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*CHAPTER 7 DOES IMMEDIATE
FEEDBACK IMPROVE THE
ALLIANCE IN ACUTE PSYCHIATRIC
TREATMENT?*

**Does immediate feedback improve the alliance in acute
psychiatric treatment?
A randomised controlled trial**

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submitted

Summary

Objective

To investigate the effect of immediate session-by-session patient feedback on the quality of the alliance in the treatment of patients with acute and severe psychosocial or psychiatric problems.

Background

Although the alliance is a predictor of treatment success and immediate client feedback can improve treatment results, it is unknown whether client feedback influences the quality of the alliance.

Method

In a naturalistic mixed diagnosis sample of patients at a Psychiatric Emergency Centre, patients were randomised to a Treatment-as-Usual or a Feedback condition. In the Feedback condition, client feedback on the alliance was discussed by therapists and patients on a session-by-session basis.

Results

No statistically significant differences between conditions were found for the alliance measures. Neither the mean alliance rating of clients nor the mean rating of therapists differed between Feedback and Treatment-as-Usual condition at any measurement point. The difference between therapist's and client's ratings in the Feedback condition did not deviate from the difference between therapist's and client ratings in the Treatment-as-Usual condition. Therapists' mean rating of alliance (4.50) was significantly lower than clients' mean rating (4.73) of alliance (estimated mean difference/standard error: -0.24/0.04).

Conclusions

Immediate feedback about the alliance on a session-by-session basis did not influence the quality of the alliance in a population of patients with psychiatric problems and severe distress seeking emergency psychiatric help.

Introduction

The alliance is one of the strongest predictors of treatment success psychotherapy research has been able to document (Hardy et al, 2007; Falkenstrom, 2014). Overall the strength of the link between alliance and psychotherapy treatment outcomes was equated to an effect size of 0.28 (Horvath et al, 2011). This is in the range of other determinants of outcome such as the use of antidepressants (ES .31, Turner et al, 2008) and psychotherapy (ES .39, Driessen et al, 2015) for depression. The alliance is estimated to account for about 7.5% of the variance in outcomes and several studies demonstrated that improvement of alliance precedes symptom change, thus suggesting it can be considered as a working mechanism for treatment outcome (Horvath, 2011). In line with this, goal consensus, collaboration between patient and psychotherapist (Shick Tryon & Winograd, 2011) and congruence in rating of alliance between therapist and client (Rozmarin et al. 2008; Marmarosh & Kivlighan, 2012) have been shown to be related to better treatment outcomes. Falkenstrom et al (2013) found that when the alliance is worse than usual for a given patient, symptoms are also likely to get worse to the next session. Similarly, improvement of the patient-therapist alliance predicts reduction of symptoms by the next session in both CBT and IPT treatment for depression (Falkenström et al, 2016).

These results support the idea that monitoring the alliance on a session-by-session basis is important to allow therapist and client strengthen the alliance, and identify possible ruptures (Duncan et al, 2003; Miller, 2004; Falkenstrom et al, 2016). Acknowledging and repairing ruptures in the alliance is strongly linked to positive treatment outcomes (Safran et al, 2011; Mc Laughlin et al, 2014). Several studies have indicated an incongruence between therapists' and clients' ratings (Shick Tyron et al, 2007) and therapists often have difficulties to identify ruptures when they do not use a monitor instrument (Hannan et al, 2005; Hatfield et al, 2010). However, none of the studies on feedback has included immediate client feedback on the alliance on a session-by-session basis while at the same time monitoring the quality of the alliance with a separate measure. Therefore it is not clear if session-by-session feedback on goals, means and collaboration can influence the quality of the working alliance in the perception of the client and the therapist and congruence between therapists' and clients' ratings (Duncan and Reese, 2015). This is important since as yet no specific tools have been developed for therapists to improve alliances, although a positive relation is found between 'facilitative interpersonal skills' of the therapist and outcomes (Anderson, 2009). If actively discussing feedback on the alliance would influence the quality of the alliance in a positive

way, this would provide such a tool. Monitoring the alliance might be especially valuable in emergency psychiatric settings since treatment is needed immediately with little time to develop a trustful working alliance with the patient (van Oenen et al, 2007).

To investigate whether immediate feedback influences alliance, alliance needs to be evaluated on a session-by-session basis. The most frequently used feedback systems monitor progress at symptom level but do not monitor alliance (Duncan and Reese, 2015). Other systems monitor alliance on an aggregated level, giving clinicians indirect instructions for improving the alliance (Crits-Christoph et al, 2012; Simon et al, 2012, 2013), or use a ‘Clinical Support Tool’ (Lambert et al, 2007) to stimulate attention for the alliance when clients are not progressing (Harmon et al, 2007; Slade et al, 2008; Whipple et al, 2003). Only the Partners for Change Outcome Management System (PCOMS) (Duncan & Reese, 2015) uses an alliance measure on a session-by-session basis. Furthermore, for patients in crisis who often have short attention spans it is important that short score forms are used. PCOMS meets this requirement.

