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The Influence of a Therapist Workshop in Alliance Strategies on Client Engagement: Feasibility and Preliminary Efficacy

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THE INFLUENCE OF A THERAPIST WORKSHOP IN ALLIANCE STRATEGIES
ON CLIENT ENGAGEMENT: FEASIBILITY AND PRELIMINARY EFFICACY

A Dissertation Presented

by

LOTTE SMITH-HANSEN

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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Clinical Psychology

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DEDICATION

To Erich

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First of all, I wish to thank my dissertation advisor and the members of my dissertation committee. Michael Constantino encouraged and mentored me starting my first semester in graduate school, and it has been exciting to discover our shared interests in the scientific study of psychotherapy process and outcome. Our mutual interest in the therapeutic relationship was evident early on, and the ideas for this project evolved naturally over time. His expertise was invaluable during all phases of the study. His careful editing of my writing was exasperating at times but I must say always improved the final product. Most importantly, his excitement about the project was contagious even when I was tired of it, and many times I left his office with renewed inspiration and energy. The three members of my dissertation committee (Christopher Overtree, Paula Pietromonaco, and Mathew Ouellett) provided helpful input in the planning stages and at the end of the study. They helped me strike the balance of adhering to rigorous scientific standards while keeping the scope feasible.

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ABSTRACT

THE INFLUENCE OF A THERAPIST WORKSHOP IN ALLIANCE STRATEGIES ON CLIENT ENGAGEMENT: FEASIBILITY AND PRELIMINARY EFFICACY

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The client-therapist relationship has long been recognized as an important element in psychotherapy, and research has demonstrated its robust association with positive outcomes. This study examined the feasibility and preliminary efficacy of training therapists in strategies for improving therapeutic relationships with clients. The strategies were compiled from the empirical literature, drawing on the work of Hilsenroth and Cromer (2007), Castonguay (1996), and Safran and Muran (2000). The study employed a manipulated training design that has the benefit of addressing naturalistic effectiveness questions, while adhering to the rigorous scientific standards of controlled efficacy research (Hayes, 2002). Participants were 57 therapists working at five community mental health clinics who were randomly assigned to the brief alliance training workshop (in which they participated prior to starting treatment with a new client) or to a delayed-training control condition. Outcomes assessed included therapists' self-reported use of alliance strategies in session 1, therapist-rated alliance quality after session 1, and early

client engagement. Engagement was operationalized in several ways: number of sessions attended in the first four weeks, planned session frequency (e.g., weekly, monthly), attendance rate (i.e., percent of scheduled sessions attended), and treatment status at the end of four weeks (e.g., therapist and client had next session scheduled, client had terminated unilaterally). Counter to hypotheses, one-way ANOVAs and chi-square analyses revealed no statistically significant differences between the training and the delayed-training conditions on the primary outcomes. However, effect size estimates suggested that clinicians in the training condition reported better alliances with their clients than clinicians who had yet to receive the training ($d = 0.40$, 95% CI [-0.13, 0.93], small to medium effect). Furthermore, therapists' use of alliance strategies taught in the workshop was significantly correlated with alliance quality. In addition to the preliminary efficacy findings, the study generated important information about the feasibility of conducting psychotherapy research in naturalistic settings, as well as recommendations for future studies. The manipulated training design holds promise for collaborations between researchers and clinicians seeking to bridge science and practice.

CONTENTS

	Page
ACKNOWLEDGMENTS	v
ABSTRACT.....	vii
LIST OF TABLES	x
LIST OF FIGURES	xi
CHAPTER	
I. INTRODUCTION	1
II. METHOD	11
III. RESULTS	23
IV. DISCUSSION.....	27
APPENDICES	50
A. THERAPIST DEMOGRAPHICS FORM	51
B. CLIENT DEMOGRAPHICS FORM	52
C. THERAPIST USE OF ALLIANCE-FOSTERING STRATEGIES	53
D. WORKING ALLIANCE INVENTORY – THERAPIST VERSION.....	54
E. CLIENT ENGAGEMENT FORMS	55
F. RECRUITMENT MATERIALS	60
F1. FLYER.....	60
F2. WHO WE ARE.....	61
F3. HOW THIS WORKS	62
G. EXPLANATION LETTERS	63
H. CONSENT FORM.....	65
I. WORKSHOP HAND-OUTS.....	68
I1. STRATEGIES FOR BUILDING A THERAPEUTIC ALLIANCE.....	68
I2. IDENTIFYING AND RESOLVING IN-SESSION ALLIANCE STRAINS.....	69
I3. THERAPEUTIC ALLIANCE RUPTURE RESOLUTION STRATEGIES.....	70
J. WORKSHOP EVALUATION FORM.....	71
REFERENCES	72

LIST OF TABLES

Table	Page
1. Intercorrelation Matrix of Working Alliance Inventory (WAI) Scores.....	42
2. Therapist Demographics by Condition	43
3. Client Demographics by Condition	44
4. Main Study Variables by Condition	45
5. Intercorrelation Matrix of Main Study Variables	46

LIST OF FIGURES

Figure	Page
1. Chart of Data Collection and Analysis	47
2. Flow of Participants Through Each Study Stage	48
3. Hypothesized Mediation Relationships Among Variables	49

CHAPTER I

INTRODUCTION

The client-therapist relationship has been recognized as an important therapeutic element since the inception of psychological treatments (e.g., Freud, 1913/1958). Over the past several decades, substantial research has demonstrated the association between the quality of the client-therapist relationship, or *alliance*¹, and positive psychotherapy processes and outcomes (Castonguay, Constantino, & Holtforth, 2006; Constantino, Castonguay, & Schut, 2002; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Wampold, 2001). With its clinical importance well-established, a second wave of alliance research has focused on predictors of its quality. Many studies have found that alliance quality is related in part to preexisting and relatively stable characteristics of the client (e.g., psychological mindedness, defensiveness, perfectionism, attachment style, interpersonal style, and social competencies; see Connolly Gibbons, Crits-Christoph, & de la Cruz, 2003; Constantino & Smith-Hansen, 2008; Horvath, 1991; Mallinckrodt, 2000; Zuroff et al., 2000) and of the therapist (e.g., clinical experience, warmth, congruence, interpersonal style; see Ackerman & Hilsenroth, 2003; Hersoug, Hoglend, Monsen, & Havik, 2001). However, research has also demonstrated that specific therapist *behaviors* (e.g., communicating empathy, demonstrating respect, working collaboratively, exploring interpersonal themes) are linked with better therapy relationships (e.g., Ackerman & Hilsenroth, 2003; Angus & Kagan, 2007; Hilsenroth & Cromer, 2007). Given the influence that therapists seem to have on fostering the alliance, the question can be raised as to whether it is possible to train therapists in specific

¹ Although the literature has distinguished between different aspects of the therapy relationship (e.g., the *ego alliance*, *therapeutic alliance*, and *working alliance*), I use the terms *alliance* and *relationship* interchangeably to encompass all of these aspects.

alliance-fostering strategies or, alternatively, if only natural and spontaneous therapist behaviors facilitate the development of a good therapeutic alliance.

The link between therapist behaviors and alliance quality has been studied mostly with observational (qualitative or correlational) designs, and only a few studies have attempted to “manipulate” or improve the therapeutic relationship experimentally and prospectively through specific interventions, such as training and supervision in alliance-fostering strategies. For example, in a pilot-feasibility training study, Crits-Christoph et al. (2006) trained five Ph.D. or Psy.D. psychologists with one to three years of post-degree experience in a manualized alliance-fostering therapy, a 16-session treatment combining psychodynamic-interpersonal strategies with techniques for strengthening the alliance. The alliance techniques were compiled from the broader alliance literature and organized around Bordin’s (1979) tripartite alliance model (i.e., agreement on therapy goals, agreement on therapy tasks, and an emotional bond between therapist and client). Therapists treated three separate cases before, during, and after training. Although the small sample precluded statistical significance, moderate to large effect sizes were observed for client-rated alliance from pre- to post-training cases. Results also showed therapist variability in alliance ratings across all three phases. During the training phase, therapist adherence to alliance techniques in a current session was significantly associated with client-rated alliance scores at the subsequent session. During the post-training phase, this relationship was similar, but only marginally significant. Small to moderate effect sizes were observed for pre- to post-training cases in improvements in depressive symptoms and quality of life.

Hilsenroth, Ackerman, Clemence, Strassle, and Handler (2002) administered a structured clinical training (SCT) to 13 advanced doctoral students in clinical psychology. The SCT involved manualized strategies for (a) a therapeutic model of assessment and (b) short-term psychodynamic psychotherapy, both of which involved building rapport, developing collaboration, establishing empathic connections, being optimally responsive to client needs, socializing the client to the therapy process, discussing client and therapist roles in the process, exploring client relational problems, focusing on client-therapist interactions, and setting collaborative treatment goals. Compared to a group of 15 doctoral students delivering treatment-as-usual (and receiving supervision-as-usual) to a matched group of clients, SCT therapists produced higher alliance ratings after session 4 from both therapist and client perspectives.

In a study by Bambling, King, Raue, Schweitzer, and Lambert (2006), 103 masters- and doctoral-level therapists were trained in brief Problem-Solving Therapy (PST) and then randomized to either no supervision or one of two supervision conditions. Supervisors were randomized to training focused on either alliance *process* or alliance *skills*. After eight sessions of PST (with eight concurrent supervision sessions for the supervised therapists), the clients receiving treatment from supervised therapists showed higher retention rates, higher working alliances ratings, lower depression scores, and greater treatment satisfaction than the clients with unsupervised therapists. No differences were found between the two groups of supervised therapists (alliance process and alliance skills focus).

In a pilot-scale randomized clinical trial, Constantino et al. (2008) examined the preliminary efficacy of an integrative form of cognitive therapy (ICT) for depression that

attempts to improve traditional cognitive therapy (CT) by adding interpersonal and humanistic strategies for addressing problems in the therapeutic alliance (termed “alliance ruptures;” see Burns, 1989; Burns and Auerbach, 1996; Castonguay, 1996; Constantino et al., 2002). Specifically, the ICT therapists were trained to pay attention to specific markers of alliance strain. In the face of such markers, therapists broke from the CT protocol and (a) invited the client to discuss negative reactions to the therapy or the therapist, (b) empathized with the client’s disclosures, and (c) disarmed the client by validating his or her concerns and taking responsibility for their own contributions to the problem. Once the rupture was deemed resolved, therapists resumed the CT protocol. Compared to CT clients ($n = 11$), ICT clients ($n = 11$) showed greater posttreatment improvement on depression and global symptomatology (small to medium effect sizes) and greater clinically significant change. Furthermore, ICT clients reported higher alliance and empathy scores (medium to large effect sizes) across the treatment course than CT clients.

Similar to Constantino et al. (2008), Newman, Castonguay, Borkovec, Fisher, and Nordberg (2008) examined the feasibility of an integrative treatment for generalized anxiety disorder (GAD), which attempts to improve cognitive-behavioral therapy (CBT) with the addition of an interpersonal and emotional processing component (I/EP). When using I/EP techniques, therapists in this study helped clients (a) identify interpersonal needs, (b) explore past and current behavior aimed at satisfying those needs, (c) pinpoint emotional experience underlying these interpersonal processes, and (d) generate more effective behaviors in relationships to better meet their needs. The techniques focused on client affective experiences in the context of past and current relationships, including the

therapeutic relationship. In this open trial, 18 clients received 14 sessions of CBT + I/EP (in consecutive 1-hour modules for each session), and demonstrated significantly decreased GAD symptoms from pre- to post-treatment and maintained their gains across the one year follow-up period. Moreover, clients evidenced clinically significant change in GAD symptoms and interpersonal functioning, with larger effect sizes than most CBT treatments for GAD. Finally, compared to a small CBT + supportive listening control group ($n = 3$), CBT + I/EP clients demonstrated more favorable outcomes.

The treatments examined by both Constantino et al. (2008) and Newman et al. (2008) are based in part on work by Safran and colleagues (Safran & Muran, 2000, 2006; see also Muran, Safran, Samstag, & Winston, 2005; Safran, Muran, Samstag, & Winston, 2005; Safran & Segal, 1990). These authors have emphasized the importance of alliance *rupture-repair* sequences, which they define as problems in the therapeutic relationship that are repaired through interpersonal exploration between client and therapist. These authors have argued that working through such problems in the alliance may be a key pantheoretical change mechanism in its own right. Based on this principle, Safran and Muran developed brief relational therapy (BRT) as a stand-alone treatment modality focused on negotiating the therapeutic alliance. However, the authors stressed that the principles and strategies can be incorporated into any type of treatment, as reflected in ICT and I/EP discussed above. BRT is based on contemporary relational psychoanalytic theory and on the authors' own research on alliance ruptures, and includes elements from humanistic/experiential traditions and Buddhist mindfulness practice. The treatment emphasizes process over content, and therapeutic change is theorized to arise from the development of mindfulness skills facilitating internal awareness, as well as new

interpersonal experiences with the therapist. In fact, the main focus in BRT is on exploring ruptures in the therapeutic alliance and using these as opportunities for growth, which is facilitated by the therapist's use of metacommunication to disembed from maladaptive interpersonal patterns being enacted with the client. In empirical investigations comparing BRT with CBT and short-term dynamic therapy, BRT produced lower drop-out rates for clients with personality disorders (Muran et al., 2005) and for clients at risk of treatment failure with whom it is difficult to establish an alliance (Safran et al., 2005).

In summary, investigating ways for therapists to improve their working relationships with clients is important because (a) the quality of the therapeutic alliance has been linked with therapy engagement (e.g., lower drop-out rates) and outcomes (Castonguay et al., 2006; Constantino et al., 2002; Horvath & Bedi, 2002; Lingardi, Filippucci, & Baiocco, 2005; Martin et al., 2000; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006; Tryon & Kane, 1995); (b) the therapeutic relationship may provide opportunities for corrective relational experiences for the client, and thus may represent an important change mechanism in and of itself (Balint, 1968; Luborsky, 1984; Rogers, 1951; Safran & Muran, 2000); and (c) poor client engagement (e.g., missed appointments and drop-outs) challenges community mental health clinics already struggling with "revolving door clients," long waiting lists, limited revenues, low morale, and high staff turn-over (Barrett, Chua, Crits-Christoph, Connelly Gibbons, & Thompson, 2008).

