Therapeutic Alliance

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Tailoring treatments to different developmental pathways and phenomenologies

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Plenary Speakers
- Martin Bohus, Germany
- Catherine Cohen-Kadosh, UK
- Patrick Luyten, UK
- Lars Mehlum, Norway
- Antonia New, USA
- Alexandra Philipsen, Germany

Special Session
- Peter Fonagy, UK
- Marsha Linehan, USA
The DoDo Bird flying in psychotherapy
The “Dodo Bird Verdict”

- Since 1975, meta-analyses show no superiority of any bona fide psychotherapy.

- Change does not depend on specific techniques.

- ‘Common factors’ are the main influencers on change

APA, 2012; Zuroff et al., 2010; Lutz et al., 2007
The **working alliance** controversy

Castonguay et al. (1996)

Depressed patients treated with CBT

took measures of:

- level of alliance
- therapist focus on **distorted thinking**

- **alliance** significantly associated with outcome
- greater **focus on distorted thinking** associated with **poorer** outcomes
- effect **disappears if alliance levels controlled for**
CBT vs. Psychodynamic Psychotherapy for Major Depression (N=341)

- **CBT**
  - 16 individual sessions
  - Manualised (Molenaar et al., 2009)
  - N = 164

- **Psychodynamic Therapy**
  - 16 individual sessions
  - Manualised (de Jonhge, 2005)
  - N = 177
Outpatients with anorexia nervosa (ANTOP) study Lancet, 2013

Body weight and end of treatment, 3-­‐months and 12-­‐months follow-­‐up.
Conclusions from Meta-Analysis of BPD Studies

- Self harm and suicide reduced against both TAU and Active control
  - TAU vs Active control accounts for small proportion of variance
- Treatment effects are less marked for self-harm than suicide attempts
  - When two combined effect comes from suicide
  - Suicide risk is halved across studies by interventions
- Admissions to hospital also dramatically reduced (.5 SD)
- There is marginal superiority of programme based rather than individual therapies
  - Evident mainly in suicide attempts
  - Also evident in self-harm
- Differences between therapies not statistically significant
Can we do any **better** than agreeing with the Do Do Bird?

“**Everybody** has won, and all must have prizes.”
The Paradigmatic Common Factor

- Centrality of the **therapeutic relationship**
  - establishment of a **strong working alliance**,  
    - My therapist and I have *figured out a good way to work* on my sad or angry emotions.  
    - My therapist and I *work well together* on things that bother or upset me
  
- therapist capacity for **understanding**
  - My therapist really *understands* what bothers or upsets me  
  - I feel uncomfortable talking about my thoughts and feelings with my therapist

- feeling supported and **cared about**
  - I *don’t get much support* from my therapist (reversed)  
  - I feel like my therapist is *on my side* and tries to help me

- **agreement** between patient and therapist *on treatment goals.*  
  - I *use my time* with my therapist to *make changes* in my thoughts and behavior  
  - I would *rather not work* on my problems or issues with my therapist
Therapeutic Alliance
Much, if not all, of the effectiveness of different forms of psychotherapy may be due to those features that all have in common rather than those that distinguish them from each other.

—Jerome Frank (1961): *Persuasion and healing*
Bordin (1979)

- A focus on patient contribution
- Bond between patient & therapist (Affective)
- Patient/therapist goals (Cognitive)
- Patient/therapist task (Cognitive)
Gaston (1990)

- Capacity to work in therapy
- Affective bond to therapist
- Therapist understanding
- Patient/therapist agreement on tasks & goals
Therapeutic alliance

Ego alliance (Sterba 1934) or Working alliance (Greenson 1965)

Patient & therapist contribution

Related to interpersonal measures

Unrelated to symptoms/demography
Therapeutic Alliance

- Alliance predictor of outcome accounting for 8-10% of variability in outcome (Horvath 2011)

- Variability in alliance/outcome relationship due to time of measurement and lack of consensus on definition

- Central aspect involves
  - bond between patient and therapist
  - Agreement about therapeutic goals
Alliance-Outcome