In sum, the primary aim of this study is to investigate whether applying session-by-session feedback on working alliance, goals and cooperation does improve the quality of the alliance over the course of treatment in an acute psychiatric setting. Secondly, we address the congruence on the experienced alliance between clients and therapists.

Method¹³

Setting

The study setting was a Psychiatric Emergency Centre Amsterdam in the period from September 2009 to May 2012. In this centre, a Crisis Intervention & Brief Therapy team (CIBT team) provides immediate assessment in crisis situations and - if needed- outpatient treatment. Patients are referred by GPs, mental-health workers and police in the region. Indication for treatment by the CIBT is based upon the need for immediate help felt by the patient, relatives or referring professionals. The team works on an outpatient basis, treating patients with severe psychiatric and/or severe psychosocial problems. Therapists have discretion to determine intensity and duration of treatment - up to 24 weeks-.

¹³ For a more detailed description of treatment elements, randomisation procedure, training of therapists and interpretation of feedback measures, see (10;11)

The CIBT works from a transdiagnostic perspective, which means that the assessment is not based solely on the diagnostic category but on the overall presentation of symptoms, and the needs and capacity of the patient and relatives. Treatment is approached from a systemic model as well as a medical model. Therapists are experienced psychiatrists, social psychiatric nurses, psychologists and family therapists. In addition, the team includes a group of – on average – eight experienced and intensively supervised residents in psychiatry who each work at the CIBT for a period of six months.

Clients are assigned to the therapist on duty, regardless of the diagnosis of the client or the discipline of the therapist. All patients undergo a full clinical psychiatric examination. Treatment may involve pharmacotherapy and psycho-education and includes outreaching care if needed.

Study design, randomisation and inclusion criteria

This study was designed as a randomised controlled trial in ‘routine emergency care’ comparing Treatment As Usual (TAU) with a Feedback condition (FB). In the experimental condition therapist received feedback from the patient about the therapeutic alliance in every session. In the TAU condition the alliance was measured every six weeks without providing feedback to either patient or therapist. Therapists treated patients in both conditions.

Intervention

Prior to the first session, a research assistant explained the principles of the feedback system, the Patient for Change Outcomes Management System (PCOMS) (Duncan & Reese, 2015), to all patients who had been randomised to the FB condition. At the end of the session, the patient evaluated the therapy session using the Session Rating Scale (SRS) and discussed the score with the therapist. When the crosses on the ‘What did you think of the session?’ form indicated reticence or plain dissatisfaction, the reasons for being dissatisfied were discussed with the therapist. When scores indicated general satisfaction, as indicated by a sum score exceeding 36 (Duncan et al, 2003) , the therapist asked for comments about how to improve therapy.

Training of therapists and application of feedback

Staff therapists were trained to administer, score and provide feedback to patients on the basis of the training manual provided for the ORS and SRS (Miller et al, 2005) before the study started. Follow-up supervision sessions were regularly provided during the course of

the research project to maintain adherence. Therapists were trained to discuss the SRS score and encourage patients to express any comments and concerns about the session by making suggestions about how to improve collaboration and therefore address potential breaches in the alliance.

Measures

Independent variables

The data collected at baseline (the emergency consultation) were: age, gender, domestic situation, ethnicity and main DSM IV diagnostic category.

The number of therapy sessions and the duration of treatment were derived from the patient registration systems of Arkin Mental Health Care in Amsterdam. The link to the database of this system was established with an encrypted code based on gender, date of birth and the first two letters of the family name. This link made it possible to deduce data for unique patients.

Outcome measures

The Partners for Change Outcome Management System (PCOMS)

PCOMS comprises two very short (VAS) scales consisting of four items each: firstly the Outcome Rating Scale (ORS) (Miller et al, 2003) – which assesses change in three areas of client functioning: individual (or symptomatic) functioning, interpersonal relationships, social role performance and overall wellbeing – and the Session Rating Scale (SRS) (Duncan et al, 2003) for scoring the quality of the working alliance.

Session Rating Scale

The therapeutic relationship as measured by the SRS is based on the concept of the therapeutic alliance by Bordin (1979) and the construct termed “client’s theory of change” (Duncan, Miller and Sparks, 2004). The SRS represents three aspects of the helping relationship: the affective bond, agreement on tasks during sessions, and agreement about the ultimate goals of the encounter and is completed and discussed at the end of the session. When scores indicate reticence or plain dissatisfaction, criticisms are discussed immediately or, in case of structural comments, during the following session.

