Summary
The central research question in this thesis is whether the achieved patient-treatment compatibility is positively associated with the process and outcome in the psychotherapeutic treatment of patients. Chapter 1 provides background information on the topic and begins with a description of the impact and the clinical relevance of the Negotiated Approach, the procedure we administered to improve patient-treatment compatibility in our study. Chapter 1 then continues with a review of the literature on the impact of the achieved patient-treatment compatibility on the psychotherapeutic process and outcome. The reviewed literature suggests that the application of the Negotiated Approach is associated with a reduction in the treatment dropout rate, especially when patients receive the treatment they desire. It further supports our assumption that achieving patient-treatment compatibility is important because it reduces the probability of a conflict between, on the one hand, the illness cognitions and the treatment preferences of the patient and, on the other, the causal interpretations of the therapist and the treatment plan originating from these interpretations. Next, the literature on the impact of patient-therapist compatibility on process and outcome is reviewed, as we wanted to differentiate the impact of patient-treatment compatibility on process and outcome from the impact of patient therapist compatibility. The consulted literature leads us to conclude that the contemporary literature on patient-therapist compatibility focuses predominantly on patient-therapist (dis)similarities in values, attitudes and beliefs, concurrently providing evidence suggesting that similarities in these domains are relevant to the psychotherapeutic process. Evidently, however, the boundaries between patient-treatment compatibility and patient-therapist compatibility in the literature substantially overlap. Interestingly, the literature further suggests that therapist-related attributes such as empathy, acceptance and congruence emerge as independent variables, aside from the patient-therapist (dis)similarities in values, attitudes and beliefs. Chapter 1 finishes with an enumeration of the research questions of our study:

1. Is treatment adherence in psychotherapy affected by the illness cognitions harbored by the patient?
2. What is the impact of the Negotiated Approach on the working alliance, drop-out rate and outcome?

3. What is the impact of the achieved patient-treatment compatibility with the Negotiated Approach on the Task, Goal and Bond subscales of the Working Alliance Inventory on patient satisfaction and outcome compared with the impact of patient-therapist compatibility?

4. And finally, in a post hoc analysis, do therapists differ in their strive and ability to achieve patient-treatment compatibility, and does this result in differences in outcome between therapists?

The impact of illness cognitions of the patient on treatment adherence was studied using a subset of the data from the Second Dutch National Survey of General Practice, which is composed of 120 depressed patients who completed a causal attributions inventory. The remaining research questions were addressed using the data of a controlled trial involving 196 depressed patients (DSM-IV) randomly assigned to one of three conditions: (1) treatment selected through the Negotiated Approach with an assigned therapist (TreatSelect); (2) standard Interpersonal Psychotherapy (IPT) with an assigned therapist (Control); and (3) standard IPT with a chosen therapist (TherpSelect).

**Chapter 2** addresses the impact of illness cognitions on treatment adherence. The chapter is motivated by the observation that despite concerns of over-treatment, the under-diagnosis and under-treatment of major depressive disorders remain prevalent. First, the literature is reviewed. It is concluded that although causal attributions are considered to play a role in help-seeking behavior, time to diagnosis and the chance for successful referral, little is known about the extent to which these processes are influenced by causal attributions. Subsequently, the Second Dutch National Survey of General Practice and the procedure that was applied to obtain the data on a subset of 120 patients with a current DSM-IV diagnosis of depression who completed a causal attribution inventory are described. We then describe how demographic and clinical data and causal attribution scores were used as independent variables in association with 1) a diagnosis of depression from a general practitioner and 2) treatment by a mental health care provider for more than 3 sessions. In the analysis that follows,
causal attributions related to intrapsychic fears emerge as significantly associated with a diagnosis of depression and successful referral. Causal attributions related to childhood are also positively associated with successful referral. In the association models derived from all the demographic and clinical data available in the survey, causal attributions substantially contributed 55% and 39%, respectively, to the explained variance. We conclude that our findings suggest that causal attributions have a statistically significant impact on both time to diagnosis and the probability of successful referral.

**Chapter 3** stems from a tentative conclusion drawn from a narrative review by Duncan and Moynihan (1994) showing that the intentional use of the client’s frame of reference may enhance treatment outcome by improving the achieved patient-treatment compatibility, which in the authors’ view is conceivably mediated by the therapeutic alliance. Chapter 3 starts with a review of the current literature regarding this assertion and ends with the research hypothesis that the association between patient-treatment compatibility and outcome is mediated by the therapeutic alliance. To distinguish patient-treatment compatibility from patient-therapist compatibility, the previously denoted trial design is followed. In this design, the Negotiated Approach is used to improve patient-treatment compatibility in the TreatSelect condition, and a patient-driven therapist selection procedure is applied to improve patient-therapist compatibility in the TherpSelect condition (for details, see the appendix concerning the therapist selection procedure). The achieved patient-treatment compatibility with the Negotiated Approach was measured using an experimental scale, the Achieving Compatibility Process Scale (ACPS). The therapeutic alliance was measured with the Working Alliance Inventory (WAI). Outcome was assessed with the Beck Depression Inventory (BDI). Multilevel Analysis, with patients nested in therapists and therapists nested in conditions, was applied to analyze the results. The assumption is confirmed that the Negotiated Approach results in a more favorable development of patient-treatment compatibility over time. There are statistically significant differences in slope on the ACPS between TreatSelect and Control patients in favor of TreatSelect. The development of the WAI total score between conditions over time parallels the development of the ACPS. There is, however, a statistically significant difference in
intercept between TreatSelect and TherpSelect patients in favor of TherpSelect. Despite these differences in the strength of the therapeutic alliance, no significant differences in outcome between TherpSelect and TreatSelect are observed. With regard to the association between patient-treatment compatibility and outcome, a mediational effect of the therapeutic alliance is observed only in the TreatSelect condition.

