

Psychotherapy Integration and Alliance: Use of Cognitive-Behavioral Techniques Within a Short-Term Psychodynamic Treatment Model

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This study examined the relationship between Psychodynamic-Interpersonal (PI) and Cognitive-Behavioral (CB) techniques used in a Short-Term Psychodynamic Psychotherapy with the therapeutic alliance early in treatment. Ninety-one outpatient participants rated their alliances, and independent videotape ratings of technique were made. Our findings did not support the primary hypothesis of a relationship between technique integration and overall patient-rated alliance. However, our findings did demonstrate a significant association between the integration of PI and CB techniques with the two alliance subscales *Goals & Task Agreement* and *Confident Collaboration*. In addition, specific PI and CB techniques were significantly correlated with higher patient alliance scores on these two subscales. Psychodynamic therapists who are more collaborative in identifying specific goals and explicitly defining the focus of the treatment with their patients, as well as providing a clear rationale for their model, may facilitate a stronger therapeutic alliance specific to patient confidence in, and agreement with, the treatment process.

Keywords: psychodynamic, cognitive-behavioral, technique, STPP, CPPS, therapeutic alliance, psychotherapy integration

The therapeutic alliance has emerged as a significant process factor across different modalities of therapy that may contribute to suc-

cessful therapy outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). Existing literature has described the therapeutic alliance as an important “barometer of therapeutic change” and a pan-theoretical correlate of patient change across various psychotherapy orientations (Frieswyk et al., 1986; Gaston, 1990; Goldfried, 1991). The alliance has also consistently emerged as an important construct in predicting treatment outcomes across varying types of therapy regardless of the focus of therapy or treatment modality (Horvath et al., 2011; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012).

There is likely a complex interplay between different technical and relational aspects of the therapeutic alliance in mediating specific treatment effects (Hilsenroth, Cromer, & Ackerman, 2012). “Pure” forms of psychotherapy may not readily exist; rather, “treatment as usual” may be better conceptualized as various interven-

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tions, techniques, and therapeutic stance (Ablon, Levy, & Katzenstein, 2006). The use of active ingredients integrated from a variety of theoretical orientations may be better suited to the patient's needs during the therapeutic process (Ablon & Jones, 1998). As such, a range of techniques from various psychotherapy orientations, including cognitive-behavioral, interpersonal, and psychodynamic models, have been positively correlated with the alliance, including the therapist's ability to be supportive, affirming, using exploration, giving accurate interpretations, attending to the patient's experience, and being active within session (Hilsenroth et al., 2012). In the literature on psychotherapy integration, such generic or cross-theoretical factors are considered to be common change factors (Gold & Stricker, 2001).

Gold and Stricker (2001; Stricker & Gold, 1996) proposed an assimilative model of integration using cognitive, behavioral, experiential, and other techniques within a relational psychodynamic model. Active and exploratory techniques may complement one another and allow for more meaningful work within session; often, an integrative approach is recommended to intervene at multiple levels of functioning. This integration facilitates deeper experiences of personal growth, while also providing a didactic structure for patients in order to target behavior change and develop effective problem solving strategies. Gold and Stricker (2001, 2012) also argue that early integration and an assimilative use of active, cognitive-behavioral techniques within a psychodynamic framework may often accelerate and strengthen the development of a positive therapeutic alliance. The shift by the therapist to use these methods may indicate a responsiveness to, and concern for, the patient, that can prevent or repair alliance strains or ruptures that derive from the patient's perception of a lack of caring by the therapist. And, if the techniques are successful, the gains might enhance the patient's trust for, and confidence in, the therapist. Likewise, the clarity and relative ease with which patients use these methods frequently leads to successful experiences that in turn enhance the patient's view of the therapist's commitment and competence.

Exploring the original Gold and Stricker (2001; Stricker & Gold, 1996) hypothesis, DeFife, Hilsenroth, and Gold (2008) used a Short-Term Psychodynamic Psychotherapy

(STPP) model to examine treatment outcomes in relation to integrated therapeutic interventions. Patient ratings of session processes were significantly correlated with treatment outcomes. Specifically, the integration of CB techniques in the STPP model was significantly associated with positive treatment outcomes in some areas of functioning. In contrast, Castonguay and colleagues (2004) examined the use of integrated cognitive therapy (ICT) in predicting patient-rated alliance and depressive symptomatology. The traditional model of CT was supplemented with certain interpersonal strategies typically used to repair alliance ruptures in order to enhance the efficacy of CT. Findings demonstrated that the addition of certain interpersonal procedures within CT led to greater improvement in patients' depressive symptoms. However, although patients evidenced significant pre-post change, the treatment was superior only to a waitlist control condition. Constantino and colleagues (2008) further supported these findings through a RCT that examined the use of ICT for depression. ICT was associated with enhanced treatment outcomes, more clinically significant change, and higher alliance scores, than traditional CT.