- Correlation is not causality
  - Contribution from patient – secure attachment form better alliance
  - Contribution from therapist – some therapists consistently form good alliance
  - Interaction between patient and therapist (match)
  - Early change in functioning may be the key
Untangling the Alliance-Outcome Correlation: Exploring the Relative Importance of Therapist and Patient Variability in the Alliance.
Odds of a clinical episode in MBT by therapist
Between-therapist and within-therapist differences in the quality of the therapeutic relationship: effects on maladjustment and self-critical perfectionism TDCRP
Between-therapist and within-therapist differences in the quality of the therapeutic relationship: effects on maladjustment and self-critical perfectionism TDCRP

Journal of Clinical Psychology
http://onlinelibrary.wiley.com/doi/10.1002/jclp.20683/full#fig2
Conclusions?

- Therapist contribution to alliance is significant predictor of outcome
- Therapists differ in ability to make alliance
- Patient contribution is of less importance
- Interactional/transactional component difficult to measure but some therapists might form alliance with some types of patients and not others
Conclusions?

- Most psychotherapy research focuses on differences in treatments.
- Need to focus on differences in therapist characteristics and disposition - flexible, respectful, warm, open, compassionate.
- Alliance interventions - reflection, support, affirming, accurate interpretation, and facilitating affective expression associated with more positive alliances.
Plakun’s Y model: Generic and specific facets

cognitive-behavioral

psychodynamic

formulation
boundaries
alliance
empathic listening

common factors
The Impact of Therapists and Therapeutic Alliance on Treatment Outcome
Incidence of Harmful Effects

- estimates are that 5-10% of therapy clients deteriorate
  - across all orientations, client groups, modalities
  - in RCTs of ‘empirically supported treatments’

- rates higher than in control groups
  - e.g. NIMH reanalysis (Ogles et al. 1995)
  - 13/162 (8%) deteriorated, all in active treatments

- in Lambert’s work therapists tend to be poor at:
  - predicting who will do badly
  - recognising failing therapies
Therapist Technique


- Therapists may overcompensate for patient's poor outcome by giving more complex explanations to patients. Higher complexity does not necessarily lead to better outcomes.

- Therapists who give over-complex explanations engage in developing a poorer outcome by not matching intervention to mentalizing capacity and so inducing harm.
Do no harm… outcomes informed care

- Most therapists see themselves as better than average:
  Dew & Riemer (2003, 16th Annual Research Conference, University of South Florida)
  - 143 counselors asked to grade their job performance on scale from A+ to F
  - 66% rate themselves as A or better
  - none rated themselves as below average

- Outcomes informed care may be a critical way of linking the EBP approach and practice based evidence
Ways of harming
inappropriate treatment choices

- critical incident stress debriefing
- grief counselling for normal bereavement
- psychodynamic therapy for schizophrenia

sub-optimal therapy

- couples therapy that benefits one partner at the cost of the other

misapplied therapy

- failure to adequately treat
- applying “technique” in the absence of a good alliance

mistakes

- therapist error
Reducing the Harmful Effects of Psychotherapy: The work of Lambert (2009)

- Across studies the rate of observed deterioration in psychotherapy was 10-25% with young people
- Some therapists have rates of deterioration of around 50% and their treatment is NEVER associated with recovery
- Introduction of outcome tracking (session by session monitoring)
  - Early warning when patient goes off trajectory
- Therapists randomized to feedback vs no-feedback
  - Deterioration reduced by 50%
  - Recovery improves by 50%
  - Average therapy is shorter
  - Patients who show early negative response receive longer and more effective treatment
Impact of individual therapists in routine practice  
Okiishi et al. 2006 (J Clin Psychol 62:9, 1157)

- 6,499 patients seen by 71 therapists

- therapists had to see at least 15 clients
  - on average saw 92

- number of sessions: range 1-203; mean 8.7

- therapists saw equivalent range of clients in terms of disturbance & presentation

- HLM used to compare ‘trajectories’ (recovery curves) of patients using OQ45
Clients of Some Therapists Improve Faster or Slower Than Others
Slope of Improvement Across Therapists unaffected by:

- therapist experience
- gender
- type of training
  - counselling psychology, clinical psychology, social work, marital/family therapist, psychiatry
- orientation
  - CBT, humanistic, psychodynamic
### Outcomes for Best and Worst Performing Therapists

<table>
<thead>
<tr>
<th></th>
<th>recovered</th>
<th>improved</th>
<th>deteriorated</th>
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<tr>
<td><strong>top 10% therapists</strong></td>
<td>22.4%</td>
<td>21.5%</td>
<td>5.2%</td>
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<tr>
<td><strong>bottom 10% therapists</strong></td>
<td>10.6%</td>
<td>17.4%</td>
<td>10.5%</td>
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Alliance and process of change
Is Therapeutic Alliance a Mediator of Change?

Therapeutic alliance may be a mediator and mechanism of therapeutic change

- The stronger the alliance the greater the change (eg Horvath & Bedi 2002; Orlinsky et al 2004)

- Correlational studies show alliance predicts improvement in symptoms at end of treatment

- Is it the good relationship with the therapist that cures?
A sample of 646 patients (76% women, 24% men) in primary care psychotherapy Administered the Working Alliance Inventory and CORE session by session,
Reciprocal Influence of Alliance to the Group and Outcome in Day Treatment for Eating Disorders


<table>
<thead>
<tr>
<th>Model</th>
<th>Alliance</th>
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<tr>
<td>Baseline ($\gamma = 0$)</td>
<td>$-0.23 (0.08)$</td>
<td>$.003$</td>
<td></td>
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<tr>
<td>Model 1 (alliance → restrict $\gamma = \text{free}$)</td>
<td>$-0.22 (0.08)$</td>
<td>$.003$</td>
<td></td>
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<tr>
<td>Model 2 (restrict → alliance $\gamma = \text{free}$)</td>
<td>$-0.18 (0.09)$</td>
<td>$.045$</td>
<td></td>
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<tr>
<td>Final model ($\gamma = \text{free}$)</td>
<td>$-0.23 (0.05)$</td>
<td>&lt;$.001$</td>
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**SO WHY DOES IMPROVED ALLIANCE IN SESSION $t-1$ LEAD TO IMPROVEMENT IN SESSION $t$?**
Understanding benefit from working alliance

- Is it to do with learning about oneself?
  - Most unlikely because improvement occurs between end of session and beginning of next session

- So what is it about working alliance that actually improves the patient?
  - a bizarre delayed reverse causality?
  - attachment mediated – but through what process?
  - opening up a social learning process that benefits the patient between sessions
Listening to an account of alliance as the effective component of all therapies
The need for EPISTEMIC VIGILANCE!

- We can accept a culturally transmitted belief for **two reasons** (Sperber, 1997, 2001, Sperber et al., 2010)
  - its **content**
  - the **authority** of its source

- To accept because of **content** is HARD!
  - grasp its **deductive** relations to the contents of other beliefs
  - **inductive** relations to the evidence, in accordance with the principles of theoretical rationality.

- Easier to accept on account of the **authority** (‘**deferentially**’ transmitted, Recanati, 1997) ➔ **EPISTEMIC TRUST**
  - its **source** is **known, remembered** and **judged** to be reliable (or trustworthy)
  - taken to be **shared common knowledge** among members of one’s community
Natural Pedagogy theory (Csibra & Gergely, 2009, 2012)

- A human-specific, cue-driven social cognitive adaptation of mutual design dedicated to ensure efficient transfer of relevant cultural knowledge

- Humans are predisposed (EVOLVED) to ‘teach’ and ‘learn’ new and relevant cultural information from each other

- Human communication is specifically adapted to allow the transmission of
  
  a) cognitively opaque cultural knowledge (Can I replicate this action / effect?)
  
  b) kind-generalizable generic knowledge (Can I apply this knowledge in an other context?)
  
  c) shared cultural knowledge (Does everyone know this?)
The signals whereby an agent makes manifest to an addressee her communicative intention: to manifest some new relevant information for the addressee (i.e. her informative intention).

