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Socialization to the Model: The Active Component in the Therapeutic Alliance? A Preliminary Study

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Background: Therapeutic alliance has been found to be a significant predictor of outcome in psychotherapy yet what constitutes therapeutic alliance remains unclear. Examining the common constructs of therapeutic alliance, it is possible that there may be a conceptual overlap between active components of therapeutic alliance and socialization to the treatment model. **Aim:** To investigate the relationship between socialization to the model and therapeutic alliance. **Method:** Participants ($N = 43$) were taken from the active treatment arm in a RCT for the treatment of chronic fatigue syndrome (CFS/ME). Therapeutic alliance was measured using a 5-item questionnaire (brief CALPAS) and socialization to the model was extracted from therapy tapes using a novel coding system. **Results:** Key findings were that when patients and therapists agreed about goals of treatment, there were higher levels of concordance, less evidence of applying principles incongruent to the model, and less resistance during the treatment sessions. **Conclusions:** The outcome of this preliminary study contributes to the potential understanding of active components in the therapeutic alliance, and supports further research to achieve a more detailed picture of "non-specific" factors in therapy, including the active process of socialization in therapeutic alliance.

Keywords: Therapeutic alliance, cognitive-behaviour therapy, socialization, active components, Chronic Fatigue Syndrome, CALPAS.

Introduction

Therapeutic alliance has consistently been found to be a significant predictor of outcome in psychotherapy (Martin, Garske and Davis, 2000) and is commonly held to be an essential ingredient across all therapies. Martin et al. (2000), in a meta-analytic review of the literature, identified three common elements within therapeutic alliance across different therapeutic approaches: collaborative nature of the relationship; patient and therapist ability to agree on treatment goals and tasks; and affective bond. These three elements relate closely to the

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predominant model of therapeutic alliance devised by Bordin (1979), which is commonly used in process research, and which suggests that therapeutic alliance comprises: (1) patient/therapist agreement on goals in treatment; (2) patient and therapist agreement on how to achieve these goals; and (3) bond. In an exploratory study of the factors involved in the cognitive behavioural therapy (CBT) therapeutic alliance, Andrusyna, Tang, DeRubeis and Luborsky (2001) showed that the first two of Bordin's three factors relating to treatment goals and how to achieve them, perhaps the "active" elements of therapeutic alliance, were statistically distinct from the third factor (bond).

Bordin's (1979) "active" elements and Martin et al.'s (2000) first two themes echo the process of socialization to a therapeutic model, whereby a therapist and patient negotiate a shared understanding and formulation of a problem and the rationale of the therapy to achieve goals of treatment is discussed and agreed (Roos and Wearden, 2009). Thus, socialization to the model and therapeutic alliance may be related constructs: socialization may represent the active components of the therapeutic alliance as described by Martin et al. (2000) and Andrusyna et al. (2001). Although to date no model of socialization has been developed that can be directly compared to Bordin's model of therapeutic alliance, a Delphi study demonstrated expert consensus on a number of elements of socialization (Roos and Wearden, 2009). These were expressing concordance with the model, demonstrating understanding of the model, making active plans in accordance with the model, using language congruent with the model, and applying principles congruent with the model. Conversely, expert consensus was that avoidance, resistance and applying principles incongruent with the model were evidence of an absence of socialization.

Building on our previous work, the present exploratory study will use data from a randomized control trial for the treatment of chronic fatigue syndrome, also known as ME (CFS/ME), to examine the associations between the "active components" of therapeutic alliance and socialization to the treatment model as conceptualized above. It is hypothesized that there will be a moderate positive correlation between dimensions of socialization to the model and therapeutic alliance dimensions that refer to joint working rather than interpersonal aspects.