Vocisano and colleagues (2004) conducted a RCT of chronically depressed individuals who were given cognitive-behavioral analysis system of psychotherapy (CBASP), the antidepressant nefazodone, or a combination of the two. CBASP is a manualized protocol that focuses on effective problem solving and relationship skills. Although it is cognitive-behavioral by nature, it includes a combination of therapeutic interventions, including the interpersonal role of the therapist and transference work (Swan & Hull, 2007). Patients had the most therapeutically effective outcomes when treated by therapists who blended CB and PI strategies. A greater emphasis on the therapeutic relationship was most strongly associated with positive outcomes, and being a psychodynamic-oriented therapist within the CBASP treatment led to greater symptom relief in patients. CB oriented therapists who used the least amount of integrative strategies yielded significantly worse outcomes. These findings substantiate the need for integrative approaches, even within manualized treatment protocols, to efficaciously target chronic symptoms and use the therapeutic alli-

ance as a means of navigating the patient's interpersonal relationships.

Given the success of this previous research, additional work on the integration of specific therapeutic techniques may provide fruitful information related to positive therapeutic alliance building. The current study seeks to extend this previous work and evaluate the integration of CB techniques within a STPP treatment model in relation to a patient's experience of early alliance. Specifically, independent clinical ratings of both Psychodynamic-Interpersonal and Cognitive-Behavioral therapist techniques will be examined in relation to patient-rated alliance early in treatment. Early session processes have proven to be integral to initial alliance development and demonstrate lasting effects across treatment (Hilsenroth, Peters & Ackerman, 2004; Horvath, 2001; Horvath et al., 2011). It is hypothesized that therapists practicing from a STPP model who use some integrative techniques, that is, a combination of some CB with PI techniques, as opposed to a more singular usage of PI techniques alone, will lead to higher ratings on the patient's experience of early alliance (Gold & Stricker, 2001). In other words, the use of an assimilative approach by the therapist will facilitate a stronger therapeutic relationship and lead to higher alliance ratings than an alliance established through PI strategies alone. Given the almost complete absence of extant research regarding the specific relationship between the integration of psychotherapy technique and patient alliance, the nature of this study is both preliminary and exploratory.

Method

The current study was developed within the body of a larger programmatic process and outcome research study (Hilsenroth, 2007). The current research questions, hypotheses, and goals were not formulated at the time of data collection, but were planned a priori specific to this investigation. Thus, this research is a prospective analysis of archival data.

Participants

The participants in this study ($n = 91$) were all admitted to a Psychodynamic Psychotherapy Treatment Team (PPTT) at a university-based community outpatient clinic (Hilsenroth, 2007).

Cases were assigned to treatment practicum and clinicians in an ecologically valid manner based on real world issues regarding aspects of clinician availability, caseload, and so forth. Moreover, patients were accepted into treatment regardless of disorder or comorbidity. In this sample of 91 individuals, 64 patients were female (70%) and 27 were male (30%). The mean age for this sample was 30 ($SD = 11.60$); 55 patients were single (60%), 21 married (23%), 14 divorced (15%), and 1 widowed (1%). All 91 patients (100%) in this study received a *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*) Axis I diagnosis (Mood Disorder = 48 [53%], V-Code Relational Problems = 15 [16%], Adjustment Disorder = 12 [13%], Anxiety Disorder = 11 [12%], Eating Disorder = 3 [3%], Impulse Control Disorder = 1 [1%], and Substance Related Disorder = 1 [1%]; American Psychiatric Association, 1994). Fifty patients (55%) also received an Axis II diagnosis and 22 patients (24%) were assessed to have subclinical, but prominent Axis II features or traits (Cluster A = 8 [9%], Cluster B = 37 [41%], Cluster C = 27 [30%]; American Psychiatric Association, 1994). Thus, this sample consisted of primarily mood-disordered patients with relational problems manifested in either Axis II personality disorders, or subclinical traits/features of Axis II personality disorders. Mean scores for psychiatric severity consisted of the following: Intake GAF [Global Assessment of Functioning] = 60 ($SD = 5.70$) and BSI-GSI [Global Severity Index of the Brief Symptom Inventory] = 1.1 ($SD = 0.58$) (American Psychiatric Association, 1994).

Therapists

Clinicians in the study were 28 advanced doctoral students (14 male and 14 female) enrolled in an APA-approved Clinical Psychology Ph.D. program. Each therapist saw between one and six patients ($M = 3.1$; $SD = 1.3$). Each clinician received a minimum of 3.5 hours of supervision per week (1.5 hours of individual and 2 hours of group) on the Therapeutic Model of Assessment (TMA, Finn & Tonsager, 1997; Hilsenroth, 2007), clinical interventions, the organization of collaborative feedback, psychodynamic theory, and review of videotaped case material. Individual and group supervision focused heavily on the review of videotaped case

material and technical interventions. All clinicians were trained in psychodynamic psychotherapy using guidelines delineated by Book (1998), Luborsky (1984), McCullough et al. (2003), and Wachtel (1993), as well as selected readings on psychological assessment, psychodynamic theory, and psychodynamic psychotherapy (for a more detailed description of this training process, see Hilsenroth, DeFife, Blagys, & Ackerman, 2006).