Although the studies reviewed above address the important question of how therapists might facilitate the therapeutic relationship, they have significant

methodological limitations, including small sample sizes and, in some cases, limited external validity (i.e., laboratory settings, use of manuals, doctoral-level or graduate student therapists, time-limited treatment, and nonrepresentative patient samples). An important methodological issue in clinical research concerns the balance that researchers must strike between, on the one hand, tight control of variables to maximize internal validity and strengthen causal inferences and, on the other hand, use of representative samples to maximize generalizability and ecological validity. In psychotherapy research, specifically, some researchers have advocated for a medical research model based on three stages. In Stage I and II, the *efficacy* of psychological interventions are tested under highly controlled laboratory conditions with homogeneous client samples. For example, a manualized treatment for panic attacks may be tested with a group of clients diagnosed with panic disorder who are randomly assigned to the intervention or some type of control group. Clients with any other diagnoses (e.g., other anxiety disorders, depression, or personality disorders) are excluded, and therapists' use of the manual-directed techniques is assured through adherence checks. Once the treatment has been found to have a demonstrable effect, a Stage III investigation examines the *effectiveness* of the intervention through the implementation of the manualized treatment in naturalistic practice settings, such as community mental health clinics. The purpose of a Stage III study is to test the external validity of the intervention by determining for whom and under what conditions it works (e.g., only for certain subtypes of panic disorder, or only with a 16-session format). Based on these findings, the treatment manual is then revised with additional details.

Although the stage approach to clinical research has its advantages, Hayes and colleagues (Hayes, 2002; see also Strosahl, Hayes, Bergan, & Romano, 1998) have argued that this model has been of little use in psychotherapy research, in part because manualized treatments and many of the accoutrements of scientific investigation are highly impractical and difficult to implement in most real-world practice settings. For example, in many clinics, clients will not agree to be randomized to different treatments and therapists will not agree to have their practice dictated by manuals. Hayes reminded us that “the ultimate purpose of psychotherapy research is the modification of actual clinical practices” (p. 410), and argued that the most useful way to improve practice through scientific studies is to examine treatments, strategies, or techniques that clinicians will actually accept and adopt. At the same time, researchers working in naturalistic practice settings must take steps to design and execute studies of high scientific rigor in order to ensure the credibility of findings, and thus benefit from the “best of both worlds” of efficacy and effectiveness research (see also Borkovec & Castonguay, 1998). Hayes has recommended a *manipulated training* method for clinical research that addresses the questions of effectiveness studies while adhering to the scientific rigor of efficacy research.

The primary aim of the current study was to employ a manipulated training design in a naturalistic setting to examine the impact of training therapists in strategies for improving therapeutic relationships with their clients. To this end, therapists across five community mental health clinics were randomly assigned to a brief alliance training workshop or to a delayed-training control condition (therapists who received the training after the study). The three outcome variables were therapists’ use of alliance-building

strategies taught in the workshop, alliance quality, and client engagement. Client engagement was operationalized in this study as (a) number of sessions attended in the first four weeks of treatment; (b) treatment plan agreed on by client and therapist in session 1 (e.g., planning to meet weekly, planning to meet monthly, etc.); (c) attendance rate calculated as the number of sessions attended divided by the number of sessions planned; and (d) treatment status at the end of the four weeks (e.g., therapist and client had next session scheduled, client had terminated unilaterally, etc.)

It was predicted that therapists who participated in the alliance training, compared to therapists who had not yet received the training, would (a) use more alliance-fostering strategies in the first session with a new client, (b) report a stronger alliance with this client after session 1, and (c) have clients who were more engaged in the early treatment process. It was furthermore predicted that the therapists' actual use of alliance strategies taught in the training, as well as the quality of the early therapeutic alliance, would mediate the effect of the training on client engagement.

The secondary aim of the study was to explore the feasibility of conducting a psychotherapy study of high scientific rigor in the naturalistic settings of five community mental health clinics. The study capitalized on the "best of both worlds" of efficacy and effectiveness research through several mechanisms: (a) the intervention was implemented in five community mental health clinics (not a university laboratory setting), (b) the intervention was a workshop for therapists similar to the standard workshops in which therapists participate for continuing education credits (not a manualized treatment), (c) the participating therapists were masters-level clinicians working at the five clinics (not doctoral-level or graduate student therapists accustomed to research procedures), (d) the

therapists were randomly assigned to the experimental and control groups, and (e) the clients in the study were similar to the clients typically served in community clinics. Although these factors maximized both internal and external validity, they were anticipated to present challenges to the study in terms of feasibility.

Given the limited number of experimental effectiveness studies on the therapeutic alliance, this study represented an important next step in advancing the research literature, while addressing a practical problem in clinical practice (poor client engagement). It was envisioned that, if effective, this alliance workshop could be added to or adapted for other training/continuing education regimens in naturalistic treatment settings where treatment-as-usual is delivered.

CHAPTER II

METHOD

Participants

Therapists. The sample consisted of 57 therapists recruited from three social service agencies: (a) Outpatient Behavioral Health Services of Cooley-Dickinson Hospital in Florence, MA; (b) ServiceNet Integrated Human Services outpatient clinics in Northampton, Greenfield, and Chicopee, MA; and (c) Clinical and Support Options outpatient clinic in Springfield, MA. The therapist sample was predominantly female (84%) and Caucasian (91%), and the therapists ranged in age from 23 to 77 with a mean age of 45.59 years ($SD = 13.66$ years). Forty-six therapists (80%) held master's degrees, two (4%) held bachelor's degrees, and nine (16%) held doctoral degrees. Therapist clinical experience since highest degree ranged from less than one year to 42 years with a mean of 12.14 years ($SD = 10.32$ years). Forty-seven clinicians (83%) were licensed, while 10 (17%) were unlicensed. The most common types of licenses were Licensed Independent Clinical Social Worker (LICSW = 19; 33%), Licensed Clinical Social Worker (LCSW = 10; 18%), and Licensed Mental Health Counselor (LMHC = 8; 14%). Four clinicians (7%) were licensed psychologists, three (5%) were Licensed Alcohol and Drug Counselors (LADC), and two (4%) were Licensed Marriage and Family Therapists (LMFTs).

The therapists reported quite eclectic theoretical orientations. To the question "To what extent do you regard your orientation as eclectic/integrative?" (from 0 indicating *not at all* to 5 indicating *very much*), most therapists reported a 4 or a 5 (83%) with a sample mean of 4.44 ($SD = .88$). When asked to rate how much their current clinical practice was

guided by each of five theoretical frameworks (same scale as above), therapists showed a slight preference for cognitive ($M = 3.98$), behavioral ($M = 3.70$), and humanistic/experiential ($M = 3.53$) theoretical frameworks, though they also endorsed using systems theory ($M = 3.25$) and psychoanalytic or psychodynamic theory ($M = 3.02$). When asked to describe their theoretical orientations in narrative form, therapists listed, for example, Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitization Reprocessing (EMDR), interpersonal therapy, client-centered/Rogarian approach, relational principles, Gestalt therapy, evidence-based techniques, network therapy, object relations therapy, eclectic approach, trauma theory, common factors approach, post-modern theory, integrative techniques, contextual approach, strength-based perspective, motivational interviewing, narrative theory, mindfulness principles, body-centered techniques, Buddhist approach, spirituality, and “do-good therapy.” Many clinicians reported using a highly pragmatic approach, making statements along the lines of “I start where the client is at,” “I use whatever techniques work,” and “I adjust my style to meet the needs of the client.”

Clients. The clients of the 57 participating therapists were 36 women (63%) and 21 men (37%), ranging in age from 18 to 61 with a mean age of 37.82 years ($SD = 12.49$ years). Forty-three were Caucasian (75%), while seven were Hispanic (12%), four were African-American (7%), and two were categorized as ‘other’ (4%, likely biracial). Twenty-nine clients were self-referred (51%), while 20 were referred by a health professional (35%), five by family (9%), and three by the court system (5%). The clients presented with complex psychiatric problems, with 43 (75%) receiving more than one diagnosis across Axis I and Axis II. Eight clients (14%) were classified as having a

severe diagnosis (a psychotic disorder or bipolar I disorder with or without psychotic features). Clients' Global Assessment of Functioning (GAF) scores ranged from 40 to 65 with a mean of 53.26 ($SD = 5.88$), thus reflecting a range of symptom severity and functional difficulty, from severe impairments in reality testing or communication (e.g., illogical, obscure speech) to milder symptoms (e.g., depressed mood and mild insomnia).

The first adult client (age 18 to 65) who initiated psychotherapy with each of the participating therapists across both conditions following the training group's alliance workshop was included in the study (see data collection chart in Figure 1). Clients were assigned to therapists according to standard clinic procedures. The only client exclusion criteria for the study were (a) living in a residential program and (b) having a diagnosis of mental retardation, given that most of these clients have staff members who arrange transportation to and from therapy (thus confounding the outcome variable of therapy engagement). If a therapist's first case post-training was excluded, his or her next assigned case that met inclusion criteria was included in the sample.

Measures

Therapist Demographics Form. Therapists provided information about their gender, age, race/ethnicity, education, license, years of clinical experience, and theoretical orientation (see Appendix A).

Client Demographics Form. Therapists provided information about their clients' gender, age, race/ethnicity, referral source, diagnoses, and Global Assessment of Functioning (GAF) score (see Appendix B).

Therapist Use of Alliance-Fostering Strategies. Therapists rated their own use of strategies for building strong working relationships and engaging clients in treatment

following session 1 with the new client (see Appendix C). The measure was a checklist of the eight most important alliance strategies taught during the training, but the strategies were described in general terms to be understandable for the control therapists who had not yet participated in the training. Therapists indicated whether they used each strategy and rated how well each strategy was received by the client (i.e., the perceived impact of using the strategy) ranging from -3 to +3. Each therapist's use of alliance strategies was operationalized in three ways: (a) Total number of strategies used, (b) sum of impact ratings, and (c) average impact rating.

Working Alliance Inventory – Short Form Therapist Version (WAI; Horvath & Greenberg, 1986, 1989). Therapists completed the 12-item short form of the WAI following session 1 with the new client (see Appendix D). The WAI is a commonly used, psychometrically sound measure of the therapeutic relationship. It is based on Bordin's (1979) pantheoretical conception of the alliance as involving agreement on therapy goals, agreement on therapy tasks, and the emotional bond between therapist and client. These three components are assessed by the measure's three subscales. Each subscale consists of four items rated on 7-point Likert scales; a higher score indicates a higher quality of the therapeutic alliance. Alliance quality was operationalized as the total score from all 12 items given that the three subscales tend to be highly correlated, including in the present study (see Table 1). Internal consistency (Cronbach's alpha) for the total score in this sample was .93.

Client Engagement. Therapists were asked to track client engagement from session 1 through the first four weeks of treatment (sessions scheduled, attended, canceled, rescheduled, and no-showed; see Appendix E). At the end of the four weeks,

therapists indicated what the status of treatment was at this point in time. Using the data submitted by the therapists, client engagement was operationalized in the following four ways:

1. Number of sessions attended in the first four weeks of treatment, a higher number of sessions indicating better engagement.

2. Treatment plan agreed on by client and therapist in session 1: 1 = planning to meet as needed, 2 = planning to meet monthly, 3 = planning to meet every other week, and 4 = planning to meet weekly. A higher number indicated better engagement.

3. Attendance rate calculated as the number of sessions attended divided by the number of sessions planned: 1 = 25% attendance rate (e.g., client agreed to meet weekly but attended only one session in four weeks); 2 = 50% attendance rate (e.g., client agreed to meet every other week but attended only one session in four weeks); 3 = 75% attendance rate (e.g., client agreed to meet weekly but attended only three sessions in four weeks); 4 = 100% attendance rate (e.g., client agreed to meet every other week and attended two sessions in four weeks). A higher number indicated better engagement.

4. Treatment status at the end of the four weeks: 1 = client had terminated unilaterally without informing the therapist and simply never returned; 2 = client had terminated unilaterally but informed the therapist in person, by phone, or through the front desk staff that he or she would not return; 3 = therapist and client had agreed to terminate, either because of no need for further treatment or because of referral to another provider; 4 = therapist and client had next session scheduled. A higher number indicated better engagement.

Recruitment and Randomization Procedure

Therapists were recruited through face-to-face visits to clinic staff meetings, email, word of mouth, flyers distributed through staff mailboxes at the clinics, and large posters posted in the clinic mailrooms (see Appendix F for recruitment materials). The clinic managers were involved in the planning of the study from the beginning, and encouraged therapists to participate. The posters and flyers highlighted the training benefits, including earning free continuing education credits, learning strategies to increase client engagement, improving working relationships with clients, and receiving a small monetary incentive for participating. The posters and flyers explained that the training was part of a research study of client engagement in treatment, and that therapists who expressed interest would be randomly assigned to receive the training at either Time 1 or Time 2. Recruitment materials also included an information sheet about the study personnel, including the principal investigator (PI), the project coordinator, two clinic managers, and the PI's dissertation chair (see *Who We Are* in Appendix F), as well as a letter addressed to therapists from the PI and clinic managers (see *How This Works* in Appendix F). Study procedures were explained in more detail in the Explanation Letters (see Appendix G) and the Consent Form (see Appendix H).

The process by which therapists were assigned to the two conditions is shown in Figure 2. Approximately 120 individuals were invited to participate in the study (though approx. 20 were ineligible, such as the clinic nurse practitioner and clinicians working only with out-reach clients) and as many as 87 therapists expressed interest in the training and signed the Consent Form. Prior to randomization, four clinicians requested to participate in the workshop at a particular time (that is, self-assigning to the training or

delayed-training condition) because of scheduled vacation, surgery, or other commitments; two requested the Time 1 workshop and two requested the Time 2 workshop.

The principal investigator randomly assigned 71 therapists to participate in the workshop at either Time 1 (the training condition) or at Time 2 (the delayed-training condition consisting of therapists who participated in the workshop after submitting study questionnaires). Thirty-three therapists were assigned to Time 1; however, seven requested to be switched to Time 2. Thirty-eight therapists were assigned to Time 2; however, eight requested to be switched to Time 1. In addition, 11 therapists at one of the sites (Clinical and Support Options) were assigned semi-randomly by the clinic manager who took turns assigning clinicians to either Time 1 or 2 as they signed up; she assigned six to Time 1 and five to Time 2. Finally, one clinician joined the study after the Time 1 workshops, and was thus included in the delayed-training condition by default.