The psychometric properties of the American and Dutch versions of this instrument have been evaluated (Duncan et al, 2004; Hafkenscheid, 2008; Hafkenscheid et al, 2010; Janse et al, 2013), resulting in coefficient alpha values ranging from 0.80 to 0.95 for the SRS for both the American and Dutch versions.

Test-retest reliability coefficients (Pearson's r) for both Dutch and American versions were reported ranging from 0.49 to 0.72 for the SRS, and a correlation of .48 has been found with the HAQ-II (Duncan et al, 2003) and .37 to .46 for the WAV-12 (Janse et al, 2013).

With respect to this relatively weak test-retest reliability, Hafkenscheid et al (2010) point out that correlations between subsequent administrations are an inappropriate operational definition of test-retest reliability for instruments designed to be sensitive to a client's perception of subjective change.

HAQ-II:

The therapeutic alliance was measured using the patient version of the 19-item Helping Alliance Questionnaire (HAQ-II; Luborsky et al, 1996). A total score is derived from the HAQ-II by summing the 19 items (each rated on a 1 to 6 scale), after reversing the scoring of negatively worded items. The range of possible scores is therefore 19 to 114 with higher scores indicating a more positive alliance. The patient version of the HAQ-II has demonstrated excellent internal consistency (Cronbach's $\alpha = .90$ to $.94$) and good test-retest reliability over a period of three weeks (.79) (Luborsky et al, 1996; Leblot et al, 2006); in the Dutch version Cronbach's α was .91 (Trijsburg et al, 1999).

Adherence check

Halfway through the study, staff therapists were asked to complete an anonymous survey about the extent to which they had been able to apply the feedback as intended as follows.

- a) the percentage of sessions in which the therapists applied the feedback measures adequately (categorised in: '10-40%', '40-70%' and 'more than 70% of the sessions)
- b) the time spent discussing the SRS.

Informed consent and data security

This study is based on secondary analyses performed on data gathered in the context of a randomized controlled trial focusing on the effect of feedback on outcome of treatment (van Oenen et al, 2013; van Oenen et al, 2016).

The study protocol and informed consent procedure were evaluated in 2009 by the ethics committee for Dutch Mental Health Institutions, (Kamer Noord of the METiGG) (approval nr. 9219, 1-9-2009). Following their conclusion, the Committee concluded that, since

feedback does not fall under the jurisdiction of the WMO (the Dutch law on scientific medical research on human subjects), the regular clinical procedure for informed consent at the department could be followed. The study was then explained to the patients, written information was provided and patients were asked to participate on a voluntary basis, which was noted in the medical file.

Data analysis

Analyses were based on an intent-to-treat sample, including all patients randomly assigned.

No sample size calculation was made based on the Helping Alliance Questionnaire score, since the sample size was a priori calculated based on a different measure (reported in a separate paper, van Oenen et al 2016).

Baseline characteristics were compared using Chi-square tests, ANOVA and Mann-Whitney tests. The proportions of early treatment termination and non-response (patients still in treatment without measurement) were compared at 6, 12, 18 and 24 weeks using Chi-square tests. To test for selective dropout at these measurement points, patient characteristics, baseline measurements and the number of sessions were compared.

Alliance scores of clients in the two treatment conditions were compared using multilevel analyses (results reaching significance when Parameter/Standard Error < 1.96). Analyses were conducted according to a two-level structure (patient and repeated measures). Number of sessions was included as a covariate.