Chapter 4 is devoted to a further exploration of the impact of the Negotiated Approach (in TreatSelect) and the applied therapist selection procedure (in TherpSelect) on scores on the ACPS, the three subscales of the WAI (Tasks, Goals and Bonds), patient satisfaction and the patient’s perception of the therapist. To measure the patient’s perception of the therapist, the Counselor Effectiveness Rating Scale (CERS) was used in all three conditions. Multilevel Analysis was applied to analyze the results of the data with patients nested in therapist and therapists nested in conditions. A consistent finding in chapter 4 is that procedures aimed at improving patient-treatment compatibility or patient-therapist compatibility produce a more favorable development over time on all the process variables applied. The only exception is scores on the Goal subscale of the WAI. There is no significant change over time in scores on the Goal subscale of the WAI. It seems that once the goals are established, agreement on this topic is stable. Another consistent finding is that all process-related scores (ACPS, WAI total score, Task subscale of the WAI, CERS, and Satisfaction) are highest in the TherpSelect condition. Yet, no differences in outcome between conditions are observed. However, across conditions, the ACPS score predicts dropout rates and outcome more successfully than the WAI total score, the scores on the Goal or Bond subscales of the WAI, or the CERS do. In other words, attaining and maintaining a good therapeutic relationship is not a prerequisite; achieving and maintaining sufficient patient-treatment compatibility is part of our core mission.

Chapter 5 presents a post-hoc analysis of the results on process and outcome variables achieved by the therapists providing IPT treatments in both the Control and the TherpSelect conditions. Starting from our conclusion in chapter 4 that achieving and maintaining sufficient patient-treatment compatibility is part of our core mission, the analyses in this chapter are aimed at elucidating the impact of the strive and ability
of individual therapists to achieve and maintain patient-treatment compatibility on outcome. We hypothesized that therapist effectiveness is associated with achieving compatibility and that there is statistically significant variation in the strive and ability of therapists to achieve compatibility. We further hypothesized that the relationship between compatibility and therapist effectiveness is mediated by the quality of the therapeutic alliance. Multilevel analysis was used to study the results of 7 therapists delivering Interpersonal Psychotherapy (IPT) to 103 depressed patients. Adherence to the IPT protocol was measured with the IPT subscale of the Collaborative Study of Psychotherapy Rating Scale. Patient-treatment compatibility was measured using the Achieving Compatibility Process Scale (ACPS), and the therapeutic alliance was measured using the Working Alliance Inventory (WAI). The Beck Depression Inventory (BDI) was applied to evaluate therapist effectiveness. Treatment adherence was satisfactory. Our hypothesis that the variation in therapists’ scores on the ACPS is statistically significant was confirmed. The analysis further showed that the score on the ACPS was the main predictor of outcome at the level of the therapist. Interestingly, the association between the ACPS score and outcome at the level of the therapist was not mediated by the therapeutic alliance. Still, ACPS scores do not translate 1:1 into outcome; other predictor variables appear to be at play.

In chapter 6, the general discussion section, the principal findings of the studies are summarized. Methodological issues, conceptual considerations, and the clinical relevance of the findings are discussed, and finally, suggestions are made for future research. Our main findings are that certain causal attributions are positively associated with staying in the commonly provided treatment, whereas others are not. Considering the theoretical relation of causal attributions and treatment preferences, this finding suggests an association of the causal attributes of the patient not only with treatment preferences but also with the achievable patient-treatment compatibility. Regrettably, the study referred to in chapter 2 does not examine the link between the findings in chapter 2 and the results in the studies discussed in chapters 3 through 5. Thus, the association between causal attributions, treatment preferences and the achievable patient-treatment compatibility remains unknown. However, the main findings in
chapter 3 through 5 suggest that patient-treatment compatibility is the main predictor of outcome, outweighing the importance of the quality of the therapeutic alliance. Therefore, achieving patient-treatment compatibility appears to be at least a part of our core business, both across conditions and at the level of the therapist, at least within the domain of time-restricted, psychotherapeutic treatments for depressive disorders. However, the avenues leading to the achievement of optimal patient-treatment compatibility are diverse. Moreover, the validity of the ACPS requires further exploration. If properly validated, the ACPS might prove a valuable training and monitoring instrument. The ACPS covers most of the constituents of the alliance for psychotherapy as outlined by Crits-Cristoph (2006) and the topics dictated by the ACPS formulate identifiable avenues for the therapist to improve both process and outcome.