In this manner, 42 therapists were assigned to the Time 1 training condition, but only 40 actually attended the workshop. Of these, only 31 took on a new client during the study period; however, one therapist failed to return any questionnaires and one therapist completed questionnaires for an ineligible client (age 7). Thus, the effective sample included 29 clinicians in the training condition. Forty-five therapists were assigned to the Time 2 delayed-training condition. Of these, only 32 took on a new client during the study period; however, four therapists returned no questionnaires. Thus, the effective sample included 28 clinicians in the delayed-training condition.

Alliance Training Workshop

Therapists attended a three-hour workshop on strategies for building stronger relationships with clients. The training was developed by the principal investigator (L. Smith-Hansen, a clinical psychology doctoral candidate with two master's degrees in clinical psychology) and one of the clinic managers (A. Remen, a licensed psychologist with a Ph.D. in clinical psychology and ten years' experience since licensure), in consultation with the PI's dissertation chair (M. Constantino, an Associate Professor with a Ph.D. in clinical psychology and a psychotherapy researcher with expertise on the alliance).

The primary training goal was to teach therapists three sets of specific alliance-fostering strategies selected from the research literature. The first set of strategies was selected from Hilsenroth and Cromer's (2007) review of therapist attitudes and behaviors shown empirically to be associated with a strong therapeutic alliance and positive outcomes, e.g., *adopt a client-centered, relational stance; try to understand the vulnerable emotions and motivations underlying your client's negative behavior; use clear, specific experience-near language (not jargon); and work collaboratively to define individualized treatment goals and tasks*. The second set of strategies was adapted from the aforementioned ICT (Castonguay, 1996). The third set of strategies was adapted from the previously discussed BRT (Safran & Muran, 2000). The workshop made use of three hand-outs outlining the three sets of strategies (Appendices I1 through I3), and therapists were encouraged to save these hand-outs in a folder provided to them, and review them as they prepared to meet with their next new client.

The training was administered by Smith-Hansen and Remen, and included a combination of formats, including lecture presentation, role-plays, video vignettes, a session transcript, and large group discussion. The training was standardized across multiple training sessions through the use of a detailed written agenda outlining all training components to be covered in sequence, specifying content to be covered in segments as short as five minutes. Although no formal adherence checks were performed, the detailed agenda ensured good to excellent fidelity of the intervention. At the start of the training, therapists completed the Therapist Demographics Form. At the end, they completed evaluation forms (see Appendix J) and received \$20 for participating. They received their continuing education certificates in the mail shortly after the training.

Procedure

Therapists were recruited and randomized to conditions in an ongoing manner during March to May 2009. To accommodate clinicians' busy schedules, the Time 1 training was offered on three different dates in June 2009 (in addition to one special workshop scheduled exclusively for CSO clinicians) so that clinicians in the training condition could choose the most convenient one (the four workshops were identical). As soon as the Time 1 trainings were completed, data collection began for both groups of therapists (see data collection chart in Figure 1). Clinic staff were given lists of the participating therapists and instructed to notify a supervisor or the project coordinator when one of the study therapists began working with a new client. Clinic staff assisting with the project included administrative staff in charge of assigning clients to therapists, professional staff conducting intakes and assigning new clients to therapists, as well as clinic managers overseeing the process. When a study therapist was assigned a new

client, clinic managers were instructed to place a folder with questionnaires in the therapist's mailbox. Each folder contained a packet of questionnaires to be completed immediately following session 1 (including Client Form, Alliance Strategies Used in Session 1, WAI, and a session 1 attendance form) and a packet of Client Engagement forms to be completed during the first four weeks of treatment showing client attendance, cancellations, and no-shows. The folder also contained \$10.

The clinic managers were instructed to inform the project coordinator each time a study therapist was assigned a new client. The project coordinator maintained documentation of therapists, clients, and dates of scheduled sessions. Before the therapist's first session with the new client, the project coordinator called the therapist with a reminder to complete the Session 1 measures after the session. Two weeks later, he called with a reminder to track client attendance, cancellations, and no-shows, and to complete the Client Engagement forms. Two weeks later, he called to remind the therapist to complete the final Client Engagement forms. He called as needed to follow up regarding missing or incomplete forms. Therapists submitted all study paperwork through drop boxes located in clinic mailrooms.

Data collection was discontinued at the same time for both groups in order to control for the effects of the seasons (holidays, weather) known to affect client attendance in treatment. The Time 2 training was scheduled to take place three months after the Time 1 training in June, but had to be postponed another month until October, 2009, to allow time for more study therapists to begin working with a new client. As with the Time 1 training, the Time 2 training was offered on three different dates in order to accommodate clinicians' busy schedules, in addition to one special workshop scheduled

exclusively for CSO clinicians (four workshops identical to the four offered at Time 1). To encourage the last clinicians to return missing forms, the principal investigator sent hand-written thank you notes requesting a prompt response, enclosed the continuing education certificates, and reminded therapists that they would be entered into a raffle to win \$100 as soon as they returned the missing forms. The study was approved by the University of Massachusetts Human Subjects Review Board.

Data Analysis

Data were imputed for two therapists who each left one or two items blank on the Working Alliance Inventory. One therapist left one item blank on the 4-item tasks subscale; the scores on the other three items were averaged to impute the missing score. Another therapist left one item blank on the 4-item tasks subscale and one item blank on the 4-item goals subscale. These scores were imputed in the same manner, using the average score from the other three items on the particular subscale.

One-way ANOVAS were used for the tests of group mean differences of five continuous variables: (a) number of alliance strategies used by clinicians in session one, (b) sum of impact scores from alliance strategies used, (c) average impact score from alliance strategies used, (d) total score from WAI, and (e) number of sessions attended by client in the first four weeks of treatment. The *a priori* significance level selected was .05. Effect sizes and their 95% confidence intervals were calculated using the formula for Cohen's (1988) $d = M1 - M2 / SD_{pooled}$.

Given the non-normal distributions of the remaining three engagement variables, the variables were dichotomized and Chi-square analyses were used to examine group differences. The variables were dichotomized as follows: (a) session 1 treatment plan was

dichotomized as weekly or not weekly (bimonthly or as needed); (b) attendance rate was dichotomized as 100% or not 100%; and (c) treatment status was dichotomized as ‘clearly engaged’ (client and therapist had next session scheduled) or ‘not engaged’ (client and therapist had agreed to terminate, client had terminated unilaterally but informed the therapist that he or she would not return, or client had terminated unilaterally and simply never returned). Effect sizes were calculated using the formula for $\phi = \text{the square root of } \chi^2 / N$. Path analysis was planned for the tests of mediation (see Figure 3), but not undertaken given the lack of associations among variables of interest (Baron & Kenny, 1986).

CHAPTER III

RESULTS

Results of Randomization

Descriptive statistics for therapist demographics by condition are presented in Table 2. Preliminary analyses showed that the randomization of therapists to the training versus delayed-training conditions yielded equal levels of education and experience in the two groups; a chi-square analysis showed no significant difference between the two conditions in terms of numbers of therapists with bachelor's, master's, and doctoral degrees, $\chi^2(2, N = 57) = 1.07, p = .59$, while a one-way ANOVA revealed no significant differences in years of experience between the training ($M = 11.52, SD = 11.72$) and delayed-training ($M = 12.78, SD = 8.81$) conditions, $F(1, 54) = .20, p = .66$.

The randomization failed to distribute unlicensed clinicians equally between the two groups; a chi-square analysis revealed significantly more unlicensed clinicians in the training condition, $\chi^2(1, N = 57) = 4.12, p = .045$. Therefore, the associations between licensure status and the main study variables were examined in order to determine whether this variable should be included as a covariate in the tests of group mean differences. Licensure status was not related to the main variables of interest.

Specifically, one-way ANOVAs indicated no significant differences in (a) number of alliance strategies used between the licensed clinicians ($M = 4.49, SD = 2.01$) and the unlicensed clinicians ($M = 4.7, SD = 1.57$), $F(1, 56) = 0.097, p = .78$; (b) sum of impact scores from the alliance strategies used between the licensed clinicians ($M = 7.6, SD = 4.25$) and the unlicensed clinicians ($M = 8.8, SD = 4.29$), $F(1, 56) = 0.66, p = .42$; (c) average impact scores from the alliance strategies used between the licensed clinicians

($M = 1.76, SD = 0.72$) and the unlicensed clinicians ($M = 1.8, SD = 0.43$), $F(1, 56) = 0.026, p = .87$; (d) alliance scores between the licensed clinicians ($M = 59.57, SD = 10.68$) and the unlicensed clinicians ($M = 64.2, SD = 11.38$), $F(1, 56) = 1.51, p = .22$; and (e) number of sessions attended by clients between the licensed clinicians ($M = 2.89, SD = 1.07$) and the unlicensed clinicians ($M = 2.8, SD = 1.03$), $F(1, 56) = 0.06, p = .80$. Chi-square analyses showed no differences between the licensed and unlicensed clinicians in (a) session 1 treatment plan, $\chi^2(1, N = 57) = 0.06, p = .64$; (b) attendance rate, $\chi^2(1, N = 57) = 0.15, p = .49$; and (c) treatment status, $\chi^2(1, N = 57) = 1.67, p = .19$. Thus, the results of the tests of group mean differences are reported without licensure status as a covariate.

Descriptive statistics for client demographics by condition are presented in Table 3. Preliminary statistics showed that the two groups (training and delayed-training) were equivalent in terms of client factors likely to influence the outcome variables. Chi-square analyses showed no significant differences between the groups in number of clients with minority status, $\chi^2(1, N = 56) = 0.03, p = .56$, or in number of clients with a severe diagnosis, $\chi^2(1, N = 57) = 0.003, p = .63$. One-way ANOVAs indicated no significant difference in GAF scores between the training condition ($M = 53.52, SD = 6.25$) and the delayed-training condition ($M = 53.00, SD = 5.56$), $F(1, 56) = .11, p = .74$, or in numbers of diagnoses between the training condition ($M = 2.00, SD = 0.96$) and the delayed-training condition ($M = 1.96, SD = 0.84$), $F(1, 56) = .02, p = .88$.

Group Differences in Use of Alliance Strategies, Alliance, and Engagement

It was hypothesized that the alliance workshop would help clinicians in the training group use more alliance-fostering strategies and build stronger alliances with

their clients, and that their clients would in turn show better engagement in treatment, compared to the delayed-training group. Contrary to hypotheses, no statistically significant differences were found between the training and delayed-training conditions, though effect size estimates showed small to medium effects for some variables (results are summarized in Table 4 and explained below).

Alliance Strategies. One-way ANOVAs revealed no significant differences in (a) number of alliance strategies used between the training group ($M = 4.17$, $SD = 1.67$) and the delayed-training group ($M = 4.89$, $SD = 2.13$), $F(1, 56) = 2.03$, $p = .16$, $d = 0.38$ (small effect size), 95% CI [-.15, .90]; (b) sum of impact scores from the alliance strategies used between the training group ($M = 7.21$, $SD = 3.45$) and the delayed-training group ($M = 8.43$, $SD = 4.93$), $F(1, 56) = 1.18$, $p = .28$, $d = 0.29$ (small effect size), 95% CI [-.24, .81]; and (c) average impact scores from the alliance strategies used between the training group ($M = 1.81$, $SD = 0.59$) and the delayed-training group ($M = 1.73$, $SD = 0.75$), $F(1, 56) = 0.17$, $p = .69$, $d = 0.12$ (negligible effect size), 95% CI [-0.40, 0.64]. These tests of group mean differences were repeated with recoded variables, using only Strategies 1, 2, 3, 7, and 8, which reflect the skills needed to *build an early alliance* (Strategies 4, 5, and 6 focus on *repairing* problems in the therapeutic alliance which may not have been relevant in Session 1), but no significant differences were indicated.

Alliance. A one-way ANOVA revealed no significant difference in total alliance scores between the training group ($M = 61.07$, $SD = 10.89$) and the delayed-training group ($M = 59.67$, $SD = 10.96$), $F(1, 55) = 0.23$, $p = .63$, $d = 0.40$ (small to medium effect size), 95% CI [-0.13, 0.93].

Engagement. A one-way ANOVA indicated no significant difference in number of sessions attended by clients between the training group ($M = 2.76$, $SD = 1.09$) and the delayed-training group ($M = 3.0$, $SD = 1.02$), $F(1, 56) = 0.75$, $p = .39$, $d = 0.23$ (small effect size), 95% CI [-.30, .75]. Chi-square analyses showed no differences between the training and delayed-training groups in (a) session 1 treatment plan, $\chi^2(1, N = 57) = 0.13$, $p = .52$, $\phi = .05$; (b) attendance rate, $\chi^2(1, N = 57) = 0.43$, $p = .35$, $\phi = .09$; and (c) treatment status, $\chi^2(1, N = 57) = 2.03$, $p = .13$, $\phi = .19$. These three Chi-square analyses showed negligible effect sizes.

Secondary Analyses

As the final step, the bivariate relationships among study variables were examined across the two groups (see Table 5). Significant correlations were revealed between therapists' use of alliance strategies and alliance quality; the correlation between sum of alliance impact scores and alliance was .30 ($p = .025$), while the correlation between average alliance impact score and alliance was .59 ($p = .000$).

One of the correlations between therapists' use of alliance strategies and client engagement was noteworthy (albeit not significant at the .05 level); the correlation between sum of alliance impact scores and sessions attended was .25 ($p = .06$).

CHAPTER IV

DISCUSSION

This study examined the effect of training therapists in alliance-fostering strategies on their use of alliance techniques, their perception of early alliance quality, and their clients' early engagement in psychotherapy. Counter to hypotheses, no statistically significant differences were found between the training and delayed-training groups in terms of alliance strategies used, alliance quality, or client engagement. However, based on descriptive statistics and between-group effect size estimates, a small to medium effect was found favoring the training condition with respect to therapist-reported alliance quality. Counter to expectation, though, small effects favored the delayed-training condition with respect to number of alliance strategies used, perceived impact of the alliance strategies, and number of sessions attended by clients. Because they were generally small according to Cohen's (1988) criteria, and their confidence intervals were wide (and included zero), the effect sizes should be interpreted cautiously. Further, the small sample raises the possibility of spurious findings for both the effect sizes and inferential findings. That being said, I offer several possible, though necessarily speculative, explanations for the results.

