received a similar 6-month manual-based training course, and benefiting from clinical supervision. The supportive care individual sessions focused on empathic listening, guidance, support and alliance. The number of individual sessions and their length were comparable in the psychodynamic and supportive protocols. Psychoanalytic supervision given to the trained nurses was balanced with an equivalent amount of clinical supervision.

The clomipramine protocol involves an increasing dosage ranging from an initial dose of 25 mg to a final dose of 125 mg on the fifth day. Drug monitoring was conducted during weeks 2, 4, 6 and 8 and at discharge. The optimal plasma concentration of both clomipramine and desmethylclomipramine was between 200 and 300 ng/ml. Both treatments involved the same NIMH protocol (Elkin et al., 1988a,b).

2.5. Assessments

2.5.1. Symptoms severity

At inclusion and after 10 weeks, three psychologists, independent from the care team, confirmed the diagnosis of depression according to the Structured Clinical Interview for the DSM-IV (SCID) and evaluated its intensity with the 17-item Hamilton Depression Rating Scale (HDRS) (Hamilton, 1967; Guelfi et al., 1981). Moreover, at inclusion and discharge, three experienced psychiatrists assessed the participants' level of functioning using the Global Assessment Scale (GAS) (Endicott et al., 1976). The intraclass correlation coefficients for these three measurements were respectively, 0.93, (SCID), 0.79 (HDRS) and 0.76 (GAS). The reliability was assessed for every 10th patient.

2.5.2. Therapeutic alliance

We used the Helping Alliance questionnaire (HAq I) (Luborsky, 2000; to evaluate the level of alliance. This 11-item self-report questionnaire was distributed to the patients and nurses by the team of psychologists at the end of the psychotherapy session: after the first treatment session (T1), twice during treatment (T2: week 2, T3: week 5) and at discharge (T4: week 10). The results were known only to the investigator and were not given to the patients or the therapists. This instrument was selected on the basis (1) of its psychometric properties (Martin et al., 2000), and (2) because it measures two important aspects of alliance (5 items measuring support: HAq type 1, and 6 items for collaboration: HAq type 2) as well as (3) its strong correlation with psychotherapeutic outcome (Summers and Barber, 2003; Martin et al., 2000; Fenton et al., 2001; Bachelor and Salamé, 2000). In its original form the scale demonstrated good psychometric properties with an overall reliability of 0.74 (Martin et al., 2000). The French translation of this scale (Gérin et al., 1991) has also shown good internal consistency with alpha = 0.88 (Bachelor, 1991). In this study, only the data pertaining to the patient's assessment of the working alliance were used.

2.6. Statistical analyses

As in Burnand et al. (2002), the analysis was only done with the 74 patients who completed the study and excluded patients with early dropout ($n = 7$, 8%) and patients with exclusion criteria undetected at entry (substance dependence: 10, intolerance to tricyclic medication: 4). As far as outcome parameters are concerned, the analysis was based on the GAS scores that revealed the most significant treatment effect (Burnand et al., 2002). After computing the basic statistics, alliance improvement was investigated with between-groups and within-groups repeated measures analysis of variance using the treatment as the grouping factor. The relationship between the HAq score at each assessment point and the outcome at discharge was explored with Spearman Rho coefficients. We then used analysis of variance (ANOVA) to estimate the effect of time and alliance improvement on the variability of GAS scores at discharge. Treatment*alliance interaction effects were investigated using analysis of covariance (ANCOVA) with the global improvement of GAS scores as the dependent variable and treatment as the categorical predictor. Secondary analyses were conducted to control for the effect of concurrent personality disorder. The statistical analysis of the data was carried using the program Systat 8.0®.

3. Results

3.1. Sample characteristics

The mean age of the population was 36.4 years old (S.D. = 9.9), with a 1.6 sex ratio (Female/Male). Most of the patients were employed (71.6%) and had good insurance coverage (100%). Half of the sample were middle class individuals (50%) with a secondary school education (55.4%) and 33 (44.6%) of them were married ($n = 25$, 33.8% single; $n = 16$, 21.6%, divorced or widowed). Just under half of the participants had been diagnosed with a personality disorder (46%) or at least one past major depressive episode (52%) or a recurrent depressive disorder (24.3%). There was no effect of treatment group on clomipramine plasma levels or duration of medication. We found no significant statistical differences concerning the demographic variables (age, sex and employment) between the two groups. In addition, we found no