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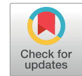
Therapeutic alliance predicts mood but not alcohol outcome in a comorbid treatment setting



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ABSTRACT

Introduction: The pan-theoretical variable of alliance has been consistently reported to have a moderate yet robust effect on psychotherapy treatment outcome. However, the relationship is less clear in the addiction field where there is more limited research. The current study investigated the relationship between alliance and treatment outcome in an alcohol dependent and depressed population.

Method: The Treatment Evaluation of Alcohol and Mood (TEAM) study was a randomized controlled pharmacotherapy trial with supportive clinical case management. Therapist and client alliance ratings were assessed using the Working Alliance Inventory (WAI) for 123 client-therapist dyads at 3 weeks. Outcome data was obtained at 3 and 12 weeks (end of treatment). Drinking-related measures included Percent Days Abstinent (PDA) and Drinks per Drinking Day (DDD). Mood outcomes were scores on the Montgomery Asberg Depression Rating Scale (MADRS).

Results: Clients rated alliance significantly higher than did therapists and client and therapist ratings were not associated with each other. Baseline motivation was the only pre-treatment client variable associated with alliance, the higher the client's Readiness to Change Questionnaire-Treatment Version (RCQ-TV) score, the higher the therapist-rated alliance. Higher therapists' ratings of alliance were significantly associated with improved mood outcomes at the end of treatment but, with one minor exception, were not related to drinking outcomes. Therapist alliance was also significantly associated with treatment completion. In contrast, client-rated alliance was not related to mood or drinking outcomes, possibly due to a ceiling effect. Subscale analysis found that of the different components that comprise the alliance concept, the task component was most important for drinking outcomes whereas the task and goal components were equally important for mood outcomes. Controlling for early symptom change did not meaningfully alter associations between therapist alliance and mood. In contrast, the strength of associations between therapist alliance and drinking outcomes was reduced for PDA and DDD 12-week change scores, whereas the association between the therapist alliance and 12-week PDA became significant when previously this had not been the case.

Conclusions: Therapeutic alliance was associated with improved mood outcomes, which is consistent with other research. However, alliance, as measured by the WAI, and drinking outcomes, were not related. Findings from these investigations signal the need to re-examine the concept and measurement of alliance in substance-using treatment populations, particularly with regard to drinking outcomes. Within this re-examination, findings support a greater focus on the therapists' role in the alliance-outcome relationship.

1. Introduction

Alliance is a pantheoretical variable involved in the therapeutic change process (Bordin, 1979). It is distinguished as a key element in the therapeutic relationship (Greenson, 1965) and involves an affective component and mutual collaboration concerning the work of therapy (Horvath & Luborsky, 1993). The role alliance plays in treatment outcome has been of particular interest as researchers have strived to understand how change occurs. Mostly research resides in the generic psychotherapy field from which reviews and meta-analyses have repeatedly concluded that alliance is the strongest process variable related to outcome with a small but robust effect size ranging from 0.21 to 0.28 (Horvath & Bedi, 2002; Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Furthermore, despite variability in conceptualisation and research design, the effect of alliance as a process variable remains regardless of

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how it is measured, when it is evaluated, the therapeutic model, how outcome is evaluated (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath et al., 2011) or who rated the alliance (client, therapist or independent observer) (Horvath et al., 2011).

Generalizing findings from general psychotherapy research to substance-using treatment populations is limited by several factors. Most importantly, characteristics of clients in generic psychotherapy may differ markedly from substance-using client groups and those with substance-use and coexisting mental health problems. General psychotherapy populations are, in general, likely to be more well (have fewer psychiatric or other symptoms), higher functioning and possibly more internally motivated to change. Differences in underlying philosophies, treatment approaches and settings, and therapist characteristics between these different fields of treatment may also affect the relevance of the conclusions drawn (Orford, 2008). That people with substance use disorders are frequently excluded from generic psychotherapy and other specific treatment research is likely to further exacerbate issues of generalizability (Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005). Moreover, Horvath and Bedi (2002), in their analysis of the alliance-outcome relationship reported that the subset of substance use research was characteristically different from that of the overall psychotherapy group. The subset of studies was small ($n = 6$), results were not homogenous and their combined effect size was 0.14, considerably less than the effect size of the larger group (minus this subset) which was 0.23.

There has been some consideration of alliance in substance-using treatment populations. Findings regarding the capacity of demographic variables to predict alliance in the substance use field have been mixed. Meier, Barrowclough, and Donmall's (2005) review of alliance and substance use treatment populations found that demographic features did not consistently predict alliance, however a number of significant findings have been reported. Findings from Project MATCH were that there was a positive association between therapist rated alliance and the client being female, in outpatient and aftercare groups, while for outpatients only client ratings of alliance were positively associated with age and negatively with educational level (Connors et al., 2000). It has also been reported that therapists rated alliance more favourably with Methadone Maintenance Treatment clients who had higher levels of education (Belding, Iguchi, Morral, & McLellan, 1997).