Treatment

Patients first received a psychological evaluation from a Therapeutic Model of Assessment (TMA; Finn & Tonsager, 1997; Hilsenroth, 2007) that attempts to optimize the evaluation phase with its use of a multimethod assessment (i.e., interview, self-report, performance tasks, and free response measures). There is also a heightened focus on developing and maintaining empathic connections with patients (e.g., alliance fostering), factors contributing to the maintenance of life problems (often relational), collaboration to define individualized treatment goals and tasks, as well as sharing and exploring assessment results with patients. The TMA used in this study consisted of four steps including three meetings between the patient and clinician totaling approximately 4.5 hours, and one patient appointment to complete a battery of self-report measures. The three meetings included the following: 1) a semistructured diagnostic interview (Westen & Muderrisoglu, 2003, 2006); 2) interview follow-up; and 3) a collaborative feedback session.

During the collaborative feedback session, there is an emphasis on prominent inter/intrapersonal themes derived from the testing results, the patient-therapist interaction, factors that contribute to the maintenance of life problems, as well as an opportunity to explore these new understandings and apply them to their current problems in living. The patient and clinician also review a Socialization Interview (SI) developed by Luborsky (1984) on what to expect in psychodynamic psychotherapy and the patient and clinician roles during formal treatment. The SI also highlights the relational focus of the therapeutic process, as well as the notion that he or she may become aware of issues that were not known before the start of psychotherapy;

thus, the SI outlines potential outcomes (both positive and negative) of this new insight. Finally, the clinician and patient work together to develop treatment goals and negotiate an explicit treatment frame (i.e., scheduling session times, frequency of treatment sessions, missed sessions, and payment plan). In all cases, the clinician who carried out the psychological assessment was also the clinician who conducted the formal psychotherapy sessions.

Individual psychotherapy consisted of once or twice weekly sessions of STPP treatment organized, aided, and informed (but not prescribed) by the technical guidelines delineated in the treatment manuals detailed above. Key features of the STPP treatment model used in these sessions included (Blagys & Hilsenroth, 2000) the following: 1) Focus on affect and the expression of emotion; 2) Exploration of attempts to avoid topics or engage in activities that may hinder the progress of therapy; 3) The identification of patterns in actions, thoughts, feelings, experiences, and relationships; 4) Emphasis on past experiences; 5) Focus on interpersonal experiences; 6) Emphasis on the therapeutic relationship; and 7) Exploration of wishes, dreams, or fantasies. In addition, relational patterns, case presentations, and symptoms were conceptualized in the context of cyclical patterns (Book, 1998; Luborsky, 1984; McCullough et al., 2003; Wachtel, 1993). The Safran and Muran (2000) model of intervention was also used for treatment ruptures and repairs as they occurred in the therapeutic relationship. Treatment was open-ended in length rather than of a fixed duration. Whenever a termination date was set, this became a frequent area of intervention, as issues related to the termination were often linked to key interpersonal, affective, and thought patterns prominent in that patient's treatment. Treatment goals were first explored during the assessment feedback session, and a formal treatment plan was reviewed with each patient early in the course of psychotherapy; this treatment plan was subsequently reviewed at regular intervals for changes, additions, or deletions. Reassessment of patient functioning on a standard battery of outcome measures as well as process ratings were completed by patients and therapists immediately after selected sessions. Patients were informed, both verbally and in writing, that their therapist

would not have access to their responses on any psychotherapy process measure (i.e., alliance, session process, etc.). Also, all sessions of these treatments were videotaped, not just the sessions during which reassessment ratings were completed. Patient process and independent technique ratings for this study were collected at the same session early in treatment (3rd or 4th session). The mean number of sessions attended by these 91 patients was 26 sessions ($SD = 22$) over an average of 8 months. The median number of sessions and length of treatment were somewhat shorter at 21 sessions and 6 months, respectively.

Measures

Global Assessment of Functioning (GAF; American Psychiatric Association, 1994). Each patient was rated on the *DSM-IV* Axis V GAF (e.g., on a scale of 0 to 100) based on patients' level of functioning at the time of assessment before beginning treatment. An independent rater scored the GAF for each participant after viewing a videotape of the clinical interview/feedback sessions, reassessment sessions, and those sessions or treatment review representative of when 90% of the psychotherapy had been completed. For all cases, the rating was completed without knowledge of patient self-report data, or the assessing clinician's ratings for the GAF. Spearman-Brown correction for a one-way random effects model Intra-class Correlation Coefficient (ICC[1,2]) was calculated for the study sample to examine the reliability of the mean score for the GAF and was found to be .88, in the excellent range (Shrout & Fleiss, 1979, $ICC > .74$). For additional details regarding the reliability data of this *DSM-IV* scale and related research design procedures, see Hilsenroth and colleagues (2000) and Peters and colleagues (2006).

Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI is a 53-item self-report inventory that assesses symptom distress in a number of different domains/problem areas using a Likert scale of 0 (*not at all*) to 4 (*extremely*) and was collected at pre- and post-treatment. The psychometric properties, reliability, and validity of this measure, as well as description of specific symptom subscale scores, a summary score, and the Global Severity Index (GSI) are provided in the manual (Derogatis, 1993). The

mean GSI for a normal population ($n = 719$, nonpatients) was 0.30 [$SD = 0.31$], and test-retest reliability was .90.

Combined Alliance Short Form–Patient Version (CASFP; Hatcher & Barends, 1996). The CASFP is a client-rated alliance measure that consists of 20 items rated on a 7-point scale consisting of 1 (*never*), 2 (*rarely*), 3 (*occasionally*), 4 (*sometimes*), 5 (*often*), 6 (*very often*), and 7 (*always*). This measure consists of a total score and four subscales: Idealized Relationship (patient's ability to acknowledge disagreement with and negative feelings toward the therapist; "How much do you disagree with your therapist about what issues are most important to work on during these sessions?"; reverse scored), Confident Collaboration (level of confidence and commitment the patient experiences regarding therapy as well as the degree to which therapy is worthwhile, reflects hopefulness of the patient; "What I am doing in therapy gives me new ways of looking at my problems"), Goals & Task Agreement (clarity of duties and agreement on goals and tasks; "My therapist and I are working toward mutually agreed upon goals"), and Bond (therapeutic bond, aspects of mutual liking, respect, and trust; "My therapist and I trust each other"; Hatcher & Barends, 1996).

Hatcher and Barends (1996) also reported on the construct validity of the CASFP through a factor analysis by holding the outcome (patients' estimate of improvement) constant and examining the unique contribution of alliance above and beyond outcome. Both Ackerman et al. (2000) and Clemence, Hilsenroth, Ackerman, Strassle, and Handler (2005) report on convergent validity data with related measures of psychotherapy process as well as criterion validity with regard to the prediction of treatment outcome using a sample of clients at the same university-based clinic as the clients in the current study. For the current sample, the coefficient alpha was .89 and the mean CASFP was 6.14 ($SD = 0.61$; range = 4.45 to 7.00) from the early treatment sessions (i.e., 3rd or 4th) used in this study.

Comparative Psychotherapy Process Scale – External Rater Form (CPPS-ER; Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005). The CPPS is a brief descriptive measure designed to assess therapist activity and techniques used during the therapeutic hour. It is

based on the findings of two empirical reviews of the comparative psychotherapy process literature (Blagys & Hilsenroth, 2000, 2002). Based on these reviews, a list of interventions was developed that represents characteristic features of Psychodynamic-Interpersonal (PI; defined broadly to include psychodynamic, psychodynamic-interpersonal, and interpersonal therapies) and Cognitive-Behavioral (CB; defined broadly to include items that are significantly more characteristic of cognitive-behaviorally oriented therapy [Blagys & Hilsenroth, 2002], cognitive, and behavioral therapies). The PI subscale measures the seven domains of therapist activity previously described as key features of the STPP treatment model (Blagys & Hilsenroth, 2000). The CB subscale consists of items which include the following: 1) Emphasis on cognitive or logical/illogical thought patterns and belief systems; 2) Emphasis on teaching skills to patients; 3) Assigning homework to patients; 4) Providing information regarding treatment, disorder, or symptoms; 5) Direction of session activity; and 6) Emphasis on future functioning. The CPPS measure consists of 20 randomly ordered techniques rated on a 7-point Likert scale ranging from 0 (*not at all characteristic*), 2 (*somewhat characteristic*), 4 (*characteristic*), to 6 (*extremely characteristic*). The CPPS may be completed by a patient (P), therapist (T), or an external rater (ER). Ten statements are characteristic of PI interventions and 10 statements are characteristic of CB interventions. These interventions can then be organized into two scales: one measuring PI features (CPPS-PI, 10 items) and one measuring CB features (CPPS-CB, 10 items).

The reliability and clinical validity of the CPPS has been well established (see Hilsenroth, 2007 for review). We have recently reported (Hilsenroth et al., 2005; Slavin-Mulford, Hilsenroth, Weinberger, & Gold, 2011; Stein, Pesale, Slavin, & Hilsenroth, 2010) on the excellent interrater reliability and internal consistency of the CPPS, as well as validity analyses conducted across several different contexts and samples. The CPPS data we use in the current study are derived from these reports, follow procedures detailed there, and are rated by trained external raters who have demonstrated the ability to rate these individual techniques in the good (ICC .60–.74; Fleiss, 1981) to excellent range (.75; Fleiss, 1981). Several sets of