- NOT PART OF EPISODIC MEMORY BUT PART OF SEMANTIC and PROCEDURAL MEMORY (CULTURAL KNOWLEDGE)

Infants display species-specific sensitivity to, and preference for, some non-verbal ostensive behavioral signals (see Csibra, 2010, Csibra & Gergely, 2009 for reviews)

Examples of ostensive communication cues
- eye-contact
- special tone (‘motherese’)
- turn-taking contingent reactivity
The pedagogic stance is **triggered by ostensive communicative cues** (E.G. CONTINGENT RESPONDING)

Ostensive cues have **in common**
- Infant recognized as a self
- Paid special attention to (noticed as an agent)

Ostensive cues **function to trigger epistemic trust:**
- **Opening** channel to receive knowledge about social and personally relevant world (CULTURE)
- Going **beyond the specific experience** and acquire knowledge relevant in many settings
- Triggers opening of an evolutionarily protected **channel** for knowledge acquisition
The Developmental Evidence

- Learning from babies learning
- Evidence for transferring knowledge for episodic to semantic memory
- Link to contingent responding
- Why attachment is key to learning
Experimental illustration of ostensive cues
Gergely, Egyed et al. (2013)

Subjects: 4 groups of 18-month-olds
Stimuli: Two unfamiliar objects
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization

Non-Ostensive Expression - Person-Specific Attribution

Egyed et al., in prep.
Social Cues that Create Epistemic Trust

- **Attachment to** person who responded *sensitively* in early development is **special condition** for generating epistemic trust → **cognitive** advantage

- Generally any **communication** marked by **recognition** of the listener as **intentional agent** will increase **epistemic trust** and likelihood of **communication** being **coded** as
  - Relevant
  - Generalizable
  - To be retained in **memory as relevant**

- **OSTENSIVE CUES TRIGGER EPISTEMIC TRUST WHICH TRIGGERS A SPECIAL KIND OF ATTENTION TO KNOWLEDGE RELEVANT TO ME**
Epistemic hypervigilance and the nature of psychopathology

- Social adversity (most deeply trauma) is the destruction of trust in social knowledge of all kinds ➔ rigidity, being hard to reach
- Cannot change because cannot accept new information as relevant (to generalize) to other social contexts on the basis of their own experience or communication from attachment figures or others
- Personality disorder is not disorder of personality (except by old definition of being enduring) but inaccessibility to cultural communication from
  - Partner
  - Therapist
  - Teacher

} Epistemic Mistrust
Implications: The nature of psychopathology

- **Epistemic mistrust which can follow** experiences of *maltreatment* or abuse leads to **epistemic hunger** combined with **mistrust**
  - Therapists ignore this knowledge at their peril
- **Personality disorder** is a **failure of communication**
  - It is not a failure of the individual but a **failure of a relationship**
  - It is associated with an **unbearable sense of isolation** in the patient generated by epistemic mistrust
  - Our inability to communicate with patient causes **frustration in us** and a tendency to **blame the victim**
  - We feel they are not listening but actually it is that they find it **hard to trust** the truth of what they hear
The implications for clinical work: Its organisation and delivery

- Disposition and characteristics of therapists
- Increase of epistemic trust as the driving force of change
- The unsung hero of therapy: the social context
3 Therapeutic Learning Systems

- All address epistemic mistrust of patients with BPD

- **Learning System I: Specific to Modality of Therapy**
  - Communication of *therapeutic model based content*
    - E.g. dynamic formulation of transference, DBT skills such as DEAR MAN
  - Serves as ‘ostensive cue’ increasing the patient’s epistemic trust

- **Learning System II: Mentalizing as a common factor**
  - Therapeutic setting serves to increase patient’s mentalizing

- **Learning System III: Social learning in the context of epistemic trust**
Learning system I

- Communication of therapeutic model based content
- **All** evidence based **models** present models of
  - mind, disorder and change
  - are accurate, helpful to patients and
  - increase capacity for understanding
- e.g. TFP dynamic formulation of internal conflicts
- e.g. DBT **skills** such as DEAR MAN
- e.g. CAT formulations of interpersonal **relationships**
- e.g. CBT for depression
- e.g. DIT for depression
Being balanced about model specificity

- The importance of System I should **neither be minimized nor overemphasized**
  
  - **Therapies without a coherent body of knowledge based on systematically established principles are observed to fail**
  
  - **Evidence on non-specific factors** in therapy and patients’ reports on what they experienced as effective **warn against exaggerating the importance** of Learning System
  
  - The **sheer variety** of modality specific knowledge argues against its importance
What is function of model specific knowledge?