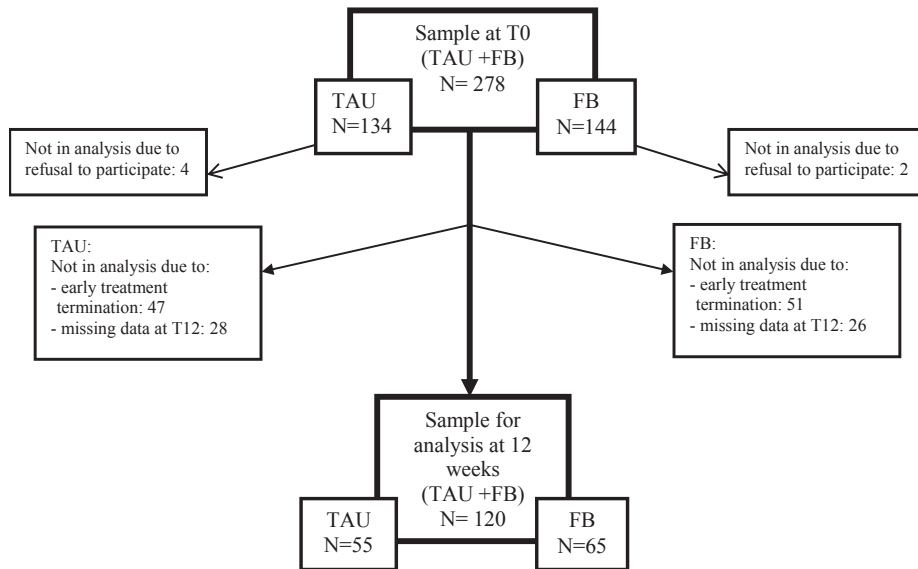
Alliance scores of therapists in the two treatment conditions were compared in a similar way. The association between alliance score of therapist and client in FB, as well as the association between alliance score of therapist and client in TAU, was analysed. Differences between, on one hand, the association between alliance scores of clients and therapists in FB versus, on the other hand, the association between alliance scores of clients and therapists in TAU were analysed at all measurement points, as well as in the slopes from T6 to the last-known-measurement. Furthermore, the slopes of alliance scores were compared. Analyses were performed with MLwiN, version 2.22 (<http://www.bristol.ac.uk/cmm/software/mlwin>). All other analyses were performed with SPSS, version 22.0.

Results¹⁴

Patient sample

Between 2009 and 2012, a total of 861 patients were referred to the Psychiatric Emergency Centre. The 222 patients who were unable to fill out a questionnaire at intake were excluded. A group of 269 patients were offered only one session for crisis evaluation, resulting in either immediate admission to a psychiatric hospital or referral to the patient's own general practitioner/ therapist (when no indication for acute psychiatric help was found). In 370 patients the crisis intervention was followed by brief therapy, which was defined as more than two sessions (including the first crisis evaluation session). Of these patients, 92 terminated treatment within six weeks or did not fill in a form, making it impossible to assess their progress at the first time point (T6). The study sample therefore included 278 patients (figure 1). As 98 (35.3 %) patients terminated treatment before T12, 28 (10.1 %) did not complete the questionnaires at this time and 6 (2.2%) refused to participate, a total of 120 patients had received either TAU (55) or FB (65) at 12 weeks.

¹⁴ Scores for outcome rating scales (ORS) have been reported and discussed in a separate paper (van Oenen et al, 2016)

Figure 1: Participant flow

Sample characteristics and representativeness testing

No differences between FB and TAU were found for any baseline characteristic (including diagnostic categories) (table 1), indicating a successful randomisation procedure. The mean number of treatment sessions in the total group of 278 participants was 9.3 (*SD* 5.1), no significant difference was found between FB (9.1, *SD* 5.0) and TAU (9.5, *SD* 5.3) ($p = .536$).

The average duration of treatment was 103 days (range 12-231 days). Half of the patients (50%) ended treatment within three months, 55% finished treatment within eight sessions and almost half of all patients (49%) had 4-8 sessions. There were no significant differences in treatment duration between the two conditions: the mean was 103 days (*SD*=54.2) for patients in TAU and 103 (*SD*=51.5) days for patients in FB ($p = .927$) (table 1).

Table 1. Baseline characteristics of TAU versus FB condition at T0 (measurement at start of treatment)