Regarding the use and impact of alliance strategies, it may be that the clinicians in the two groups had different reference points. Specifically, the trained clinicians may have reported using fewer strategies (and with lower impact scores) because they were measuring their own in-session behavior against a higher standard after having participated in the alliance workshop. In addition, the measurement of alliance strategies may have been inaccurate; some clinicians seemed unsure of how to use the

questionnaire, e.g., indicating use of a strategy without rating its impact or rating an impact without checking the box for that particular strategy. Nevertheless, as hypothesized, effect size estimates showed that the clinicians in the training condition reported better alliances with their clients.

Regarding client engagement, it may be that clinicians who had already participated in the training were more eager or anxious to show that the workshop had improved their skills and, paradoxically, they may have acted in ways that actually impeded their clients' engagement. For example, a therapist who had participated in the workshop might be preoccupied with applying the strategies he or she had learned, and might in the process fail to connect with the client in a genuine manner. Alternatively, the measurement of engagement may have been inaccurate; many clinicians returned the engagement forms weeks or months after last contact with the client, raising the possibility that their reports of attended vs. missed sessions may have been imprecise. In addition, clinicians were asked to report on the status of treatment at the end of week 4 (that is, at a particular point in time); however, it was difficult for many to recall where things stood with the client exactly at that time, especially because the client may later have begun to engage in treatment or alternatively may have dropped out.

Although the planned tests of mediation were not conducted given the lack of group differences in client engagement, significant bivariate correlations were found between two conceptualizations of therapists' use of alliance strategies and alliance quality. Although caution is warranted because therapists rated both of these variables (increasing the likelihood of shared method variance or a 'halo effect'), these results are of interest from a hypothesis-generating point of view. In addition, one noteworthy

correlation was found between therapists' use of alliance strategies and client engagement (number of sessions attended). Although this correlation was smaller and not statistically significant, it may be said to carry more weight (from a hypothesis-generation standpoint) because therapists rated their own use of alliance strategies, but had no direct influence over this particular index of client engagement. The lack of association between the therapist-rated alliance quality and all four measures of client engagement may be explained in part by previous studies showing that therapists tend to overestimate the quality of the therapeutic alliance they have with clients (suggested by the low correlations with therapist-rated alliance and outcome), while *client* ratings of the alliance tend to show stronger associations with outcomes (Horvath & Bedi, 2002).

In addition to the limitations in sample size, intervention efficacy, and measurement accuracy, the lack of support for study hypotheses may be attributable to certain limitations in ecological validity, as the accoutrements of scientific investigation may have adversely affected the validity of the findings. Specifically, the study features detracting from its external validity included the randomization of therapists to experimental vs. control group (though clinicians knew that the workshops were identical), the monetary incentive for participating in the workshop, the requirement to complete study paperwork, the phone calls from the project coordinator reminding clinicians to complete the forms following session 1 and to track client engagement weeks 1-4, and the monetary incentive for returning the questionnaires. Additional factors detracting from the study's findings include the compromises made to the randomization procedures and the fact that unlicensed clinicians were not equally distributed between the two groups.

Despite these limitations, the study had significant strengths in terms of external validity. Most importantly, the sample of clinicians and clients were representative of the populations in community mental health clinics; most of the therapists had a masters-level education and the clients presented with a mix of psychiatric conditions including the entire range of adjustment difficulties, anxiety disorders, mood disturbance, substance use, personality disorders, and psychosis. In contrast, previous studies have used university laboratory-based designs with doctoral-level or graduate student therapists, strict patient exclusion criteria, and nonrepresentative patient samples. Furthermore, the alliance-building skills taught in the workshop were techniques with a high likelihood of being implemented by clinicians seeing clients for open-ended psychotherapy in naturalistic settings. In contrast, previous studies have examined the use of treatment manuals (in the context of time-limited therapy) less likely to be adopted in clinical practice.

In addition to the preliminary efficacy findings, the present study generated important information about the opportunities and challenges of conducting psychotherapy research in community mental health clinics. Such feasibility information will help facilitate possible replication and adaptation in future studies.

The successful completion of the study required access to five clinics across three large agencies. Gaining such access was due in large measure to the existing relationships that I had with the clinic managers prior to the study. I had connections at two of the three agencies by virtue of having worked at them as a part-time employee and practicum student. To begin a research collaboration, I contacted the director of clinical services and the manager of the outpatient clinic of one of the agencies (ServiceNet) to see if they had

questions about clinical practice around which a study could be designed, if they wanted to design a project collaboratively, and/or if they were interested in the study I proposed about implementing a training for clinicians in how to build stronger working relationships with clients. The large waste of resources from clients who fail to properly engage in treatment was an important reason the clinic administrators agreed to the proposed project. I had connections at the second agency (Cooley-Dickinson Hospital) as well, having worked as a practicum student in the outpatient clinic. I approached the clinic manager (my former clinical supervisor), who felt the study fit well with the quality improvement efforts they were implementing already. I had a remote connection at the third agency (Clinical and Support Options), having interviewed for a practicum position with the director of outpatient services. This director gave her blessings for the project, and encouraged the clinic managers at the two outpatient clinics to participate. I then contacted the two clinic managers by email and visited in person. Although both were interested in participating, only one followed through with the efforts to advertise the study to therapists.

My existing relationships with agency directors and clinic managers greatly facilitated the process; however, establishing new relationships was feasible as well, in part because the workshop topic was important to the clinicians, the study had potential to decrease no-shows and drop-outs, and the research questions had relevance for clinical practice. Ultimately, the buy-in from the administrators at the top was crucial. It gave the project credibility during the recruitment phase because therapists knew that the managers supported it. The buy-in also facilitated the data collection phase because administrative staff members had to be called on many times to assist with practical

matters. Getting the clinic managers' input on study procedures was also helpful, especially regarding therapist time and effort, client records and privacy, etc. Finally, the director of clinical services at one of the agencies offered to cover half of the catering expenses for the Time 1 workshops.

For future studies, researchers hoping to gain access to the rich data of clinical settings should seek to establish long-term, collaborative relationships starting with organization administrators. They should offer to apply their expertise and resources (statistical know-how, research assistants, etc.) to questions of direct relevance to directors, managers, and clinicians alike (see also practice-research network proposals, e.g., Borkovec, 2004; Borkovec, Echemendia, Ragusea, & Ruiz, 2001).

Choosing a study design was an exercise in balancing concerns about internal validity and external validity. In addition, the therapists at the clinics were not used to the accoutrements of science, so study procedures had to be kept as unobtrusive as possible. In the end, the pros and cons of four different designs were considered: Design 1 involved training all therapists who signed up to participate and comparing their clients' engagement with a matched sample of therapists with similar levels of education and experience. The drawbacks of this design included a strong selection bias and the limited data available from standard medical records with relevance for the study (medical records typically include data only on number of sessions attended by clients). Design 2 involved gathering pre-test and post-test data from each therapist who signed up. The potential drawbacks of this design included the fact that therapy attendance is known to vary over time depending on season, weather, and holidays, which could affect the pre-post comparisons. Design 3 involved randomizing therapists to an experimental group

(the workshop) or a control group (no workshop), but it was deemed unlikely that therapists would sign up and complete the paperwork knowing that they might not receive the training. In the end, a fourth design was selected, with the previously noted benefits of random assignment. Although this study focused solely on between group comparisons, it is also possible to include a within-subjects component whereby the delayed-training participants are followed for their first client post-training. These therapists would then have data both pre- and post-training, which would allow them to serve as their own controls in within-group comparisons. The between-group component of this design proved highly feasible. The therapists seemed comfortable with the randomization procedure, likely in part because of the clear explanations in the recruitment materials. The Time 1 workshops were scheduled before recruitment began, so therapists knew that they could choose one of three specified dates if assigned to Time 1. It was made clear that the Time 2 workshops would be offered on at least 3 to 4 different dates to accommodate the therapists assigned to Time 2. At one of the agencies, the two workshops were arranged to be part of the clinic's regular in-service training series, so both workshops were scheduled for a date and time that therapists already had set aside for trainings.

The study recruitment efforts were relatively successful, although the final number of therapists enrolled was lower than the initial target sample. The recruitment process seemed to be facilitated by the colorful and detailed materials that explained the study procedures. The continuing education credits and the \$30 incentive seemed to encourage therapists to sign up, and great efforts were made to secure CE credits for therapists with different types of licenses (social workers, mental health counselors,

marriage and family therapists, substance abuse counselors, and psychologists). The materials highlighted that the workshops for two of the agencies were to be held at a restaurant where many of the therapists had previously attended in-service trainings, conveniently located within walking distance of the main clinic; at the third agency, the trainings were held at the clinic itself. To highlight the clinic managers' endorsement of the project, all recruitment materials included the names of the managers. In addition to the printed recruitment materials, the clinic managers' face-to-face announcements during meetings and my follow-up phone calls to the therapists also likely contributed to the successful recruitment. Finally, the consent form emphasized that no study-related information would be shared with clinic managers or affect therapists' job performance evaluations. It emphasized that clients would not be asked to provide any information for the study and would remain unaware that the therapist was participating in the project. Based on my prior involvement with social service agencies, I speculated that fewer therapists would participate if their clients were required to complete study paperwork. However, given the immense scientific value of client process and outcome data, future work of this kind should attempt to include client data (especially given adequate time and financial resources, which were not abundantly available for the current project).

To make the randomization process as palatable as possible for therapists, I made a point of randomizing and notifying therapists of their condition as soon as possible after they signed up to participate. Thus, therapists knew quickly when they would be attending the workshop, and had few questions about the procedures. These recruitment and randomization strategies will likely prove effective in future studies as well. As described above, some therapists compromised the randomization process by self-

assigning to conditions, requesting to be switched to the opposite condition, and/or (in the case of one of three agencies) being semi-randomly assigned to conditions by the clinic manager. Although allowing for this flexibility created good-will and had the benefits of speed and convenience (and thus increased sample size), these compromises represented an important limitation of the study. In future studies, researchers may limit such problems by keeping the randomization process centralized and recruiting a larger sample so that therapists not fully agreeing to be randomized or to the randomization results can be excluded.

In designing the intervention, the duration of the workshop was considered carefully. It was necessary to design an intervention substantial enough to have an effect, but it was likely that fewer therapists would sign up for a workshop requiring them to miss work a full day or multiple days. The 3-hour workshop was deemed an acceptable compromise. To enhance the chance of the workshop having an effect, therapists were given three handouts summarizing the alliance strategies taught in the workshop, and encouraged to keep the handouts in a folder provided to them and to review the strategies before meeting with their next new client. To ensure good attendance, I called therapists with a reminder 1-2 days prior to their assigned workshop. As a result, workshop attendance was excellent at Time 1 (only one therapist no-showed) and good at Time 2 (two therapists no-showed and two therapists canceled because of illness). Although adherence to the workshop agenda was not assessed formally with adherence checks, the detailed nature of the agenda (specifying content to be covered in segments as short as five minutes) allowed us to standardize the workshops across time and to implement the intervention with good to excellent fidelity. Overall, the evaluations of the workshop

completed by the therapists were extremely positive. Nevertheless, the workshop may have been too short to produce the hypothesized effect, especially given the large gap in time between the workshop and the next new client for some clinicians (from one week to 2½ months), and future studies should be designed to address such concerns.

Operationalizing and designing the measure of therapist use of alliance strategies proved difficult for several reasons. First, it is possible that the measure created for this study confounded the use of alliance *building* strategies (strategies 1, 2, 3, 7, and 8) and alliance *repairing* strategies (strategies 4, 5, and 6). Given that session 1 usually involves mostly information gathering and empathic reflection, it is possible that the alliance repair strategies were less relevant for the session 1 measurement; some therapists in fact rated these strategies “not applicable.” Although the analysis with the recoded variable (using only the five alliance building strategies) showed no effect, future studies should take steps to operationalize and measure this construct carefully. Second, some therapists voiced concern that they have little time in session 1 to attend to the therapeutic relationship given the pressure to gather information and complete paperwork. It was nevertheless decided to keep the measurement at session 1 because the client’s return for a second session was not guaranteed. Third, as discussed above, some therapists seemed confused about how to use the form to rate strategies and impacts. In future studies, clearer instructions may ameliorate these problems.

Measuring the quality of the alliance was difficult for several reasons. As noted above, session 1 is at some clinics spent gathering information and completing paperwork, leaving little room for developing an alliance. In addition, a few therapists voiced concern that some of the questions on the WAI assume that therapy has been

proceeding for a while, e.g., “Client and I feel confident about our current activity in therapy,” “Client believes the way we are working with his/her problem is correct,” and “Client and I have built a mutual trust.” Some therapists responded “not yet” and “not applicable” to these questions despite the instructions to apply the questions to the session 1 interaction. In future studies it may be important to distinguish between session 1 intakes and session 1 therapy sessions, or measure the alliance across multiple sessions.

Operationalizing and measuring client engagement proved exceedingly difficult. The complexity of the construct required therapists to keep track of detailed information, yet the measure had to be quick and easy to complete, and could not discourage therapists from returning the forms even if incomplete. The measure created for the study asked therapists to report on client attendance, lateness, cancellations, and no-shows, as well as the client’s degree of responsibility for arriving late or missing sessions. However, only a few therapists provided this level of detail; most simply indicated that client had attended on a given date without specifying if sessions had been cancelled, rescheduled, or missed since the last attended appointment. Thus, it was possible to calculate only the number of sessions attended, not the planned indices of lateness, cancellations, and no-shows weighted by client responsibility. Furthermore, it proved impossible to track sessions missed due to therapist’s illness or vacation.

The number of sessions attended in the first four weeks of treatment proved to be an incomplete measure of client engagement in part because it penalizes highly engaged clients whose treatment plan is to meet every other week (either because of less acute need or clinic policies); therefore, it was decided to create the attendance rate variable. However, measuring attendance rate was complicated by the fact that this number is a

ratio of sessions attended and sessions planned, and it was in some cases difficult to determine the denominator since the planned frequency of sessions changed over time. For example, a client and therapist may initially plan to meet weekly, but subsequently change the treatment plan to meeting monthly. For these reasons, it was decided to use the treatment plan decided on in session 1 as the denominator of attendance rate (and as an independent indicator of engagement). One drawback was the uniformly high attendance rates (only a few clients had rates below 100%) and in future studies researchers may consider increasing the treatment period from four to six weeks in order to capture more variability.

