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THE WORKING ALLIANCE: A COMPARISON OF TWO THERAPIES

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Alliance ratings of single significant sessions of cognitive-behavioral and psychodynamic-interpersonal therapies were compared using the observer form of the Working Alliance Inventory (WAI-O). Eighteen cognitive-behavioral and 13 psychodynamic-interpersonal therapists, nominated by experts in the field, participated in the study. Results indicate significantly higher total alliance scores for cognitive-behavioral sessions, and greater variability in alliance for psychodynamic-interpersonal sessions. In addition, SCL-90 scores were negatively correlated with the alliance solely in psychodynamic therapy, indicating that more symptomatic patients may have greater difficulty with the work required in this kind of therapy.

The working alliance, defined broadly as the relationship between the therapist and the client, has been recognized as one of the most important factors leading to therapeutic change (e.g., Gaston, 1990). Indeed, Goldfried and Padawer (1982) have identified the therapeutic relationship as one of the basic strategies common across different psychotherapies. According to these authors, the therapist uses the relationship, directly or indirectly, to encourage a change in clients' patterns of functioning.

Within the three major psychotherapy orientations—psychoanalytic, experiential, and cognitive-behavioral—the concept of the alliance has received different degrees of emphasis. Psychoanalytic theorists (Freud, 1912/1966; Greenson, 1965; Sterba, 1934; Zetzel, 1956) have distinguished the working alliance from the transferential, or distorted, aspects of the relationship by defining the former as the patient's ability to work with the therapist. From the experiential approach, Rogers (1951, 1957) has identified empathy, unconditional positive regard, and congruence as the three necessary and sufficient therapist-offered conditions for therapeutic change. Cognitive-behaviorists have also recognized the importance of the relationship, viewing it as a means to promote positive expectancies, facilitate the therapist's influence and value as a model, and encourage between-session risk

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taking (Goldfried & Davison, 1976; Raue & Goldfried, in press; Wilson & Evans, 1976).

Early efforts to measure the impact of the therapeutic relationship have focused on client and therapist perceptions of their interaction (Gurman, 1977). More recently, there have been corresponding attempts using external raters (see Gaston, 1990). Although observers are removed from the interaction and are unable to directly access the thoughts and feelings of the participants, they do possess some advantages. Observers are not personally involved and therefore are more able to objectively characterize the nature of the relationship. Moreover, they are able to apply their ratings to archival data. Research with observer-based measures has found that the early development of a positive alliance is predictive of successful outcome (Garfield, 1990; Orlinsky & Howard, 1986).

Whereas most measures of the alliance reflect a psychodynamic definition of this construct (e.g., Alexander & Luborsky, 1986; Hartley & Strupp, 1983; Marmar, Gaston, Gallagher & Thompson, 1989), one scale was designed to investigate the alliance from a transtheoretical perspective (Horvath & Greenberg, 1989). The Working Alliance Inventory (WAI) relies primarily on Bordin's (1979) eclectic conceptualization of the working alliance as consisting of three components: the development of a therapeutic *bond,* an agreement between client and therapist on *tasks,* and an agreement on *goals.* In contrast to previous notions of the alliance, which have looked separately at therapist or client contributions, this theory emphasizes the mutuality of the interaction between the therapist and client.

The therapeutic *bond* is defined as the mutual liking, attachment, and trust between the client and therapist. To attain a good bond, the therapeutic interaction must be characterized by therapist understanding, client comfort, and reciprocal respect. The therapeutic *tasks* consist of those activities that the client and therapist engage in during the session (e.g., interpretation, cognitive restructuring, role playing). For a high degree of agreement to be present, each participant must perceive the tasks as important for change. The therapeutic *goals* are the objectives of the client and therapist, or those areas specifically targeted for change (e.g., decrease in symptomatology, improvement in interpersonal relationships). A high degree of agreement occurs when both participants perceive the goals as clear, important, and capable of being accomplished.