| Variable | TAU condition (N=134) | FB condition (N=144) | Total group (N=278) | <i>p</i> * |
|------------------------------------|--------------------------|-------------------------|------------------------|------------|
| Age, mean (<i>SD</i>) | 38.0 (11.1) | 38.1 (11.1) | 38.1 (11.1) | 0.929 |
| Age subgroups | | | | 0.848 |
| Gender, <i>N</i> (%): | | | | 0.317 |
| - male | 69 (51.5) | 69 (47.9) | 138 (49.6) | |
| - female | 65 (48.5) | 75 (52.1) | 140 (50.4) | |
| Cultural background, <i>N</i> (%): | | | | 0.638 |
| - Dutch | 55 (41.0) | 65 (45.1) | 120 (43.2) | |
| - Surinam | 7 (5.2) | 9 (6.3) | 16 (5.8) | |
| - Turkish | 2 (1.5) | 6 (4.2) | 8 (2.9) | |
| - Moroccan | 10 (7.5) | 8 (5.6) | 18 (6.5) | |
| - other | 29 (21.6) | 30 (20.8) | 59 (21.2) | |
| - unknown | 31 (23.1) | 26 (18.1) | 57 (20.5) | |
| Living situation, <i>N</i> (%): | | | | 0.302 |
| - alone | 56 (44.0) | 69 (47.9) | 128 (46.0) | |
| - with children without partner | 9 (6.7) | 12 (8.3) | 21 (7.6) | |
| - with parents in family | 10 (7.5) | 4 (2.8) | 14 (5.0) | |
| - with partner | 32 (23.9) | 25 (17.4) | 57 (20.5) | |
| - other | 10 (7.5) | 15 (10.4) | 25 (9.0) | |
| - unknown | 14 (10.4) | 19 (13.2) | 33 (11.9) | |
| Diagnosis: | | | | 0.524 |
| - psychotic disorder | 22 (16.4) | 21 (14.6) | 43 (15.5) | |
| - depression | 30 (22.4) | 25 (17.4) | 55 (19.8) | |
| - adjustment disorder | 28 (20.9) | 29 (20.1) | 57 (20.5) | |
| - personality disorder | 16 (11.9) | 13 (9.0) | 29 (10.4) | |
| - psychosocial problems | 7 (5.2) | 8 (5.6) | 15 (5.4) | |
| - other | 31 (23.1) | 48 (33.3) | 79 (28.4) | |
| Referring service: | | | | 0.246 |
| GP | 76 (56.7) | 72 (50.0) | 148 (53.2) | |
| Mental health Service | 20 (14.9) | 19 (13.2) | 39 (14.0) | |
| Patient | 4 (3.0) | 8 (5.6) | 12 (4.3) | |
| Family/friends | 2 (1.5) | 8 (5.6) | 10 (3.6) | |
| ER | 7 (5.2) | 15 (10.4) | 22 (7.9) | |
| Public Health (GGD) | 7 (5.2) | 7 (4.9) | 14 (5.0) | |
| Other | 18 (13.4) | 15 (10.4) | 33 (11.9) | |

* 'Unknown' is excluded in *p*-analysis

Session Rating Scale and HAQ-II

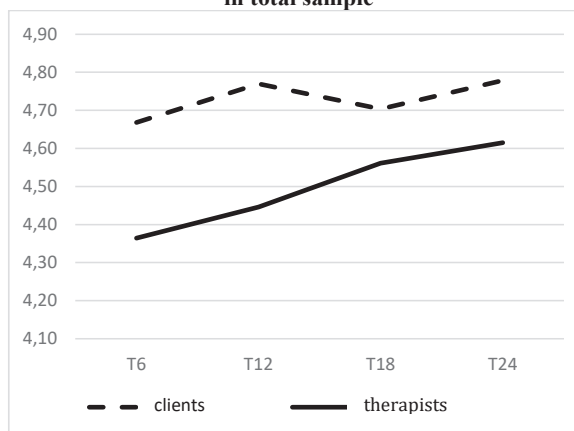
SRS forms were filled in by 146 clients at T0, 130 at T6, 84 at T12, 53 at T18 and 25 at T24 (table 2). The mean score on the SRS varied between 32.2 (*SD* 6.8) at T0 and 34.8 (*SD* 5.8) at T18, the mean score over all time points was 33.4 (*SD* 7.2).

Table 2: SRS scores at different time points

| Time point | Mean score | SD | N |
|------------|------------|------|-----|
| 0 wks | 32,2 | 6,84 | 146 |
| 6 wks | 33,3 | 7,59 | 130 |
| 12 wks | 32,7 | 7,99 | 84 |
| 18 wks | 34,8 | 5,83 | 53 |
| 24 wks | 34,1 | 7,53 | 25 |

In the adherence check, 67% of the staff therapists reported that they had applied the SRS forms adequately in more than 70% of the sessions; 14% had applied it in 40-70% of the sessions, and 19% in 10-40%. On average, therapists ($N=21$) estimated that they spent 4 minutes on the SRS. Almost all patients completed SRS forms: only two patients did not fill out a single SRS form.

On the HAQ-II, in the total group, when combining scores of all measurement points, the mean rating of therapists (4.50) was found to be significantly lower than the mean rating of clients (4.73) (estimated mean difference/standard error: $-0.24/0.04$; $p<.05$). Ratings of therapists were lower than ratings of clients at every single measurement point (figure 2).

Figure 2. Mean HAQ-II scores of clients and therapists in total sample

Mean rating of therapists 4.50; mean rating of clients 4.73 (emd/se: $-0.24/0.04$)

*Feedback and quality of alliance**Client scores*

Firstly, we compared scores of the clients on HAQ-II in FB and TAU. Mean scores of clients in FB (4.73) were similar to mean scores in TAU (4.73). After six, twelve, eighteen and twenty-four weeks (T6, T12, T18 and T24) none of the scores in the FB condition were significantly different from TAU, as shown in table 3.