Finally, assessing the treatment status at the end of week 4 was complicated, as therapists were required to report on the state of affairs at a particular point in time. As noted above, the project coordinator called therapists and reminded them to return the form around four weeks after session 1, but for many therapists who returned the forms late it was difficult to recall where things stood with the client exactly at that time, especially considering that the client may later have begun to engage in treatment or may have dropped out. In addition, it was occasionally unclear why the client had terminated; for example, moving out of the area likely had no relation to the therapy, while a decision to transfer to a different therapist may or may not have reflected problems in the alliance with the study therapist. Furthermore, determining whether client and therapist truly agreed to terminate or transfer was extremely difficult. In the end, the four engagement variables of the study were not uniformly highly correlated, suggesting that they measured different aspects of the construct. In future studies, researchers should employ user-friendly forms to gather as detailed information as possible while not discouraging

therapists from returning incomplete paperwork. The measurement of engagement has long been elusive in psychotherapy research, and optimal standards await further development and empirical scrutiny.

Several obstacles complicated the process of collecting data on therapist and client demographics. First, therapist reports of education, license, and years of experience were occasionally unclear, given that many therapists held multiple degrees and multiple licenses (e.g., licensed first in another state and later in Massachusetts, or licensed at different levels such as LCSW and LICSW). The self-reported ‘years of experience in clinical practice since highest degree’ was clearly not comparable across therapists in many cases. For example, one therapist had earned a master’s degree, practiced full-time for 15 years, and earned a doctorate degree, but only practiced one year since her highest degree; another therapist had earned a bachelor’s degree and practiced for five years, but only part-time, since her highest degree. In future studies, researchers may benefit from knowing the year of each degree and each license held by therapists, as well as asking therapists to report on the number of fulltime-equivalent years in clinical practice since completing bachelor-level studies.

The successful data collection evidenced by high response rates and few missing data was attributable in large part to (a) the diligent efforts of the project coordinator who used a detailed tracking system and followed up with therapists frequently, (b) the drop boxes with extra forms (in case therapists lost the paperwork) conveniently located in clinic mailrooms, and (c) my personal follow-up letters and phone calls to encourage the last clinicians to return missing forms. The project coordinator’s detailed tracking prevented confusion even when new clients assigned to study therapists no-showed for

session 1 and therapists had to be assigned a new client (up to four times). Administrative and clinical staff at the clinics showed good adherence to data collection procedures likely because of simple and clear instructions; as a result, only a few misunderstandings ensued about client eligibility.

As noted above, the Time 2 workshops had to be postponed one month to allow more therapists to complete the questionnaires, in part because therapists took on new clients less frequently than anticipated. In addition, some participating therapists worked only with out-reach clients, and the clinic manager reported that some of them felt pressured to take on an in-office client, with unknown effects on the working relationship. Thus, not all 87 clinicians were able to take on new clients within the study period, and the small sample size of 57 was an important study limitation. In future studies, the study period could be expanded and therapists could be given incentives to take on an additional client, though such incentives could detract from ecological validity and complicate the development of the therapeutic relationship.

The study was feasible from a financial perspective, but additional funding may have allowed for a larger sample size and an expanded data collection (including a within-group pre-post component). Overall, the feasibility of the design, intervention, measures, and procedures used in the study showed promise for a larger-scale implementation, especially if funding were secured.

The study has important implications for training. The continuing education workshop format is commonly used in the mental health profession, but an important empirical question is whether it in fact improves practice. The assumption is that trainings help therapists update existing skills and learn new ones, but it remains unclear

if one-time workshops are sufficient to make a difference, or if perhaps only in-depth or ongoing trainings have an impact (or if perhaps ongoing supervision is more likely to help therapists grow). In addition, regarding the questions examined in this study, it may be that it is not possible to train therapists in the specific behaviors typically associated with positive therapy process and outcomes; in other words, it may be that only natural and spontaneous behaviors promote an authentically positive relationship. Taking this idea one step further, the degree to which good therapists are born, not made, is unknown.

In summary, the hypotheses of the study were not supported by the null hypothesis significance tests, and analyses found some effects in the opposite than expected direction. In support of hypotheses, there was a small to medium effect for clinicians in the training condition reporting better alliances with their clients than clinicians in the delayed-training group, as well as two significant correlations between therapists' use of alliance strategies and alliance quality. In addition to these preliminary efficacy findings, the study generated important information about the feasibility of conducting psychotherapy research in naturalistic settings, as well as recommendations for future studies. Overall, the type of training condition design employed in the study holds promise for collaborations between researchers and clinicians seeking to bridge science and practice.

Table 1

Intercorrelation Matrix of Working Alliance Inventory (WAI) Scores (n = 56)

	1.	2.	3.	4.
WAI total score	1			
WAI bond subscale score	.895	1		
WAI tasks subscale score	.961	.812	1	
WAI goals subscale score	.900	.670	.818	1

Table 2

Therapist Demographics by Condition

	Training n = 29				Delayed-Training n = 28			
Continuous Variables	<i>M</i>	<i>SD</i>	Min	Max	<i>M</i>	<i>SD</i>	Min	Max
Age	45.58	16.00	23	77	45.60	11.05	25	65
Years of Experience ^a	11.52	11.72	1	42	12.78	8.81	1	30
Categorical Variables	n	%			n	%		
Women	23	79			25	89		
Men	6	21			3	11		
Caucasian	29	100			25	89		
African-American	0	0			2	7		
Other	0	0			1	4		
Education Level ^b								
Bachelor's Degree	1	3			1	4		
Master's Degree	22	76			24	85		
Doctorate Degree	6	21			3	11		
Licensure Status ^c								
Licensed	21	72			26	93		
Unlicensed	8	28			2	7		

Note. Numbers may not add to 29 and 28 because of missing data. Percentages may not add to 100% due to rounding.

^a No difference between groups (ANOVA). ^b No difference between groups (chi-square).

^c Significant difference between groups (chi-square).

Table 3

Client Demographics by Condition

Continuous Variables	Training n = 29				Delayed-Training n = 28			
	<i>M</i>	<i>SD</i>	Min	Max	<i>M</i>	<i>SD</i>	Min	Max
Age	40.25	12.57	18	60	35.39	12.17	18	61
GAF ^a	53.52	6.25	40	65	53.00	5.56	42	61
Number of Diagnoses ^a	2.00	0.96	1	6	1.96	0.84	1	5
Categorical Variables	n		%		n		%	
Women	19		66		17		61	
Men	10		34		11		39	
Caucasian	22		76		22		78	
African-American	3		10		1		4	
Hispanic	3		10		4		14	
Other	1		4		1		4	
Minority Race ^b	7		24		6		21	
Severe Diagnosis ^b	4		14		4		14	

Note. Numbers may not add to 29 and 28 because of missing data. Percentages may not add to 100% due to rounding. GAF = Global Assessment of Functioning; Minority Race = Non-Caucasian race; Severe diagnosis = A psychotic disorder or bipolar I disorder with or without psychotic features.

^a No difference between groups (ANOVA). ^b No difference between groups (chi-square).

Table 4

Main Study Variables by Condition

	Training n = 29				Delayed-Training n = 28				Group Differences	
Continuous Variables	<i>M</i>	<i>SD</i>	Min	Max	<i>M</i>	<i>SD</i>	Min	Max	<i>F</i>	<i>d</i>
Alliance Strategies										
Number of Alliance Strategies	4.17	1.67	1	8	4.89	2.13	1	8	2.03	0.38
Sum of Impact Ratings	7.21	3.45	2	15	8.43	4.9	0	20	1.18	0.29
Average Impact Rating	1.81	0.59	0.38	2.50	1.73	0.75	0.00	3.00	0.17	0.12
Working Alliance	61.07	10.89	41	82	59.67	10.96	30	80	0.23	0.40
Client Engagement (Sessions Attended)	2.76	1.09	1	4	3.00	1.02	1	4	0.75	0.23
Categorical Variables										
		n				n			χ^2	ϕ
Client Engagement										
Session 1 Tx Plan:	Weekly Tx	25				25			0.13	.05
	Less Than Weekly Tx	4				3				
Attendance Rate:	100%	12				14			0.43	.09
	Less Than 100%	17				14				
Treatment Status:	Clearly Engaged	19				23			2.03	.19
	Not Clearly Engaged	10				5				

Table 5

Intercorrelation Matrix of Main Study Variables

Variables	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Treatment (training vs. delayed-training)	1 n = 57								
2. Number of alliance strategies used	.19 n = 57	1 n = 57							
3. Sum of impact scores from alliance strategies used	.15 n = 57	.64** n = 57	1 n = 57						
4. Average impact score from alliance strategies used	-.06 n = 57	-.17 n = 57	.57** n = 57	1 n = 57					
5. Working Alliance Inventory total score	-.07 n = 56	-.21 n = 56	.30* n = 56	.59** n = 56	1 n = 56				
6. Number of sessions in first 4 weeks	.12 n = 57	.14 n = 57	.25 n = 57	.21 n = 57	-.08 n = 56	1 n = 57			
7. Treatment plan decided on in session 1	-.04 n = 57	-.08 n = 57	-.06 n = 57	-.00 n = 57	-.08 n = 56	.31* n = 57	1 n = 57		
8. Attendance rate	.08 n = 57	.14 n = 57	.18 n = 57	.09 n = 57	-.10 n = 56	.91** n = 57	.07 n = 57	1 n = 57	
9. Treatment status at the end of the first 4 weeks	.06 n = 55	.02 n = 55	.00 n = 55	-.03 n = 55	-.14 n = 54	.63** n = 55	.36** n = 55	.61** n = 55	1 n = 55

Note. * $p < .05$, two-tailed. ** $p < .01$, two-tailed.

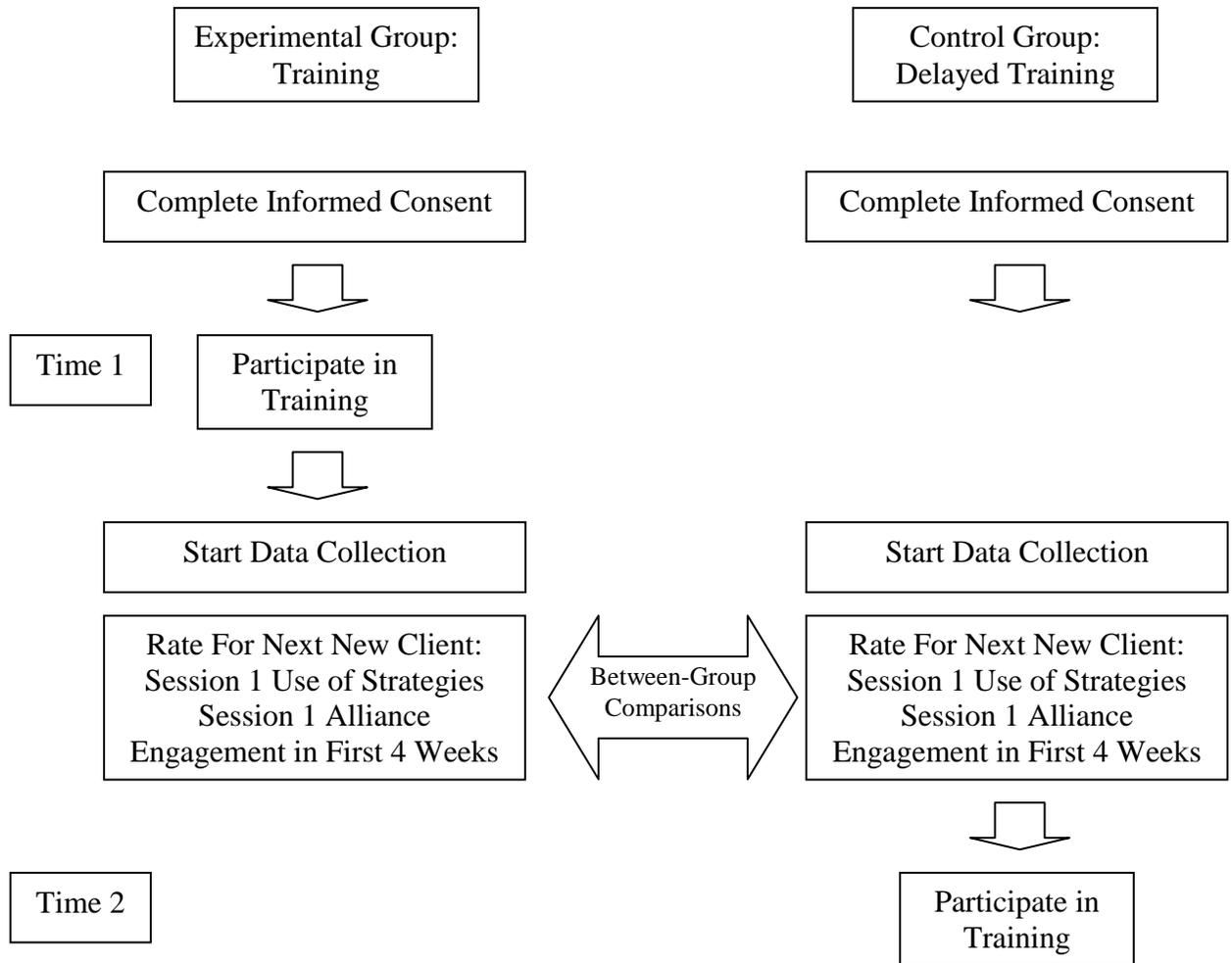


Figure 1. Chart of Data Collection and Analysis.