external raters demonstrated good to excellent reliability on the CPPS for the sessions utilized in the current study (Stein et al., 2010). All Spearman-Brown corrected mean ICCs for the individual CPPS-PI and CPPS-CB techniques were also in the good to excellent range (and thus were examined individually) as were the ICCs for the CPPS-PI and CPPS-CB subscale scores. Corrected average ICCs were reported for both CPPS technique items and subscales; two external raters rated all of the sessions, allowing for their more reliable average ratings across their pair. In the current study, the mean CPPS-PI subscale score for the rated sessions was 3.31 ($SD = 0.73$) and the mean CPPS-CB subscale score was 1.26 ($SD = 0.56$), representing a significant level of adherence to a psychodynamic treatment model (degrees of freedom [df] = 90, $t = -20.79$, $p < .0001$, $d = 3.2$), in the same session that patient alliance was rated. Coefficient Alphas for the CPPS-PI and CPPS-CB subscales from the 91 sessions rated in this study were .82 and .75, respectively.

Videotapes of an early treatment session (3rd/4th session) for each patient were arranged in random order and entire sessions were watched/rated by two raters independently. Raters were graduate students in Clinical Psychology. Immediately after viewing a videotaped session, judges independently completed the CPPS; each subscale (PI & CB) was coded in random order. Regular reliability meetings were held during the coding process to prevent rater drift (for a more detailed description of this rater training process, see Stein et al., 2010).

Results

Preliminary Analyses

Regarding the potentially confounding effects of patient symptoms, other control variables were tested. Of note, patient self-report and independent clinician ratings of severity of symptoms demonstrated a very limited (e.g., no effect) relationship to patient alliance (BSI-GSI: $r = .08$, $p = .44$; GAF: $r = -0.02$, $p = .89$; $N = 91$). Thus, there did not appear to be any justification to include these variables in the final models, as it would have decreased power.

MLM analyses were used to account for therapist effects (Raudenbush, Bryk, Cheong,

& Congdon, 2005). Therapist effects (ICC) were calculated for each variable in the study and the following values were observed: PI = .38; CB = .06; CASF-Total = .20; Confident Collaboration = .03; Goals & Task Agreement = .13.

Are different types of therapist techniques, or the integration of these techniques, related to patient-rated overall alliance early in treatment? We conducted a two-level random intercept MLM (e.g., clients nested within therapists). The level 1 equation was as follows:

$$\text{Alliance} = B_{0ij} + B_{1ij}(\text{PI}) + B_{2ij}(\text{CB}) + B_{3ij}(\text{PI} \times \text{CB}) + e$$

where B_{0ij} is the intercept for client i treated by therapist j , B_{1ij} is the estimate for the association between PI and alliance for client i treated by therapist j , B_{2ij} is the estimate for the association between CB and alliance for client i treated by therapist j , B_{3ij} is the estimate for the association between the interaction of PI and CB and alliance for client i treated by therapist j , and e is the level 1 error. Note: PI and CB were grand-mean centered prior to the creation of the interaction effect. The level 2 equation was as follows:

$$\begin{aligned}\beta_{00} &= \gamma_{000} + u_{0j}, \\ \beta_{01} &= \gamma_{010} + u_{1j}, \\ \beta_{02} &= \gamma_{020} + u_{2j}, \\ \beta_{03} &= \gamma_{030} + u_{3j}.\end{aligned}$$

Of note, there were no level 2 predictors but the level 1 associations (e.g., the relationship between PI and alliance) were allowed to vary across therapists. Additionally, we assumed that the alliance (intercept) would vary across therapists. Inconsistent with our original hypotheses, none of the technique variables (PI, CB, PI \times CB) demonstrated a significant relationship with overall patient-rated alliance ($p = .12, .22, .26$, respectively).¹

Are different types of therapist techniques, or the integration of these techniques, related to patient-rated subscales of alliance early in treatment? When accounting for therapist effects and examining the relationship between technique and the Confident Collaboration alliance subscale ($M = 5.88$, $SD =$

0.90), only the amount of cognitive-behavioral techniques (CB) was significantly related to this alliance subscale ($b = -0.19$; $SE = .12$; $t = 3.37$; $df = 87$; $p = .001$).² Therefore, those therapists using more CB interventions early in treatment were related to greater levels of patient-rated collaboration.

When examining the relationship between technique and the alliance subscale Goals & Task Agreement ($M = 6.20$, $SD = 0.76$), results in Table 1 demonstrate that the interaction term, PI \times CB, was associated with Goals & Task Agreement ($b = -0.24$; $SE = .12$; $p = .057$), whereas neither PI ($b = 0.02$; $SE = .08$; $p = .833$) nor CB ($b = .05$; $SE = .08$; $p = .517$) were significantly associated with Goals & Task Agreement.³ Figure 1 shows the association between PI and CB with Goals & Task Agreement.⁴

Exploratory Analyses

What individual therapist techniques are related to patient-rated Confident Collaboration as well as Goals & Task Agreement aspects of the alliance early in treatment? To better understand the specific applied nature of which psychodynamic-interpersonal and cognitive-behavioral techniques were being integrated in relation to the Confident Collaboration and Goals & Task Agreement subscales,

¹ OLS regressions were also conducted ($n = 91$) and revealed that higher levels of CPPS-PI, CPPS-CB, and CPPS PI \times CB early in treatment were not significantly related to global patient self-reported alliance (CASF Total; $p = .29$, $p = .19$, $p = .14$, respectively).

