Socialization to the Model:

The active component in the therapeutic alliance?*

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INTRODUCTION

Therapeutic alliance has been found to be a significant predictor of outcome in psychotherapy (Martin et al. 2000) yet what constitutes therapeutic alliance remains unclear. Examining the common constructs of therapeutic alliance such as Bordin's (1979) three factor model, it is possible that there may be a conceptual overlap between active components of therapeutic alliance, and socialization to the treatment model. Socialization is defined as the process by which the patient and therapist negotiate a shared understanding of the presenting difficulty, where the therapist presents hypotheses and a formulation of the symptoms and experience in terms of the model to be used for intervention. During this process, the therapist provides information concerning the practical implications of the chosen model of therapeutic intervention, to enable the patient to fully engage with and understand both the therapeutic process and the rationale for intervention (Roos & Wearden, 2009).

AIM

To investigate the theoretical overlap and relationship between socialization to the model and therapeutic alliance.

METHOD

Participants (*N* = 43) were taken from the active treatment arm of a RCT for the treatment of chronic fatigue syndrome (CFS/ME) – the FINE trial (Wearden et al., 2010). The brief 5-item California Therapeutic Alliance Scale (CALPAS, Muran et al. 1995) based on Bordin's model was used to measure therapeutic alliance. Data on socialization to the model was extracted from therapy tapes using a novel coding system (Daniels & Wearden, in submission) and was correlated with data from the CALPAS dimensions which were theoretically similar. Data from the socialization measure was also correlated with the 'bond' element of the CALPAS which would not correlate with the socialization dimensions, if indeed socialization represented the 'active component' in therapeutic alliance.

Table 1. Results from correlation analysis between data generated from CALPAS questionnaire and socialization dimensions

		Socialization to the model dimensions						
CALPAS dimensions		Concordance	Resistance	Understand	Active plans	Evidence Congruent	Evidence Incongruent	Avoidance
Question 2: Agreed treatment goals	Correlation Coefficient	.377	-.429	.073	.076	.265	-.496	-.335
	Sig. (2-tailed)	**.013***	**.004***	.640	.629	.086	**.001***	**.028***
Question 3 Treatment Match	Correlation Coefficient	.479	-.546	.260	.104	.455	-.260	-.534
	Sig. (2-tailed)	**.001***	**.000***	.092	.506	**.002***	.093	**.000***
Question 4: Joint working	Correlation Coefficient	.282	-.396	.025	.004	.246	-.435	-.296
	Sig. (2-tailed)	.067	**.009***	.875	.981	.112	**.004***	**.054***

RESULTS & INTERPRETATION

Correlations were moderate in strength and in the expected directions. More specifically, analysis indicated that the more agreement expressed by the participant in terms of the treatment goals, the more they demonstrated concordance with the therapist in session, the less avoidance and resistance was shown, and the more they made changes to ameliorate their symptoms in a way that was consistent with the model. This suggests that agreement about goals of treatment between therapist and participant are important to the process of therapy. If the therapist and participants have different ideas and a lack of agreement about goals, then it is logical that participants may not follow the rationale, and subsequently show resistance, avoidance and make changes that are inconsistent with the rationale of the therapy.

The higher the match between participant expectation of what would help and therapist expectation of what would help, the more concordance is demonstrated in session, and the more participants gave examples of how they had correctly applied the principles of the treatment model. This reinforces the suggestion that agreement of the process and rationale of therapy is imperative in motivating the participant to actively participate in therapy. Joint working was associated with less resistance to the treatment model, highlighting the importance of adopting a collaborative approach in therapy. Data correlated between the proposed "bond" component of the measure and socialization to the model dimensions found no significant associations, supporting findings by Andrusnya et al. (2001) that the "bond" component may be distinct from the other "active components" of the therapeutic alliance.

CONCLUSION

The outcome of this preliminary study contributes to the potential understanding of active components in the therapeutic alliance, and supports further research to achieve a more detailed picture of "non-specific" factors in therapy. The nature of the findings suggest important clinical implications associated with the promotion of therapeutic alliance/socialization and hence the likely impact on positive engagement in therapy.

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