Table 3: Mean alliance scores (HAQ-II) of clients and therapists in FB and TAU; comparison between FB and TAU

| Time point | TAU (mean, SD, N) | FB (mean, SD, N) | Total group (mean, SD, N) | Estimated mean difference (emd, se) |
|------------------------------------|--|--|------------------------------|--|
| Client ratings | | | | |
| 6 wks | 4,68 (.67) N=82 | 4,66 (.67) N=80 | 4,67 (.67) N=162 | 0.03 (0.10) |
| 12 wks | 4,80 (.55) N=55 | 4,74 (.67) N=65 | 4,77 (.61) N=120 | 0.03 (0.11) |
| 18 wks | 4,73 (.62) N=32 | 4,68 (.72) N=35 | 4,70 (.67) N=67 | -0.02 (0.13) |
| 24 wks | 4,72 (.64) N=18 | 4,83 (.48) N=20 | 4,78 (.56) N=38 | 0.15 (0.15) |
| Slope client ratings 6-24 weeks | | | | |
| | Scores over time all clients (FB + TAU) (emd, se) | Interaction over time between conditions (emd, se) | | Mean difference between conditions (emd, se) |
| | -0.00(0.00) | 0.00 (0.01) | | 0.01 (0.11) |
| Therapist ratings | | | | |
| 6 wks | 4,35 (.57) N=118 | 4,38 (.55) N=123 | 4,36 (.56) N=241 | 0.04 (0.07) |
| 12 wks | 4,48 (.59) N=74 | 4,41 (.60) N=78 | 4,45 (.60) N=152 | -0.02 (0.09) |
| 18 wks | 4,66 (.46) N=37 | 4,49 (.59) N=50 | 4,56 (.54) N=87 | -0.11 (0.11) |
| 24 wks | 4,71 (.42) N=24 | 4,52 (.63) N=24 | 4,61 (.54) N=48 | -0.13 (0.13) |
| Slope therapist ratings 6-24 weeks | | | | |
| | Scores over time all therapists (FB+TAU) (emd, se) | Interaction over time between conditions (emd, se) | | Mean difference between conditions (emd, se) |
| | 0.01 (0.00) | -0.01 (0.01) | | 0.10 (0.09) |

Results of multilevel analysis

emd: estimated mean difference ; SE: standard error

Data in bold are significant values (estimated mean difference > standard error x 1.96; $p < .05$)

In addition, the slope of alliance scores of clients over all measurement points in TAU and in FB showed no significant interaction.

Therapist scores

Secondly, we compared the scores of the therapists on the therapist-rated HAQ-II scores in FB and TAU. Mean scores of therapists in FB (4.45) did not significantly differ from mean scores in TAU (4.55). Scores in both conditions did neither differ significantly at any measuring moment (see table 3).

Also, the slope of therapists' alliance scores over all measurement points in TAU and in FB showed no significant interaction.

Association between therapists' and clients' scores

Thirdly, we compared the association between therapists' and clients' ratings. The mean differences between client and therapist ratings within TAU (figure 3) as well as within FB (figure 4) showed differences at all time points, therapists scoring consistently lower than clients, reaching significance at 5 of all 8 measurement points (table 4).

Figure 3. Mean HAQ-II scores of clients and therapists in TAU

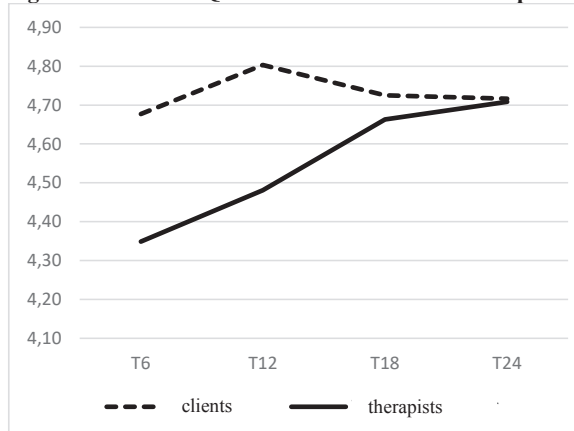
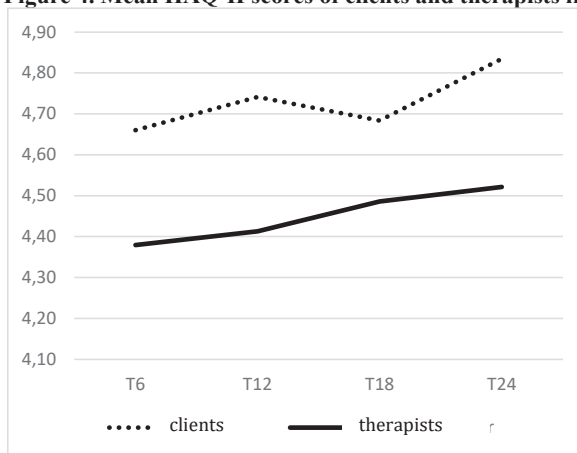


Figure 4. Mean HAQ-II scores of clients and therapists in FB

The differences between clients' and therapists' ratings in TAU decreased over treatment (not reaching significance at 18 and 24 weeks), while in FB those differences did not consistently decrease (significant difference at 24 weeks).