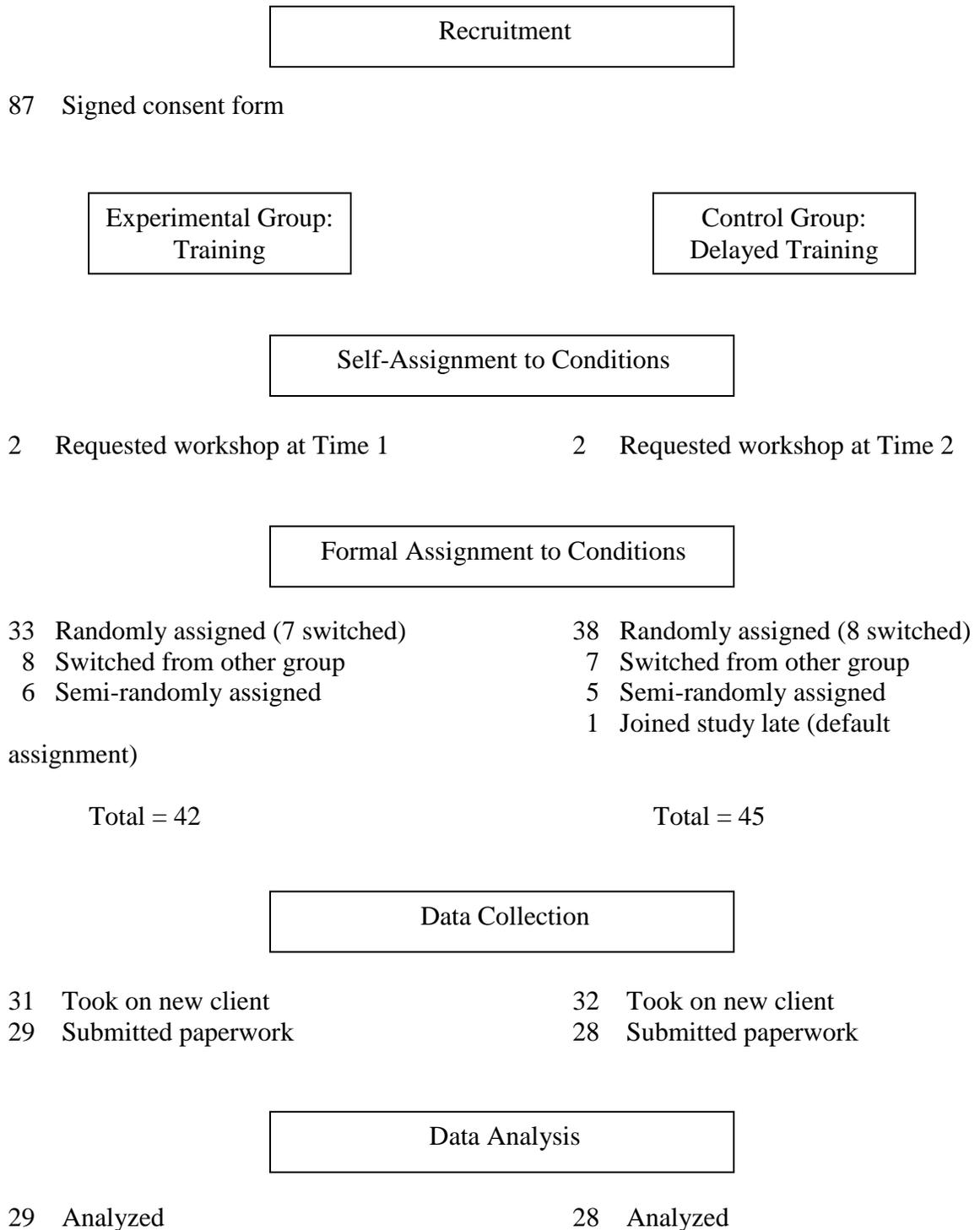


Figure 2. Participant Flow Through Each Study Stage.

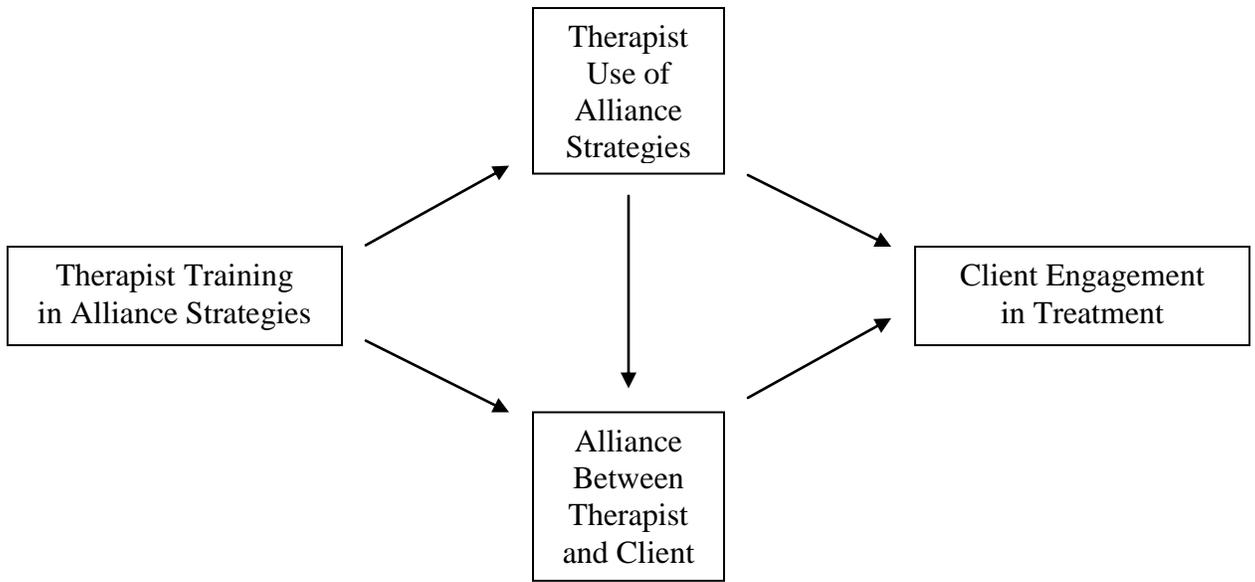


Figure 3. Hypothesized Mediational Relationships Among Variables.

APPENDICES

APPENDIX A
THERAPIST DEMOGRAPHICS FORM

Therapist Demographics Form

Personal Information

Name: _____

Gender: M F Transgender

Age: _____

Race/Ethnicity: _____

Highest Degree: _____

Year of Degree: _____

Type of License: _____

Year of License: _____

Years of experience in clinical practice since degree: _____

Theoretical Orientation

How much is your current clinical practice guided by each of the following theoretical frameworks?

	Not at all					Very Much						
Psychoanalytic/Psychodynamic	0	1	2	3	4	5	0	1	2	3	4	5
Behavioral	0	1	2	3	4	5	0	1	2	3	4	5
Cognitive	0	1	2	3	4	5	0	1	2	3	4	5
Humanistic/Experiential	0	1	2	3	4	5	0	1	2	3	4	5
Systems Theory	0	1	2	3	4	5	0	1	2	3	4	5
Other:	0	1	2	3	4	5	0	1	2	3	4	5

Please describe your theoretical orientation:

To what extent do you regard your orientation as Eclectic/Integrative?

0 1 2 3 4 5

APPENDIX B
CLIENT DEMOGRAPHICS FORM

Client Form
Session 1

Client Initials _____

- Referral Source**
- Self
 - Family/Spouse/Partner/Friend
 - Health Professional
 - Court Ordered/Mandated

Age _____

Gender _____

**Race/
Ethnicity** _____

Diagnoses

Primary _____

Secondary _____

Rule-Out _____

Make your best guess, and include provisional and rule-out diagnoses

Global Assessment of Functioning (GAF) _____

Consult the criteria on the back of this form, if needed, and make your best guess

Please put your completed form in the drop box in the mailroom

APPENDIX C
THERAPIST USE OF ALLIANCE STRATEGIES

Alliance-Building Strategies

Session 1

Instructions: On the left, please indicate if you used any of the specific alliance-building strategies listed. You may or may not have used these strategies, and you may have used other effective interventions, but please check the boxes on the left only if you used that specific strategy. On the right, indicate how well each intervention was received by your client.

	-3 Negative impact	0 Neutral	+ 3 Positive impact
Strategies I used			What the impact was
<input type="checkbox"/> I engaged my client in a conversation about the tasks and goals of therapy (what we will do in sessions and what we will try to accomplish)	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I communicated empathy for my client’s suffering, and expressed positive regard for him/her as a person, even if I disapproved of certain attitudes or behaviors	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I spoke directly with my client about how we communicated during the session	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I invited my client to voice his or her concerns and reservations at times when he/she seemed to be withdrawing, passively complying, or just going along during the session	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I explored and validated any negative sentiments my client expressed about therapy or about me	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I took responsibility for my contribution to any difficulties we had in relating to each other, e.g., misunderstandings, mistakes, pursuing my agenda, having my own limitations	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I reached out specifically in the service of trying to help my client truly engage in the session	-3	-2	-1 0 +1 +2 +3
<input type="checkbox"/> I asked my client for feedback about today’s session	-3	-2	-1 0 +1 +2 +3

Please put your completed form in the drop box in the mailroom

APPENDIX D
WORKING ALLIANCE INVENTORY – THERAPIST VERSION

Working Alliance Inventory

Session 1

Instructions: Below are some sentences that describe some of the different ways a therapist might think or feel about his or her client. Please complete these ratings in terms of your experience with your client during the session. As you read the sentences, mentally insert the name of your client in place of the _____. Work fast; your first impressions are the ones we want to see.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

We understand that it may be difficult to complete this form after only one session (especially if it was an intake and you were required to gather information and fill out paperwork), but please do your best, and try to apply the questions to your interaction with your client today.

- _____ 1. _____ and I agree about the things I will need to do in therapy to help improve his/her situation
- _____ 2. _____ and I both feel confident about the usefulness of our current activity in therapy
- _____ 3. I believe _____ likes me
- _____ 4. I have doubts about what we are trying to accomplish in therapy
- _____ 5. I am confident in my ability to help _____
- _____ 6. We are working on mutually agreed upon goals
- _____ 7. I appreciate _____ as a person
- _____ 8. We agree on what is important for _____ to work on
- _____ 9. _____ and I have built a mutual trust
- _____ 10. _____ and I have different ideas on what his/her real problems are
- _____ 11. We have established a good understanding between us of the kind of changes that would be good for _____
- _____ 12. _____ believes the way we are working with his/her problem is correct

APPENDIX E
CLIENT ENGAGEMENT FORMS

Therapy Attendance Form
Session 1

AFTER SESSION 1

When did you meet? _____ (date)

Did you schedule your next appointment?

yes no

Was your client late? yes no

If so, how responsible was he or she? Consider factors outside his/her control, e.g., relying on others for transportation, etc.
not at all responsible _____ to _____ completely responsible

0%	10	20	30	40	50	60	70	80	90	100%
----	----	----	----	----	----	----	----	----	----	------

How often do you plan to meet?

weekly twice weekly every other week as needed

What is your best assessment of your client's interest in continuing therapy (verbal/nonverbal signs)?

genuinely interested

mixed feelings

decided not to return, and told me explicitly

we agreed to not meet again

Please put your completed form in the drop box in the mailroom

APPENDIX E
CLIENT ENGAGEMENT FORMS

Therapy Attendance Form
Session 2

BETWEEN SESSION 1 AND 2													
Any changes to scheduled appointment?	How responsible was your client? Consider factors outside your client's control, e.g., relying on others for transportation												
date	e.g. client no-showed/rescheduled, I cancelled	not at all responsible								to	completely responsible		
		0%	10	20	30	40	50	60	70	80	90	100%	
		0%	10	20	30	40	50	60	70	80	90	100%	
		0%	10	20	30	40	50	60	70	80	90	100%	
		0%	10	20	30	40	50	60	70	80	90	100%	

AFTER SESSION 2											
<p>When did you meet? _____ (date)</p> <p>Did you schedule your next appointment? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>Was your client late? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If so, how responsible was he or she? Consider factors outside his/her control, e.g., relying on others for transportation, etc.</p> <p>not at all responsible _____ to _____ completely responsible</p> <p>0% 10 20 30 40 50 60 70 80 90 100%</p>										

How often do you plan to meet?

- weekly
 twice weekly
 every other week
 as needed

What is your best assessment of your client's interest in continuing therapy (verbal/nonverbal signs)?

- genuinely interested
 mixed feelings
 decided not to return, and told me explicitly
 we agreed to not meet again

Please put your completed form in the drop box in the mailroom after session 2

APPENDIX E
CLIENT ENGAGEMENT FORMS

Therapy Attendance Form
Session 3

BETWEEN SESSION 2 AND 3	
Any changes to scheduled appointment?	How responsible was your client? Consider factors outside your client's control, e.g., relying on others for transportation
date e.g. client no-showed/rescheduled, I cancelled	not at all responsible to completely responsible
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%

AFTER SESSION 3	
When did you meet? _____ (date)	Was your client late? <input type="checkbox"/> yes <input type="checkbox"/> no
Did you schedule your next appointment? <input type="checkbox"/> yes <input type="checkbox"/> no	If so, how responsible was he or she? Consider factors outside his/her control, e.g., relying on others for transportation, etc. not at all responsible to completely responsible
	0% 10 20 30 40 50 60 70 80 90 100%

How often do you plan to meet?

- weekly twice weekly every other week as needed

What is your best assessment of your client's interest in continuing therapy (verbal/nonverbal signs)?

- genuinely interested mixed feelings decided not to return, and told me explicitly we agreed to not meet again

Please put your completed form in the drop box in the mailroom after session 3

APPENDIX E
CLIENT ENGAGEMENT FORMS

Therapy Attendance Form
Session 4

BETWEEN SESSION 3 AND 4	
Any changes to scheduled appointment?	How responsible was your client? Consider factors outside your client's control, e.g., relying on others for transportation
date e.g. client no-showed/rescheduled, I cancelled	not at all responsible to completely responsible
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%
	0% 10 20 30 40 50 60 70 80 90 100%

AFTER SESSION 4	
When did you meet? _____ (date)	Was your client late? <input type="checkbox"/> yes <input type="checkbox"/> no
Did you schedule your next appointment? <input type="checkbox"/> yes <input type="checkbox"/> no	If so, how responsible was he or she? Consider factors outside his/her control, e.g., relying on others for transportation, etc. not at all responsible to completely responsible
	0% 10 20 30 40 50 60 70 80 90 100%

How often do you plan to meet?