Mixed findings have been reported in substance use treatment research regarding most baseline diagnostic and symptom severity variables. A number of studies have found a positive association between symptom severity and alliance (Bethea, Acosta, & Haller, 2008; Connors et al., 2000; Klein et al., 2003; McCabe & Priebe, 2003) whereas others have not (Belding et al., 1997; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005; Öjehagen, Berglund, & Hansson, 1997).

In regard to psychosocial variables there seem to be more consistent trends emerging. For example, socialisation, social support, motivation and treatment readiness appear to be predictive of alliance (Calsyn, Klinkenberg, Morse, & Lemming, 2006; Connors et al., 2000; Cook, Heather, & McCambridge, 2015; Meier, Donmall, et al., 2005). A secure attachment style has also been reported to be associated with alliance (Meier, Donmall, et al., 2005).

1.1. Alliance and treatment outcomes

Comparatively little alliance-outcome research has focused specifically on substance use disorders and only a few studies have focused on alcohol use alone. In a review of 18 studies that focused on other drug treatment, Meier, Barrowclough et al. (2005) concluded that an early measure of therapeutic alliance predicted engagement and retention in treatment. This finding on retention was echoed in a more recent study by Knuuttila, Kuusisto, Saarnio, and Nummi (2012).

Consistent with the modest effect size of alliance outlined above, there are mixed findings from investigations of alliance and outcomes in substance-using populations. Some studies have found that alliance is predictive of improved outcomes (Ilgen, McKellar, Moos, & Finney, 2006; Ilgen & Moos, 2005; Najavits & Weiss, 1994; Tunis, Delucchi, Schwartz, Banys, & Sees, 1995), others have not (Belding et al., 1997; Long, Williams, Midgley, & Hollin, 2000; Öjehagen et al., 1997; Raytek, McCrady, Epstein, & Hirsh, 1999), while others have found partial support for this association (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Bethea et al., 2008; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Cook et al., 2015; Crits-Christoph et al., 2009; Dundon et al., 2008; Fenton, Cecero, Nich, Frankforter, & Carroll, 2001; McCabe & Priebe, 2003; Richardson, Adamson, & Deering, 2012).

Most research investigations have shown that alliance had a significant role in influencing treatment outcomes for people with depression (Arnow et al., 2007; Barber et al., 2000; Cunningham, Caslyn, Burger, Morse, & Klinkenberg, 2007; Klein et al., 2003; Krupnik et al., 1996; Priebe & Gruyters, 1993; Zuroff & Blatt, 2006) or a trend towards significance (Feeley, DeRubeis, & Gelfand, 1999). Unfortunately, extrapolating findings from this research to people with co-existing substance use and depressive disorders is hindered by the exclusion criteria used in several studies which specifically excluded subjects who had substance use disorders currently or within the last six months (e.g. Arnow et al., 2007; Barber et al., 2000; Klein et al., 2003).

To explicate the role alliance plays in treatment outcome investigators have sought to determine if and how other factors moderate this relationship. Meta-analysis has repeatedly found that client demographic characteristics do not alter the relationship between alliance and outcome, including studies of alcohol dependent or depressed populations (Connors et al., 1997; De Weert-Van Oene, Schippers, De Jong, & Schrijvers, 2001; Klein et al., 2003; Zuroff & Blatt, 2006). With regard to symptom specific factors, research with depressed populations has found that the relationship between alliance and treatment outcome cannot be attributed to the level of symptom severity present prior to the alliance becoming established (Krupnik et al., 1996). Findings are more varied in substance-using populations (Belding et al., 1997; Connors et al., 1997; Ilgen et al., 2006; Ilgen & Moos, 2005). Also, despite motivation having been consistently found to be associated separately with both alliance and treatment outcome in substance-using populations, findings on the role that motivation may play on the alliance-outcome relationship are mixed (Cook et al., 2015; De Weert-Van Oene et al., 2001; Ilgen et al., 2006).

Several studies have tested whether the alliance-outcome association is an artefact of symptom improvement prior to alliance being measured predicting later improvement and also leading to more positive alliance ratings. This hypothesis is not supported in depression studies (Barber et al., 2000; Klein et al., 2003; Zuroff & Blatt, 2006). However, there is support for the argument that, when tracking alliance and outcome over time, the relationship is confounded by prior symptom change when this is measured *later* in treatment (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011).

In summary, research pertaining to substance-using populations suggests that the alliance-outcome relationship may differ in this treatment population compared to general psychotherapy research populations. Further investigation in this population is therefore warranted. The aim of the current research was to investigate alliance and the alliance-outcome relationship in a treatment population that has thus far received comparatively little attention; those people with co-existing alcohol dependence and depression. The examination of predictors of alliance and potential moderators was included in the investigation.

2. Material and methods

2.1. Setting

The Treatment Evaluation of Alcohol and Mood (TEAM) study was a double blind randomized controlled trial designed to evaluate the short-term effectiveness of citalopram compared with placebo, when

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