² All CASF subscales were examined in the present analyses in relation to the CPPS PI and CB subscales. The CASF subscales, Bond and Idealized Relationship, were not significantly related ($p > .10$) to any of the technique variables and therefore were not examined further.

³ Intercept (Coeff = 6.20; $SE = .09$; $p = <.0001$). Note: estimates above are the fixed effects in a MLM wherein all predictors were allowed to freely vary across therapists.

⁴ OLS regressions were also conducted ($n = 91$) and revealed that CPPS-PI was not significantly related to patient self-reported Confident Collaboration ($p = .56$) or Goals & Task Agreement ($p = .28$). Higher levels of CPPS-CB indicated a nonsignificant trend for patient self-reported Confident Collaboration ($p = .05$) as well as Goals & Tasks Agreement ($p = .08$). The interaction between psychodynamic-interpersonal and cognitive-behavioral techniques early in treatment (PI \times CB) was significant and positively related to patient-self reported Confident Collaboration ($p = .04$) and demonstrated a nonsignificant trend in relation to Goals & Tasks Agreement ($p = .06$).

Table 1
Summary of Fixed Effects From Multilevel Model
Predicting Patient-Rated Goals and Task Agreement

	<i>b</i> (SE)	<i>p</i> value
Intercept	6.20 (.09)	<.0001
PI	0.02 (.08)	.833
CB	0.05 (.08)	.517
PI × CB	−0.24 (.12)	.057

the relationships between particular therapist interventions with these patient ratings of alliance were further explored. The results of these bivariate pairwise correlations (two-tailed; $n = 91$) revealed that two CPPS-PI items were significant and positively related to the patient self-reported Goals & Task Agreement alliance subscale. The first was as follows: “The therapist links the patient’s current feelings or perceptions to experiences of the past (#4)” ($r = .23, p = .03$); the second was as follows: “The therapist focuses attention on similarities among the patient’s relationships repeated over time, settings, or people (#5)” ($r = .25, p = .02$). In addition, one CPPS-PI item demonstrated a nonsignificant trend in relation to

Goals & Task Agreement; specifically, “The therapist identifies recurrent patterns in patient’s actions, feelings and experiences (#14)” ($r = .18, p = .08$). One CPPS-PI item was also significant and negatively related to the patient self-reported Confident Collaboration alliance subscale; “The therapist allows the patient to initiate the discussion of significant issues, events, and experiences (#16)” ($r = -.21, p = .05$). The results of pairwise correlations also revealed that two CPPS-CB items were significant and positively related to the patient self-reported Confident Collaboration alliance subscale. The first was “The therapist actively initiates the topics of discussion and therapeutic activities (#3)” ($r = .22, p = .04$) and the second was “The therapist provides the patient with information and facts about his or her current symptoms, disorder, or treatment (#15)” ($r = .28, p = .01$). In addition, one CPPS-CB item demonstrated a nonsignificant trend in relation to Confident Collaboration; specifically, “The therapist explains the rationale behind his or her technique or approach to treatment (#11)” ($r = .18, p = .09$). Three CPPS-CB items were also significantly related to the patient self-

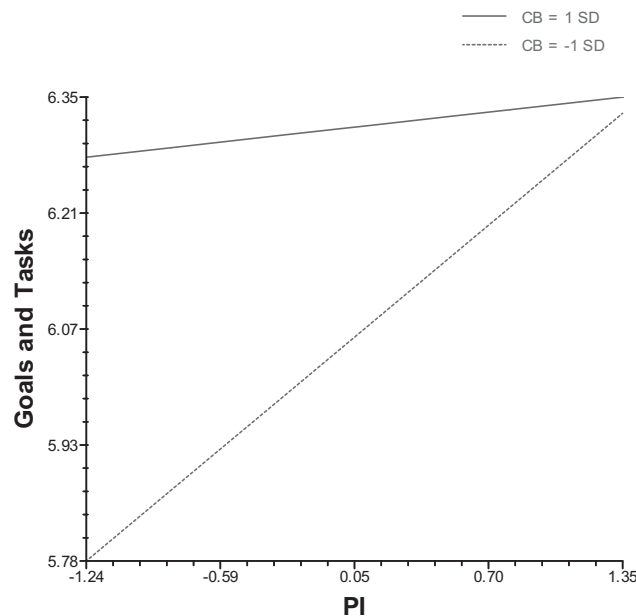


Figure 1. Fixed effects for PI and CB techniques in the prediction of patient-rated Goals & Task Agreement.

reported Goals & Task Agreement alliance subscale. The first was “The therapist explains the rationale behind his or her technique or approach to treatment (#11)” ($r = .24, p = .02$); the second was “The therapist provides the patient with information and facts about his or her current symptoms, disorder, or treatment (#15)” ($r = .25, p = .02$); and the third was “The therapist explicitly suggests that the patient practice behavior(s) learned in therapy between sessions (#17)” ($r = .22, p = .03$). These findings reveal that specific psychodynamic-interpersonal and cognitive-behavioral techniques were significantly correlated with higher patient-rated alliance subscales, specific to Goals & Task Agreement and Confident Collaboration within treatment.