- weekly twice weekly every other week as needed

What is your best assessment of your client's interest in continuing therapy (verbal/nonverbal signs)?

- genuinely interested mixed feelings decided not to return, and told me explicitly we agreed to not meet again

Please put your completed form in the drop box in the mailroom after session 4

- over -

APPENDIX E
CLIENT ENGAGEMENT FORMS

AFTER SESSION 4

or four weeks after Session 1 even if your client has not yet attended four sessions

Please check any that apply:

- Client and I agreed to terminate (no need, refer to a different provider, etc.)
- Client terminated unilaterally, and informed me in person, by phone, or through the front desk staff that he/she will not return.
- Client terminated unilaterally, did not notify me, and simply never returned.

Comments:

Please put your completed form in the drop box in the mailroom

APPENDIX F
RECRUITMENT MATERIALS

Flyer

[see scanned flyer in pdf file in Supplemental Files]

APPENDIX F RECRUITMENT MATERIALS

Who We Are



Hi everybody. My name is Lotte Smith-Hansen. I am a doctoral student in clinical psychology at UMass Amherst. I am inviting you to participate in a workshop as part of my dissertation project. I worked at the ServiceNet outpatient clinic in Northampton and at the Cooley-Dickinson Hospital clinic in Florence last year, so I know the difficult clients that you work with. I think the workshop will be really useful to you, so I hope you sign up to participate!

Hi, I am Anna Remen. I'm a psychologist at the ServiceNet outpatient clinic in Northampton. I'm so excited about Lotte's workshop that I am helping her to spread the word about it. I am also looking forward to co-facilitating the workshop with her. It will be really interactive and we've got some great videotaped sessions to show you. I encourage all clinicians to sign up because you will learn state-of-the-art techniques and have fun, too!



Hi, I'm Sandro Piselli. I'm a graduate student in clinical psychology at UMass Amherst. I am the project coordinator. If you sign up for the workshop, I will be in touch with friendly reminders about completing the questionnaires.

Hi, I am Chris Rose, manager of Cooley-Dickinson Hospital outpatient behavioral health services in Florence. I am most excited about the project's impact on the quality of patient care. And I think the workshop will offer many practical strategies for clinicians. So many resources are wasted when clients cancel, no-show or drop out prematurely.



Hi, I'm Mike Constantino. I'm an assistant professor in clinical psychology at UMass Amherst, and the chair of Lotte's dissertation committee. I am really happy to be part of this important project. As a psychotherapy researcher with a keen interest in the alliance, I can attest to the state-of-the-art quality of the workshop that Lotte and Anna have developed.

APPENDIX F
RECRUITMENT MATERIALS

How This Works

Dear Clinician,

How does this work? Here are the steps in the process:

1. Complete the little slip and put it in the mailroom dropbox to express your interest in the workshop.
2. We will put a consent form in your mailbox with additional information about the workshop and the project. Please sign the consent form and put it in the mailroom dropbox.
3. We will randomly assign you to either June or September, and invite you to participate in the workshop in either June or September.
4. You can sign up for the workshop that best suits your schedule. We will offer the workshop at 3-4 different dates and times in both June and September.
5. You will attend the 3-hour workshop, **get paid \$20, enjoy a free breakfast, and earn free CE credits**. Clinicians at Cooley-Dickinson Hospital and Clinical Support Options will get free CE credits through ServiceNet which is an approved Continuing Education provider.
6. You will **get paid \$5** to complete two brief questionnaires after session 1 with your next new client.
7. You will **get paid \$5** to complete a brief questionnaire four weeks after session 1.
8. You will be entered into a raffle to **win \$100** if you complete all of the above steps.

Please call us if you have any questions. We hope you sign up to participate!

Sincerely,

Lotte Smith-Hansen, MS, MA
(413) 559-1595

Anna Remen, Ph.D.
(413) 587-7548

APPENDIX G
EXPLANATION LETTERS

Dear Clinician,

We hope you enjoyed our workshop “Building a Therapeutic Alliance with Challenging Clients.”

Next steps:

We will be in touch over the summer when you are assigned your next new adult client. The client must be 18-65 years old, be seen in-office (no out-reach clients), and have no diagnosis of mental retardation. Jen will give you a folder with questionnaires when you are assigned a new client.

After session 1, you will receive \$5 for completing two brief questionnaires about the session.

You will receive another \$5 for completing a brief questionnaire about how therapy is proceeding with this client over the first four weeks of treatment. You can return the forms by putting them in the drop box in the mailroom.

At the completion of the study, you will receive a summary of the findings.

If you have any questions at this point, please contact Lotte by phone at (413) 559-1595 or by email at lotte@psych.umass.edu.

Thank you!

Lotte Smith-Hansen, MS, MA
(413) 559-1595

Anna Remen, PhD
(413) 587-7548

Susan Karas, LICSW
ServiceNet Integrated Human Services

Jennifer Jakowski, LICSW
Clinical and Support Options

APPENDIX G
EXPLANATION LETTERS

Dear Clinician,

Thank you for your interest in our workshop “Building a Therapeutic Alliance with Challenging Clients.”

You have been assigned to participate in the workshop in September.

This means that you will complete the questionnaires about a new client you begin working with over the summer before participating in the workshop in the fall.

Over the summer, we will be in touch when you are assigned your next new adult client. The client must be 18-65 years old, be seen in-office (no out-reach clients), and have no diagnosis of mental retardation. Jen will give you a folder with questionnaires when you are assigned a new client.

After session 1, you will receive \$5 for completing two brief questionnaires about the session. You will receive another \$5 for completing a brief questionnaire about how therapy is proceeding with this client over the first four weeks of treatment. You can return the forms by putting them in the drop box in the mailroom.

At the end of the summer, we will be in touch with a reminder about the workshop on Tuesday September 15 at 11am-2pm in the conference room. Please mark your calendar now.

You will earn 3.5 hours of free Continuing Education credits and receive \$20 for participating in the workshop. At the completion of the study, you will receive a summary of the findings.

If you have any questions at this point, please contact Lotte by phone at (413) 559-1595 or by email at lotte@psych.umass.edu.

Thank you!

Lotte Smith-Hansen, MS, MA
(413) 559-1595

Anna Remen, PhD
(413) 587-7548

Susan Karas, LICSW
ServiceNet Integrated Human Services

Jennifer Jakowski, LICSW
Clinical and Support Options

APPENDIX H CONSENT FORM

Consent Form for Participation in a Research Study University of Massachusetts-Amherst

Principal Investigator: Lotte Smith-Hansen, MS, MA, UMass Department of Psychology
Faculty Sponsor: Michael J. Constantino, PhD, UMass Department of Psychology
Clinic Sponsors: Susan Karas, LICSW, ServiceNet Outpatient Clinic
Chris Rose, PsyD, Behavioral Health Services of Cooley-Dickinson Hospital
Study Title: The Effects of a Therapist Workshop in Alliance-Building Strategies

1. WHAT IS THIS FORM?

This Consent Form will give you information about the study so you can make an informed decision about whether you want to participate. It describes why this study is being done, what you will need to do to participate, and any known risks, inconveniences or discomforts that you may have while participating. We encourage you to take some time to think this over and ask questions. If you decide to participate, you will be asked to sign this form and given a copy.

2. WHO IS ELIGIBLE TO PARTICIPATE?

All therapists working at the three ServiceNet outpatient clinics (Northampton, Greenfield, and Chicopee), at Cooley-Dickinson Hospital Outpatient Behavioral Health Services in Florence and Amherst, and at the Clinical Support Options clinics in Greenfield and Springfield are being invited to participate. We will exclude therapists working only with children or only with clients with mental retardation.

3. WHAT IS THE PURPOSE OF THIS STUDY?

We are conducting this research study to examine the effect of a workshop for therapists in strategies for building strong therapeutic relationships with clients. The strategies taught in the workshop are aimed at increasing client initial engagement in treatment.

4. WHEN AND WHERE WILL THE STUDY TAKE PLACE?

The study will be conducted at the outpatient mental health clinics of ServiceNet, Cooley-Dickinson Hospital, and Clinical Support Options during the spring and summer of 2009.

5. WHAT WILL I BE ASKED TO DO?

If you agree to participate in the study, you will be asked to attend a 3-hour workshop. You will be randomly assigned to attend the workshop either in June or in September. You will receive \$20 and free Continuing Education credits for attending. Whether you attend the early or the later training, it will be the same workshop, and you will earn the same amount of money and number of CE credits. Note: Continuing Education applications have been submitted. We anticipate that 3 hours of CE credits will be available for social workers, licensed mental health counselors (LMHCs), and psychologists. You will be notified of final approval status for the CE credits before the workshop.

As part of the study, you will also be asked to fill out three brief research questionnaires about your work with a new therapy client (a client that you begin therapy with after the study begins). If you are assigned to attend the workshop in June, you will complete these questionnaires for a client you begin working with *after* the workshop. If you are assigned to the later workshop, you will complete the questionnaires for a client over the summer, then participate in the workshop in September.

You will NOT be asked to take on any more clients than you would normally. As part of the study, you will work with your clinic to take on new clients the same way you do currently.

After session 1 with the new client, you will be asked to complete two brief questionnaires about the session, your interventions during the session, and your rapport with the client. We expect that it will take you approx. 5-10 minutes to complete them, and you will receive \$5 for your time.

Four weeks after session 1, you will be asked to complete another brief questionnaire about how therapy is proceeding with this client. We expect that it will take you approx. 5-10 minutes to complete it, and you will receive \$5 for your time. The study coordinator will put all questionnaires in your clinic mailbox, and contact you by phone and email to remind you to complete them. You will return the questionnaires in a box conveniently located at your clinic.

6. WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?

You may benefit from participating in several ways. As part of the study, you will 1) attend a free workshop on evidence-based strategies for building strong therapeutic relationships with clients, 2) learn strategies aimed at decreasing client cancellations, no-shows, and drop-outs, 3) attend the voluntary briefing about the findings at the end of the study, and 4) contribute to the advancement of scientific knowledge about the psychotherapy process.

7. WILL I RECEIVE ANY PAYMENT FOR PARTICIPATING?

As compensation for your time (attending the 3-hour workshop and completing the questionnaires), you will receive FREE Continuing Education credits and earn up to \$30. Specifically, you will receive \$20 after you attend the workshop. You will receive \$5 when you complete the questionnaires after session 1, and \$5 when you complete the questionnaire four weeks after session 1. In addition, if you complete all of these study requirements, you will be entered into a raffle to win \$100.

8. WHAT ARE THE RISKS OF BEING IN THIS STUDY?

We believe there are minimal risks associated with this research study. A possible inconvenience may be the time it takes to attend the workshop and complete the study questionnaires; therefore, we will compensate you for your time with the Continuing Education credits and money as described above.

9. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?

To protect your privacy and confidentiality, we will assign you a study # so that your name will not be on any of the questionnaires you complete. A master key linking study #s and names will be kept in a secure location and accessible only by the principal investigator and study coordinator, not research assistants or other individuals. No information from the questionnaires will become part of your client's medical record. No information from the study will be communicated to your supervisors and employers, and your participation in the study will in no way affect your job performance evaluations. The therapy sessions will not be audio- or videotaped. Thus, the study poses no risk of breach of confidentiality to you.

To protect your client's privacy and confidentiality, we will gather only the most necessary information about him or her. Specifically, when we contact you or your clinic to ascertain if you have been assigned a new client, we will ask only if this client meets any of our exclusion criteria (being under 18 or over 65, living at a residential program, or carrying a diagnosis of mental retardation). We will gather no identifying information about the client (such as name or medical record number), and will need to access no information in the client's medical records.

The questionnaires completed by you will remind you to not include the name of the client or any other identifying information. No information from the study will become part of the client's medical records. Your client will not be contacted or required to do anything as part of the study. Thus, the study poses no risk of breach of confidentiality to your client.

We will keep all study questionnaires in a secure, locked file cabinet in a locked office in Tobin Hall (Department of Psychology) on the University of Massachusetts-Amherst campus. The questionnaire data will be entered into an electronic file by research assistants (the paper sheets and the electronic files will contain no names, only each therapist's study #). A master key linking therapist names and study #s will be maintained in a separate and secure location, and only the principal investigator and the study coordinator will have access to any of your personal information. All electronic files will be password protected, as will any

computer hosting such files, in order to prevent access by unauthorized users. At the conclusion of this study, we may publish the findings, but information will be presented in summary format, and you and your client will not be identified in any way.

10. WHAT IF I HAVE QUESTIONS?

We will be happy to answer any questions you have. You may contact the principal investigator (Lotte Smith-Hansen, 413-559-1595) or the faculty sponsor (Michael J. Constantino, 413-545-1388) with any questions before you decide to participate. You may also contact them if you decide to participate and later have a question or problem.

If you have any questions concerning your rights as a research participant, you may contact Melinda Novak, chair of the Department of Psychology at the University of Massachusetts-Amherst, at (413) 545-5958 or by email at mnovak@psych.umass.edu, or the Human Research Protection Office at (413) 545-3428 or by email at humansubjects@ora.umass.edu.

11. CAN I STOP PARTICIPATING?

If you agree to participate, you may skip any question on the questionnaires that you do not wish to answer. If you agree to participate, but later change your mind, you may stop participating at any time. There are no penalties or consequences if you decide that you do not want to participate.

12. STATEMENT OF VOLUNTARY CONSENT

I have read this form and decided that I will participate in the project. The general purposes and particulars of the study, as well as possible hazards and inconveniences, have been explained to my satisfaction. I understand that I can withdraw at any time.

Participant Signature

Print Name

Date

By signing below, I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this consent form and has been given a copy.