Table 4 Differences (HAQ-II) between client rating and therapist rating; comparison within and between FB and TAU

| Time point | TAU <i>N</i> | within TAU diff (se) | FB <i>N</i> | within FB diff (se) | Total group <i>N</i> | between TAU and FB emd (se) |
|--------------------|-----------------|-------------------------|----------------|------------------------|----------------------------|-----------------------------------|
| 6 wks | <i>N</i> =71 | -0.29 (0.07) | <i>N</i> =70 | -0.24 (0.06) | <i>N</i> =141 | 0.06 (0.09) |
| 12 wks | <i>N</i> =46 | -0.27 (0.08) | <i>N</i> =54 | -0.29 (0.07) | <i>N</i> =100 | -0.02 (0.11) |
| 18 wks | <i>N</i> =18 | -0.15 (0.11) | <i>N</i> =28 | -0.19 (0.10) | <i>N</i> =46 | -0.04 (0.15) |
| 24 wks | <i>N</i> =14 | -0.02 (0.14) | <i>N</i> =15 | -0.36 (0.13) | <i>N</i> =29 | -0.35 (0.20) |
| Slope 6- 24 wks | | 0.02 (0.01) | | -0.00 (0.01) | | -0,01 (0.01) |

Results of multilevel analysis

Data in bold are significant values (estimated mean difference > standard error x 1.96; $p < .05$)

However, comparison of the association between therapists' and clients' ratings in FB versus the association between therapists' and clients' ratings in TAU showed no significant interaction between conditions at any measurement point (table 4).

We also made a comparison between FB and TAU regarding the association between the slope of clients and the slope of therapists. No significant interaction was found between conditions either.

Finally, we made a ‘first-last comparison’, comparing the differences between client and therapist ratings at the first measurement point (T6) and at the end of treatment (i.e. the last known measurement). Overall, no significant interactions were found between client-therapist discrepancies at T6 and client-therapist discrepancies at the end of treatment. However, the limited power at T24 (TAU $N=18$, FB $N=20$) does not allow drawing firm conclusions.

Discussion

Summary of findings

This study aimed to determine whether immediate session-by-session feedback on the alliance would lead to a better alliance between patient and therapist in short-term psychiatric treatment delivered in an outpatient emergency centre.

Overall, clients rated the alliance higher than therapists, with differences reaching significance at the majority of measurements points. This is in line with other studies. Shick Tyron et al (2007) found in a meta-analysis that clients’ ratings were higher than ratings by their therapists ($d .63$, $SD .42$).

We found no effect of discussing immediate feedback about the alliance on the quality of the alliance: the absolute mean scores of therapists, and the absolute mean scores of clients did not differ between conditions. Similarly, the association between the scores of clients and therapists in either condition was not statistically different, either in first-last comparison or in slope of alliance ratings over time. Contrary to our hypothesis, frequent discussion the alliance between client and therapist did not improve its quality, nor did it bring client and therapist closer to each other in their rating of the relation.

This finding extends an earlier reported absence of an overall effect of feedback at symptom level in the setting of acute psychiatric treatment (van Oenen et al 2016).

Three possible clinical explanations can be offered for our findings.

Alliance is hard to influence

Our results indicate that the alliance is hard to influence through interventions specifically aiming to do so. Crits-Christoph et al (2009) found, in a study on patients with

substance abuse, that applying Motivational Enhancement Therapy - a method that focusses on empathy, acceptance and positive regard and therefore would be expected to show higher levels of alliance - did not lead to differences in patient HAQ-II-ratings compared to treatment as usual. Our study seems to extend this finding to the emergency psychiatric setting, since despite the heightened attention on the alliance, HAQ-II scores remained unchanged during treatment.

As these authors have suggested, innate personality characteristics of therapists may in part determine the alliance, and the alliance has also been shown to be related to patient pretreatment characteristics that are relatively stable over time, so these would not be expected to change depending on type of intervention. However, other literature suggests that the alliance would be amenable to specific interventions aiming to improve it (Safran et al, 2000; Anderson, 2009; Miller et al, 2013).