Despite the useful applied clinical implications of these exploratory individual technique analyses, further replication is needed. According to Cohen's (1988) criteria ($r > .1$ = small, $r > .30$ = medium; $r > .5$ = large), the majority of these findings are considered small effects. Moreover, a Bonferroni adjustment for these exploratory analyses on individual technique would lead to the more conservative level of significance of $p < .0025$.

Discussion

This is one of the first studies of its' kind to investigate the relationship between the integration of specific therapeutic techniques and patients' experience of alliance early in treatment. In exploring the impact of therapist effects on the relationship between technique and patient-rated alliance, our findings revealed that overall alliance was not impacted by therapist technique or technique integration. However, we did find that dynamic therapists who used more CB techniques had patients who reported greater Confident Collaboration, particularly when therapists provided information about the patient's condition or the therapy process. That is, when traditional cognitive-behavioral elements, such as providing patients with explicit information and rationale about their symptoms and treatment, are presented from a psychodynamic perspective (i.e., relational, affective, intrapsychic; see TMA procedure), this may give patients more confidence to face their challenges and a greater sense of collaboration with their therapist. Additionally, our findings also

demonstrated that the interaction effect ($PI \times CB$) evinced a trend toward significance for the alliance subscale, Goals & Task Agreement. Simply, in the context of brief dynamic therapy, higher levels of CB techniques were associated with greater agreement on Goals and Tasks, regardless of the level of PI techniques; whereas, lower levels of CB were associated with lower agreement on Goals and Tasks only when PI techniques were also infrequently used. Finally, exploratory analyses demonstrated that specific psychodynamic-interpersonal and cognitive-behavioral techniques were significantly related to higher patient-rated alliance scores on the Confident Collaboration and Goal and Tasks Agreement subscales in clinically meaningful ways.

Several interpretations can be made with regard to the interaction effect ($PI \times CB$) for Goals & Task Agreement. In brief psychodynamic therapy, CB techniques may be needed to establish Goals and Tasks aspects of the alliance (e.g., high CB levels regardless of PI levels). Thus, by increasing the use of CB techniques within a psychodynamic session (in particular, psychoeducation and increased therapist activity), the clinician can ensure a stronger emphasis on goals and tasks aspects of the alliance by providing explanations for their approach. As previously described, psychodynamic clinicians may want to consider having an explicit discussion regarding how psychodynamic psychotherapy works and how this approach might offer specific aid to aspects of patients' functioning to enhance the goals and task aspects of the alliance.

Yet, in the face of limited CB use (e.g., low CB levels), more PI techniques may be needed to help establish agreement on the Goals and Tasks. For these patients, it may be necessary that the sessions contain more exploration of patterned behavior. This would allow the therapist to properly evaluate what tasks would be needed to ensure that both patient and therapist are on the same page with regard to the direction and goals of the treatment. Lastly, low levels of CB or PI may reflect a bad session (or therapeutic process in general) and support previous findings that therapists need to be relatively active to promote positive session outcomes (Owen, Hilsenroth, & Rodolfa, 2012).

These findings provide significant clinical implications for therapists by using certain

psychodynamic-interpersonal and cognitive-behavioral strategies to successfully predict aspects of a strong therapeutic alliance. Psychodynamic therapists who collaboratively develop patient goals, along with an explicit treatment plan, may strengthen the early alliance by being an active participant in initiating discussions with the patient (Yeomans et al., 1994). Likewise, therapists who collaboratively develop explicit goals and tasks of the treatment with their patient may facilitate stronger early alliances by specifically providing information about the patient's symptomatology and treatment, as well as explaining the psychodynamic model, rationale, and approach to therapy (DeFife & Hilsenroth, 2011). Additionally, identifying significant and persistent relational patterns over time (both past and present), as well as exploring various behavioral observations and different activities the patient might consider when faced with these scenarios in-between sessions (i.e., anticipation, homework, etc. - see Stricker, 2006) seem to have a positive association with a greater sense of shared goals and tasks early in treatment.