Signature of Researcher

Print Name

Date

APPENDIX I WORKSHOP HAND-OUTS

Strategies for Building a Therapeutic Alliance

Adapted from Hilsenroth & Cromer (2007)

HELP YOUR CLIENT TALK, THINK AND FEEL

- ✓ At first, allow your client to take the lead and initiate discussion of salient topics, help him or her engage actively, and explore these issues; take a more active stance later
- ✓ Explore your client's lay explanation of his or her problems
- ✓ Facilitate your client's emotional experiencing in the session, and explore uncomfortable feelings

SET THE RELATIONSHIP TONE

- ✓ Adopt a client-centered, relational stance
- ✓ Be active and focused – don't be overly relaxed, casual, pleasant, or comfortable
- ✓ Adjust your style to meet your client's need for a nurturing, collaborative, or insight-oriented session, as client needs and preferences differ
- ✓ Explore the in-session affect and interactions between you and your client, and point out if a relational theme from his or her life is played out in the room

SEIZE THE MOMENT

- ✓ Facilitate an involved, in-depth, powerful, valuable, and special first session
- ✓ Listen actively and attentively, and let your client know you are listening

EMPATHY

- ✓ Try to understand the vulnerable emotions and motivations underlying your client's negative behaviors
- ✓ Communicate empathy for your client's suffering, and express positive regard for him or her as a person, even if you do not approve of his or her behaviors
- ✓ Convey attunement, understanding, warmth, respect, nonjudgment, liking, trustworthiness, support, competence, and confidence

GIVE THE CLIENT NEW AND USEFUL INFORMATION

- ✓ Don't give vague or superficial information about mental health problems in general
- ✓ Offer clear and concrete information about your client's specific problems or disorder, and stress the uniqueness of his or her problems
- ✓ Clarify sources of distress, identify cyclical relational themes, and provide your client with new insight and understanding of his or her problems

LANGUAGE

- ✓ Use clear, specific experience-near language (not jargon)
- ✓ Use both emotional and cognitive/rational language

DISCUSS WHAT'S NEXT

- ✓ Emphasize that your client can be helped, but it will require effort on both of your parts
- ✓ Assess your client's attitudes and expectations toward therapy
- ✓ Work collaboratively to define individualized treatment goals and tasks

WRAP UP

- ✓ Ask your client what it was like to talk about his or her problems with you today

APPENDIX I WORKSHOP HAND-OUTS

Identifying and Resolving In-Session Alliance Strains

Adapted from Castonguay (1996), Burns (1989), Burns & Auerbach (1996), and Safran & Segal (1990)

ALWAYS

- ✓ Adopt a “participant-observer” stance
- ✓ Monitor the relationship for any strains during sessions
- ✓ Use self-report measures to get client feedback after sessions

MARKERS OF ALLIANCE STRAIN

Withdrawal Markers

1. Indirect expression of negative sentiments
2. Compliance
3. Avoidance maneuvers
4. Non-responsiveness

Examples

Client behaves passive-aggressively
Client begrudgingly acquiesces or hastily agrees
Client cancels or no-shows, or is tangential in sessions
Client fails to follow through on agreed-upon tasks

Confrontation Markers

1. Direct expression of negative sentiments
2. Disagreement about the goals or tasks of therapy, either a fundamental disagreement about the treatment or a more specific disagreement
3. Self-esteem enhancing operations

Client directly attacks you
Client voices disagreement with your general approach, argues about the usefulness of an intervention, wants more direct advice, etc.

Client attempts to justify or defend him- or herself in response to feeling criticized

HAVE AN ALLIANCE PROBLEM?

Recognize any alliance strain as an interactional process

Stop using formal therapy techniques

Start communicating about the process of therapy, the therapeutic relationship, and the in-session process

WHAT TO DO?

1. INVITE your client to explore the potential alliance rupture. Encourage him or her to open up and to feel safe enough to discuss any negative thoughts or feelings resulting from your interaction.
2. EMPATHIZE. Rephrase your client’s words to demonstrate that you are tuned in to his or her disclosures about both thoughts and feelings. Make sure your client feels validated, understood, and respected.
3. DISARM your client by validating explicitly his or her negative feelings or criticisms toward you or the process of treatment. Find and recognize some truth in what your client is saying, even if it seems exaggerated, distorted, unreasonable, or unfair. Accept at least part of the blame for any difficulties in the relationship. Do not become defensive or blaming. Create a sense of shared experience between two fallible individuals, as opposed to imposing an invalidating (and invalid) expression that “I am right and you are wrong.” Explore your own potential contribution to the relational strain by being open to the process happening in the room. Use empathic communication to help your client identify and describe his/her experience in the room, and admit to potential mistakes or misunderstandings.
4. RESUME your use of standard treatment techniques once the alliance strain has been addressed.

APPENDIX I
WORKSHOP HAND-OUTS

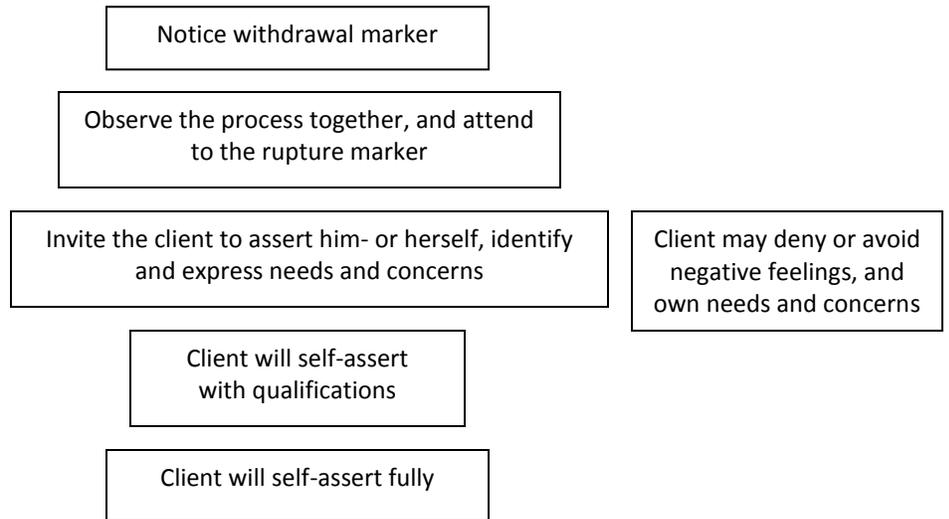
Therapeutic Alliance Rupture Resolution Strategies

Adapted from Safran & Muran (2000)

WITHDRAWAL MARKERS

Denying unpleasant feeling states, e.g., anger	Intellectualizing
Giving minimal responses to open-ended questions	Shifting the topic
Telling stories	Talking about others

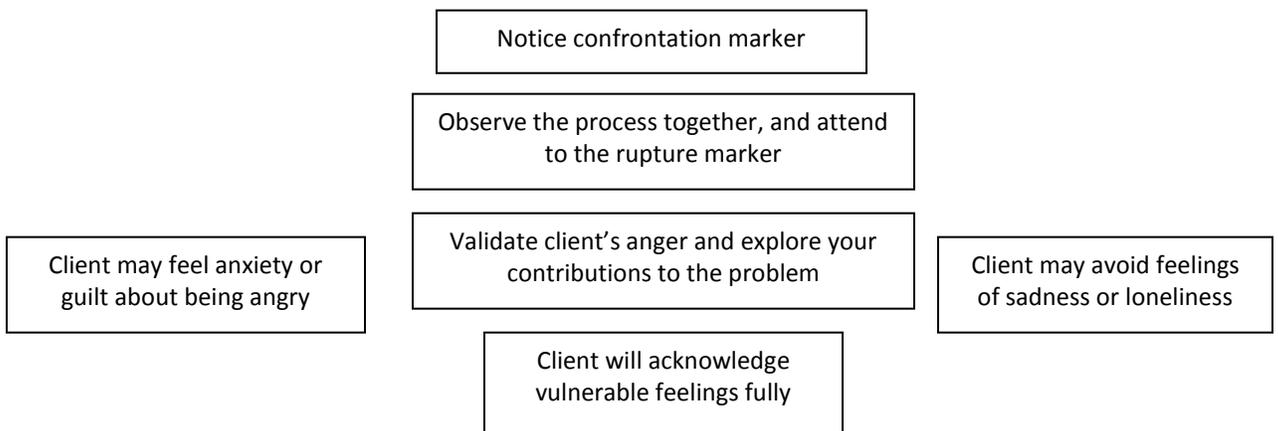
Stages of Rupture Resolution Process:



CONFRONTATION MARKERS

The client voices complaints about:	
Parameters of therapy (inconvenient, unfair)	The therapist as a person
Activities of therapy (useless, irrelevant)	The therapist's lack of competence
Being in therapy (pointless, hopeless)	Lack of progress in therapy

Stages of Rupture Resolution Process:



APPENDIX J
WORKSHOP EVALUATION FORM

Evaluation Form

Did the program meet the learning objectives?	Ineffective		Very Effective		
Participants will be able to:	1	2	3	4	5
1. Discuss 3 or more effective strategies for building rapport and engaging clients in treatment during initial sessions					
2. Identify in-session markers of alliance strain in the therapeutic relationship	1	2	3	4	5
3. Apply alliance rupture repair strategies	1	2	3	4	5
Was the workshop relevant?	Irrelevant		Very Relevant		
1. Was course content appropriate to participant education, experience, and licensure level?	1	2	3	4	5
2. Was course content current and relevant to professional practice?	1	2	3	4	5
Speakers: Anna Remen, PhD; Lotte Smith-Hansen, MS, MA	Poor		Excellent		
1. Did the speakers' expertise enhance the session?	1	2	3	4	5
2. Were the speakers responsive to participants?	1	2	3	4	5
3. Were teaching strategies and instructional materials appropriate for the course objectives and content?	1	2	3	4	5
Physical Facilities	Poor		Excellent		
1. Accessibility	1	2	3	4	5
2. Comfort	1	2	3	4	5
Comments & Suggestions					

REFERENCES

- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.
- Angus, L., & Kagan, F. (2007). Empathic relational bonds and personal agency in psychotherapy: Implications for psychotherapy supervision, practice, and research. *Psychotherapy: Theory, Research, Practice, Training, 44*, 371–377.
- Balint, M. (1968). *The Basic Fault*. London: Tavistock.
- Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317-331.
- Barrett, M. S., Chua, W., Crits-Christoph, P., Connelly Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. [Special issue]. *Psychotherapy: Theory, Research, Practice, Training, 45*, 247-267.
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.
- Bordin, E. S. (1979). The generalizability of the psycho-analytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.
- Borkovec, T. D. (2004). Research in training clinics and practice research networks: A route to the integration of science and practice. *Clinical Psychology: Science and Practice, 11*, 211-215.
- Borkovec, T. D., & Castonguay, L. G. (1998). What is the scientific meaning of “empirically supported therapy?” *Journal of Consulting and Clinical Psychology, 66*, 136-142.
- Borkovec, T. D., Echemendia, R. J., Ragusea, S. A., & Ruiz, M. (2001). The Pennsylvania Practice Research Network and future possibilities for clinically meaningful and scientifically rigorous psychotherapy effectiveness research. *Clinical Psychology: Science and Practice, 8*, 155-167.
- Burns, D. D. (1989). *The feeling good handbook*. New York: William Morrow.

- Burns, D. D., & Auerbach, A. (1996). Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 135-164). New York: Guildford Press.
- Castonguay, L. G. (1996). *Integrative cognitive therapy for depression treatment manual*. Unpublished manuscript, The Pennsylvania State University.
- Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy, 43*, 271-279.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Mahwah, NJ: Erlbaum.
- Connolly Gibbons, M., Crits-Christoph, P., & de la Cruz, C. (2002). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychotherapy Research, 13*, 59-76.
- Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002). The working alliance: A flagship for the “scientist-practitioner” model in psychotherapy. In G. S. Tryon (Ed.), *Counseling based on process research: Applying what we know* (pp. 81-131). Boston: Allyn & Bacon.
- Constantino, M. J., Marnell, M. E., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., & Arnow, B. A. (2008). Integrative cognitive therapy for depression: A randomized pilot comparison. [Special issue]. *Psychotherapy: Theory, Research, Practice, Training, 45*, 122-134.
- Constantino, M. J., & Smith-Hansen, L. (2008). Patient interpersonal factors and the therapeutic alliance in two treatments for bulimia nervosa. *Psychotherapy Research, 18*, 683-698.
- Crits-Christoph, P., Connolly Gibbons, M., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research, 16*, 268-281.
- Freud, S. (1958). On beginning treatment (Further recommendations on the technique of psychoanalysis). In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published 1913).
- Hayes, S. (2002). Getting to dissemination: Commentary. *Clinical Psychology: Science and Practice, 9*, 410-415.

- Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Research, 10*, 205-216.
- Hilsenroth, M., Ackerman, S., Clemence, A., Strassle, & Handler, L. (2002). Effects of structured clinical training on patient and therapist perspectives on alliance early in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 39*, 309–323.
- Hilsenroth, M., & Cromer, T. (2007). Practice review: Clinician interventions related to alliance during the initial interview and psychological assessment. *Psychotherapy: Theory, Research, Practice, Training, 44*, 205–218.
- Horvath, A. O. (1991). *What do we know about the alliance and what do we still have to find out?* Paper presented at the annual meeting of the Society for Psychotherapy Research, Lyon, France.
- Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford University Press.
- Horvath, A. O., & Greenberg, L. (1986). The development of the Working Alliance Inventory. In L.S. Greenberg, & W.M. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford.
- Horvath, A. O., & Greenberg, L. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223–233.
- Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. [Special issue]. *Psychotherapy Research, 15*, 45-53.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books.
- Mallinckrodt, B. (2000). Attachment, social competencies, social support, and interpersonal process in psychotherapy. *Psychotherapy Research, 10*, 239-266.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.
- Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83*, 57-64.

- Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. [Special issue]. *Psychotherapy: Theory, Research, Practice, Training*, 42, 532-545.
- Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. S. (2008). An open trial of integrative therapy for generalized anxiety disorder. [Special issue]. *Psychotherapy: Theory, Research, Practice, Training*, 45, 135-147.
- Rogers, C. R. (1951). *Client-centered therapy*. Oxford: Houghton Mifflin.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.
- Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, 43, 286-291.
- Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. [Special issue]. *Psychotherapy: Theory, Research, Practice, Training*, 42, 512-531.
- Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.
- Strosahl, K. D., Hayes, S. C., Bergan, J., & Romano, P. (1998). Assessing the field effectiveness of Acceptance and Commitment Therapy: An example of the manipulated training research method. *Behavior Therapy*, 29, 35-64.
- Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research*, 5, 189-198.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Zuroff, D. C., Blatt, S. J., Sotsky, S. M., Krupnick, J. L., Martin, D. J., Sanislow, C. A., & Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment for depression. *Journal of Consulting and Clinical Psychology*, 68, 114-124.