- Model specific interventions help
  - They \textit{relate} to the patient’s \textit{specific needs}
    - E.g. lack of \textit{knowledge about the self}
    - E.g. lack of practical \textit{self management skills}
    - THEREFORE they \textit{can serves as an ostensive cue} and \textit{increase epistemic trust}

- Learning channel gradually opens, \textit{patients can benefit increasingly from their social experience} (including experience with therapist)
Role of mentalizing in Learning System II

To get over epistemic hypervigilance (‘not true’, ‘not relevant to me’) need System II

- **Mentalizing** interventions demand collaboration (working together)
  - Seeing from **other’s perspective**
  - Treating the **other as a person**
  - **Recognizing** them as an **agent**
  - Assuming they have things to **teach you** – since mental states are opaque
  - Responding **contingently** to a patient
Learning System II: The general increase in Epistemic Trust

- Therapy is not just about the **what** but the **how of learning:**
  - Opening the person’s mind via establishing epistemic trust (collaboration) so he/she can once again trust the social world by changing expectations
  - It is **not just what is taught** in therapy that teaches, but the evolutionary **capacity for learning from social situation** is rekindled
  - Therapy interventions are effective because they open the person to **social learning experience** which feeds back in a virtuous cycle
Learning System II: Ending Epistemic Isolation

- **Learning System II**: Learning about **sources of knowledge** by providing a clear **social illustration of trust** we undo epistemic isolation
  - By using **ostensive cues** and establishing a sense that we are concerned to see the **world from the patient’s standpoint** we model a situation of interpersonal epistemic trust
  - **Improved understanding** of social situation leads to better understanding of the **important others** more trusting (less paranoid) interpersonal relationships it opens up the potential to feel sensitively responded to in **virtuous cycle**
Learning System III: Beyond therapy

- Enhanced mentalizing achieves improved social relationships
- Improved epistemic trust/abandonment of rigidity enables learning from experience
- But change is probably due to how a person uses their social environment, not to what happens in therapy
- Benefit remains contingent on what is accessible to patients in their particular social world
- We predict that psychotherapy is more likely to succeed if the individual's social environment at the time of treatment is by and large benign
Summary of the Model

- The **specific frame of the therapy** around which mentalizing occurs
  - the model of **mind**,
  - the model of **interaction**,  
  - the model of **underlying dysfunction**,  
  - the model of **therapeutic goals**

- The enhancing of mentalizing is **also** a common factor that achieves **improved social relationships through increased epistemic trust**

- Improved sense of epistemic trust enables **learning from experience** ➔ change due to what happens beyond therapy.

- The **enhancing of epistemic trust** may be **achieved by treatment** but also a **consequence of improved social relationships** and consequent on the social world.
Returning to Common factors research in psychotherapy

- Traditional common factors
- Common principles
- Cross modality predictors
Common Factors: The relationship

- Measures of the quality of the therapeutic relationship load heavily on quality of communication
  - Mentalizing in clinical setting
  - sense of collaboration
  - increased epistemic trust
  - greater general openness to social learning
  - increasingly accurate interpretation of others’ intentions
  - further development of relationships imbued by epistemic trust
  - further improvement in learning from social experience
Common Factors: The treatment frame

- The importance of establishing a **clear treatment frame**
  - the sense that the therapeutic environment is **safe and structured**
  - enhances potential for **signaling**
  - enhances **interpretation of ostensive cues**
  - and **enables communication**
  - feeds into **virtuous cycle**.
Fostering optimal alliance

- Feedback systems and tracking patient outcomes
- Supervision and training strategies
- Responsiveness to information
- Rogerian empathy, positive regard, congruence is patient perception of therapist – inadequate for alliance which includes active transactional elements
Thank you for listening

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