The present work, in conjunction with the DeFife et al. (2008) study that uses a subsample of the current data, offers consistent evidence that supports the assimilative model of psychotherapy integration (Stricker & Gold, 1996; Messer, 1992). In DeFife et al.'s findings of *patient-rated* techniques, the integration of both active and exploratory interventions appeared to enrich the therapy work, leading to favorable treatment outcomes over time, whereas in the present work, the use of assimilative integration of *independently rated* techniques had benefit in the context of patient-rated alliance subscales. Our investigation of independent clinical ratings of technique also demonstrated that the integration of some cognitive-behavioral interventions within a psychodynamic oriented model early in therapy facilitated a stronger therapeutic alliance specific to collaboration on treatment focus and goals within therapy. Thus, active ingredients from both psychodynamic-interpersonal and cognitive-behavioral orientations appear to have a relationship in facilitating aspects of a strong alliance at the start of treatment. Through the exploration of cyclical relational-affective patterns over time, psychodynamic techniques can aid the patient in developing new perceptions of him/herself and

changing their interpersonal dynamics with others (Gold & Stricker, 2001). Yet, in combination with cognitive-behavioral, systematic, and strategic interventions, this may allow for behavioral change and may deepen the psychodynamic exploration (Gold & Stricker, 2001; Stricker & Gold, 1996).

These recommendations also fit with emerging knowledge on between-session processes. Intersession activity has been related to higher alliance scores, as patients may be more likely to practice therapeutic activities outside of sessions based on their trust in the therapist about the goals set forth in treatment (Owen, Quirk, Hilsenroth, & Rodolfa, 2012). A greater emphasis on the integration of PI and CB techniques in increasing intersession activity may reciprocally strengthen the alliance as well (Owen, Quirk, Hilsenroth, & Rodolfa, 2012). To this end, one of our future aims is to identify whether the relationship between therapist technique integration and patient-rated alliance transforms over the course of treatment; for example, middle and late stages of treatment. This will promote our understanding of how specific psychodynamic-interpersonal and cognitive-behavioral techniques can influence psychotherapy treatment outcomes. Yet, it is also important to note that these process results come from a sample of patients who have demonstrated positive large effects for both process and outcome data, including depressed patients (Hilsenroth et al., 2003), comorbid depressed and borderline personality disorder patients (Hilsenroth, DeFife, Blake, & Cromer, 2007), and anxiety disorder patients (Slavin-Mulford et al., 2011). Within this sample, patients reported very high overall alliance scores with their therapists (average scores >6 on a 7-point scale).

Despite its relevance as one of the first studies to empirically examine therapeutic integration in relation to patient-rated early alliance, some limitations must be addressed. First and foremost, the current study examined patients' experience of early alliance in treatment; as such, we did not focus on subsequent treatment outcomes in relation to the interaction of therapeutic interventions. However, this does not detract from the unique psychotherapy process findings that enhance our understanding of specific therapeutic interventions, all of which successfully influence aspects of the therapeutic alliance at the outset of treatment. Our findings

highlight the importance of certain techniques that therapists may draw upon to supplement their own clinical work and enhance the quality of the therapeutic alliance, specific to collaboration on treatment focus as well as the goals and tasks aspects of therapy. We hope to direct future efforts toward the exploration of early alliance in mediating the relation between psychotherapy technique integration and treatment outcomes.

Regarding the MLM analyses, we examined therapist effects as a level 2 effect or nesting effect; this is where the variability is allocated and commonly referred to as such in the literature. Although effects exist at the therapist level, the reason for these specific effects is unknown and it is possible that they could be unrelated to the therapists per se (e.g., lack of random assignment of patients). Likewise, the multilevel analyses only revealed a nonsignificant trend ($p < .05 - .06$) interaction effect for Goals & Task Agreement. While some of the interactions ($PI \times CB$) were not statistically significant and others were at the trend level, as commonly known, interaction effects reduce power by nearly half (Aiken & West, 1991). Thus, moderation effects may be slightly difficult to detect in most psychotherapy studies, where sample sizes are generally not very large. Accordingly, most studies do not have power to detect interactions. Typically, when interaction effects are found in sample sizes similar to the present study, they are based on large effects. But, large effects (especially with large confidence intervals) may be a bit misleading if they are not replicated. Thus, the present study strongly demonstrates that the integration of techniques is not a panacea for enhancing all aspects of the alliance, but rather may be a useful area for investigation regarding some specific aspects.

Other limitations include our patient population, which was comprised of an outpatient sample; patients tended to experience mild to moderate levels of distress in their functioning. There were a disproportionate number of Caucasian females within the sample; this may be representative of individuals seeking psychotherapy at a university-based clinic. Nonetheless, efforts must be directed towards increasing patient sample size, broadening our patient sampling to include diverse clinical settings, that is,

inpatient and other outpatient settings, and examining the impact of patient characteristics.

These limitations notwithstanding, this is one of the first treatment studies to examine the interaction between psychodynamic and cognitive-behavioral techniques in the context of the alliance. Our findings are among the very first to shed light on the assimilation of some CB techniques within a larger Psychodynamic model early in treatment to facilitate a stronger therapeutic alliance specific to collaboration on treatment focus as well as the goals and tasks agreed upon within that therapy. These process results also have therapeutic application, providing a relevant framework for when and how specific therapist techniques can be used to enhance different aspects of alliance formation in clinical practice.

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