Method

Sample

Participants, aged 18 or over and meeting the Oxford Criteria for CFS/ME (Sharpe et al., 1991) were taken from the active treatment arm of a randomized controlled trial for CFS/ME – the FINE Trial (Wearden et al., 2010). Participants in this arm received a treatment called "Pragmatic Rehabilitation" (PR), which presents an eclectic evidence-based explanatory model of CFS/ME at the first session, providing an initial strong stimulus for socialization to the model. Therapist and patient then collaboratively develop a rehabilitation programme congruent with the PR model, providing further opportunity to continue socialization to the PR model. In the FINE trial, therapy consisted of five face-to-face sessions delivered at home, and five telephone sessions, delivered over 18 weeks by specially trained general nurse therapists (Wearden et al., 2010). Fifty participants from the PR arm were selected for a study of the roles of socialization to the model and change in illness beliefs during PR treatment (Roos and Wearden, submitted). These were the 25 patients who showed the most and those who showed the least improvement in primary outcomes of fatigue

and physical functioning after completing therapy, and for whom therapy tapes were available and usable.

The FINE study was granted ethical approval by Eastern MREC (03/5/62).

Procedure

Participants completed a brief questionnaire measure of therapeutic alliance after the final face to face therapy session (session 10). The first author extracted measures of socialization to the PR treatment model from tapes also from session 10.

Measures

Brief 5-item CALPAS (Muran et al., 1995). The Brief CALPAS was chosen as a measure of therapeutic alliance in the FINE trial specifically because it is short and has been shown to have good psychometric properties (Muran et al., 1995). It consists of five items, each rated using a 0–100 visual analogue scale:

1. Does your therapist express a sincere desire to understand you?
2. Do you feel your therapist agrees with you about what could be valuable goals for your treatment?
3. Does the type of treatment you are receiving match your ideas about what helps people with your illness?
4. Do you feel that you are working together with your therapist, that is, joined in a struggle to overcome the things that trouble you?
5. Do you feel satisfied with the services you have received so far?

Questions 2–4 relate to the "active components" of therapeutic alliance: agreement on goals and agreement on how to reach these goals. Therefore, these questions were hypothesized as relevant to correlate with socialization to the model.

Question 1 related to the bond aspect of the therapeutic alliance measure. As there is no proposed conceptual overlap between the bond component of therapeutic alliance and the dimensions of the socialization to the treatment model, it was hypothesized that there would be no significant relationships found between question 1 and socialization to the treatment model dimensions.

Question 5 related to service satisfaction and was considered to be irrelevant to the present study, and the data from this question were not used in analysis.

Socialization to the model measure

A manual was devised to extract and code relevant utterances made by participants during treatment sessions (Roos and Wearden, in submission). All utterances that related to CFS/ME and its management were extracted. Each utterance was then rated on each of the socialization to the model dimensions. Dimensions of socialization were: concordance, explicit understanding, making active plans, evidence of applying the principles congruent with the treatment model. Dimensions of resistance were: evidence of applying the principles incongruent to the model, resistance, avoidance. For each extracted utterance, the presence or absence of each of these dimensions was coded e.g. did the extracted utterance indicate that

the participant had explicit understanding of the PR model, yes or no? The number of "yes" codings for each dimension was then obtained to provide a measure for each dimension of socialization or resistance to the model. (Additional details of the coding manual are in the online extended version).

Results

For Question 2 scores ranged from 10–100 (Median = 100, IQR = 80,100); for Question 3 scores ranged from 10–100 (Median = 80, IQR = 50,100); for Question 4 scores ranged from 10–100 (Median = 100, IQR = 80,100). Socialization scores ranged from 0–21 (Median = 1.00, IQR = 0,3) for concordance, from 6.72–27 (Median = 6, IQR = 2,10) for understanding; from 0–19 (Median = 2, IQR = 1,3.25) for active planning; from 0–19 (Median = 8, IQR = 4.74,10.25) for evidence of applying (congruent); from 0–9 (Median = 1.5, IQR = 0,3) for evidence of applying (incongruent); from 0–11 (Median = 1, IQR = 0,2.25) for resistance and from 0–12 (Median = 3, IQR = 2,4) for avoidance.

Items relating to socialization and resistance had good internal consistency (alphas 0.82 and 0.77 respectively; Roos and Wearden, submitted) although overall socialization and resistance scores were not analyzed in the present study.

Seven participants failed to return CALPAS questionnaires so data come from 43/50 participants (86% of sample). Data were not normally distributed, so Spearman's rank correlations were performed (see Table 1).