Feedback on alliance takes a specific attitude

The results indicate that in this study the SRS had no added value in the feedback process. It is possible that former results are related to feedback on outcome scores (ORS) and not to alliance feedback. This may be related to the fact that receiving feedback on alliance is a more demanding process for the therapist than discussing outcomes. It might be that profiting from feedback on the alliance takes more specific training that does not focus on the content of the feedback but on the attitude and skills needed to receive feedback as a therapist (Anker et al, 2011). Earlier papers have described this as ‘deliberate practice’ of specific elements (Miller et al, 2013) or ‘facilitative interpersonal skills’ (Anderson et al, 2009) or have focused on the role and the theoretical framework of the therapist (van Oenen et al, 2014).

TAU focused on optimal alliance

The CIBT therapists are trained to focus on tailor made treatment and connect to clients in an optimal way. The relatively high scores (ranging from 4.67 to 4.78) in TAU - Leblot et al (2006) report scores from 4.2 to 4.7- support the hypothesis that the therapists form strong alliances, especially given the fact that this population has a high level of distress (van Oenen et al, 2016) and research indicates that high initial symptom level might interfere with the capacity to trust and accept help from a therapist (Falkenstrom, 2014; Puschner et al., 2008). It may be that this did not leave enough margin for further improvement of the alliance as a result of adding formalised feedback. This might also indicate that formalised feedback

does not have surplus value compared to feedback gathered in an informal way by experienced therapist who seek to connect to clients, but more research is needed to confirm this hypothesis.

Setting

Influences on the alliance might be less clear in emergency psychiatric treatment since many factors can influence the perception of the alliance. For instance, the frequent involvement of relatives might water down differences in the alliance process, the same applies for changes in external stress factors (divorce, finances, housing) during the crisis treatment. Also, given the (time)pressure to find a solution in crisis situations, clients and therapists might have been less prone to discuss negative feedback on the alliance.

Furthermore, the mean score on the SRS over all time points in this study was 33.4 (*SD* 7.2). This is in line with the mean score in Dutch samples of 32.4 reported by Hafkenscheid et al (2010) and 32.1 by Janse et al (2013), but lower than the scores reported in an US sample (varying between 36.1 and 37.3) (Reese et al, 2013) and the score of 34.9 in an Norwegian study (Anker et al, 2009). In general, the scores found in this study support the impression that scores found in European studies tend to be lower than in US studies. This suggest that alliance scores have to be interpreted in the cultural context and the context of the specific treatment.

Method: strengths and limitations

Limitations

A limitation of this study is that the SRS covers different aspects of cooperation, working alliance and therapy process and that it is not clear which apart of the working alliance was addressed exactly and which elements might have improved and which might have burdened the quality of the alliance.

Furthermore, alliance is a complex concept and discussing SRS scores may not cover all aspects of the relationship. Besides, some of these aspects will probably not so easily be adjusted.

Also, it is not known to what extent the therapists used the feedback in any meaningful way. We did not check in what way therapists discussed the SRS. Possibly it was not always discussed in an open way.

Another limitation is that many therapies were done with co-therapists. This might have influenced the feedback on the alliance since the feedback often concerned two therapists which perhaps made the process of reflecting on the cooperation less personal or less precise.

Strengths

Since the study was performed in a naturalistic setting, it has ecological validity, and the study is unique, to our knowledge, in measuring the effect of applying feedback about the alliance on the quality of the working alliance.

Another unique aspect of this study is that an independent alliance measure was provided to measure the effect of discussing feedback on another alliance instrument.

Conclusions

To our knowledge, this is the first study exploring the link between immediate formal feedback on the alliance and the quality of the alliance in an acute psychiatric setting. The finding that no link is found, suggests that discussing client's alliance ratings scored on a formal feedback instrument does not improve the alliance.

To improve alliance ratings, perhaps therapists should be trained more intensively to handle the feedback process, focussing on specific and personal elements of the cooperation between therapist, client and relatives, especially the role of the therapist in the treatment process, as an expert, consultant or as a person (van Oenen et al, 2014).

It might also be that in acute psychiatric treatment feedback does not add to the quality of the alliance since to many other factors interfere with the process of allying.

Apart from that, feedback can be considered valuable for therapists because it stimulates them to reflect on their own skills in cooperating, for patients and relatives because they feel empowered by directing the treatment process and for mental health care because it meets the expanding need for shared decision making.

Since the alliance is proven to be an important factor for treatment success, further research is needed to examine if and how clients and relatives can profit from the use of immediate feedback on the alliance, in particular in more psychotherapeutic settings, and if specific training of therapists can influence the effect of alliance feedback.

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