Scores on brief CALPAS question two, "Do you feel your therapist agrees with you about what could be valuable goals for your treatment" were significantly positively correlated with concordance, and negatively correlated with resistance, evidence of applying principles incongruent with the model, and avoidance.

Brief CALPAS question three, "Does the type of treatment you are receiving match your ideas about what helps people with your illness?" was significantly positively correlated with concordance and evidence of applying the principles congruent with the model, and significantly negatively correlated with resistance, applying principles incongruent with the model, and avoidance.

Brief CALPAS question four, "Do you feel that you are working together with your therapist, that is, joined in a struggle to overcome the things that trouble you?", was negatively correlated with resistance and evidence of applying principles incongruent with the model.

There were no significant correlations between data from question 1 "Does your therapist express a sincere desire to understand you?" and any of the socialization dimensions.

All the significant correlations observed were of at least moderate strength. Even if the significance value was corrected to $p < .002$ to take account of 21 comparisons, all correlations between CALPAS question 3 and socialization to the model constructs remained significant.

Discussion

Our findings provided tentative support for the hypothesis that socialization to the model might overlap with the "active" component of therapeutic alliance. The analysis revealed that the more agreement expressed by the participant in terms of the treatment goals, the more they demonstrated concordance with the therapist in session, the less avoidance and resistance was shown, and the less they made changes to ameliorate their symptoms in a way

Table 1. Spearman's rho correlations between CALPAS questions and socialization dimensions

		Concordance	Understand	Active plans	Evidence Congruent	Evidence Incongruent	Resistance	Avoidance
Question 2: Agreed treatment goals	Correlation Coefficient	**.377**	.073	.076	.265	**−.496**	**−.429**	**−.335**
	Sig. (2-tailed)	.013	.640	.629	.086	.001	.004	.028
Question 3: Treatment Match	Correlation Coefficient	**.479**	.260	.104	**.455**	−.260	**−.546**	**−.534**
	Sig. (2-tailed)	.001	.092	.506	.002	.093	.000	.000
Question 4: Joint working	Correlation Coefficient	.282	.025	.004	.246	**−.435**	**−.396**	−.296
	Sig. (2-tailed)	.067	.875	.981	.112	.004	.009	.054

that was not consistent with the model. This suggests that agreement about goals of treatment between therapist and participant are important to the process of therapy. If the therapist and participants have different ideas and a lack of agreement about goals, then it is logical that participants may not follow the rationale, and subsequently show resistance, avoidance and make changes that are inconsistent with the rationale of the therapy.

The higher the match between participant expectation of what would help and therapist expectation of what would help, the more concordance is demonstrated in session, and the more participants gave examples of how they had correctly applied the principles of the treatment model. This reinforces the suggestion that agreement of the process and rationale of therapy is imperative in motivating the participant to actively participate in therapy – i.e. that appropriate socialization to the model is achieved. Joint working (as measured by brief CALPAS question four) was associated with less resistance to the treatment model, underlining the importance of adopting a collaborative approach in therapy.

Data correlated between the proposed "bond" component of the measure and socialization to the model dimensions found no significant associations, supporting findings by Andrusnya et al. (2001) that the bond component may be distinct from the "active components" of the therapeutic alliance.

In summary, the observed pattern of findings suggest that socialization to the model may constitute the active components of a good therapeutic alliance. We acknowledge that demonstrating correlations between some questions on a reliable yet brief measure of therapeutic alliance, and dimensions of a new measure of socialization derived from therapy tapes can only be suggestive of theoretical similarity between the two constructs. Additionally, the study is limited by a relatively small sample size. Furthermore, the sample was derived from a trial of a treatment that begins with a psycho-educational rather than formulation driven approach, including only participants for whom there were data available. It would be valuable to repeat the study with a larger sample undergoing a more formulation based treatment. However, as a preliminary study investigating the theoretical and conceptual overlap of the therapeutic alliance and socialization to the model constructs, this study has generated promising findings for further research that may be of clinical importance.

Future research into refining the current concept of socialization and developing a standardized patient/therapist measure of socialization may be useful in both replicating findings of the present study, and also in exploring the relationship between socialization to the model and other common active components in therapy.

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