The Working Alliance Inventory was originally designed to be rated only by clients (WAI-C) and therapists (WAI-T). Not only does it have good predictive validity, but by clearly defining the components of a good working alliance and remaining independent of theoretical orientations, the WAI possesses broad clinical utility. In a series of studies, Horvath and Greenberg (1989) demonstrate adequate reliability for the WAI, as well as support for its convergent, divergent, and predictive validity. An observer version of the Working Alliance Inventory (WAI-O) was later constructed and compared to five other measures of the alliance: the California Psychotherapy Alliance Scale (CALPAS), the Penn Helping Alliance Scale (Penn HAS), the Vanderbilt Therapeutic Alliance Scale (VTAS), the WAI-C, and the WAI-T (Tichenor & Hill, 1989). All measures demonstrated high internal consistency, and observers attained high levels of interrater agreement on all observer-rated measures. CALPAS, VTAS, and the WAI-O were all highly correlated with one another, whereas the Penn correlated only with the WAI-O.

Although the therapeutic alliance has been identified as a common factor that is responsible for change across different orientations, comparative process research is needed to uncover similarities and differences across orientations and the relation of

the alliance to other variables (Goldfried, 1991). Thus, the present study compared alliance ratings from the WAI-O of single significant sessions of cognitive-behavioral and psychodynamic-interpersonal therapies. In line with Greenberg's (1986) suggestion that psychotherapy researchers would be well-advised to investigate those processes within the therapy session that result in some immediate change, we deemed it important to compare the therapeutic alliance within the context of significant sessions. These sessions consisted of a unique data set, where experienced, expert-nominated therapists from both orientations identified what they judged to be important change sessions.

We also explored the extent to which level of symptomatology (assessed with the Global Severity Index of the Symptom Checklist; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) and overall level of functioning (assessed with the Global Assessment of Functioning Scale; Endicott, Spitzer, Fleiss, & Cohen, 1976) were related to alliance ratings. Although one study comparing behavioral, cognitive, and brief psychodynamic therapies found no relation in any therapy between pretreatment depression and patient contribution to the alliance (Gaston, Marmar, Thompson, & Gallagher, 1988), another looking solely at psychodynamic therapy found that the higher the pretreatment symptomatology, the lower the patient contribution to the alliance (Eaton, Abeles, & Gutfreund, 1988). To our knowledge, no studies have been conducted using overall level of functioning as a predictor. In our study, the above measures were taken after the selected session, so direction of causality unfortunately cannot be determined.

METHOD

SUBJECTS

Thirty-one therapists who were identified by experts of cognitive-behavioral and psychodynamic-interpersonal backgrounds participated in the study. The experts were therapists who have written books in the field and/or have been actively involved in therapist training. There were approximately 30 cognitive-behavioral experts (e.g., Arnkoff, Beck, Glass, Lazarus, Mahoney, Meichenbaum) and 30 psychodynamic-interpersonal experts (e.g., Benjamin, Carson, Chevron, L. Horowitz, Kiesler, Mitchell). These experts were asked to identify therapists within their own orientation to whom they would personally refer a close friend or relative. Any therapist who received two or more nominations was invited to participate. Additionally, therapists were asked to rank order their primary orientations (cognitive-behavioral, psychodynamic-interpersonal, experiential, or other), and they must have ranked first the orientation they were nominated under in order to qualify. Of the 31 therapists who participated in the study, 18 identified themselves as primarily cognitive-behavioral and 13 as primarily psychodynamic-interpersonal. There were 12 male and 6 female cognitive-behavioral therapists and 12 male and 1 female psychodynamic-interpersonal therapists. The mean years of therapist experience for the sample as a whole was 15.4 (SD = 8.8). For cognitive-behavioral and psychodynamic-interpersonal therapists, the mean years of experience was 13.1 (SD = 6.2) and 18.6 (SD = 10.9), respectively.

As each therapist worked with a different client, 31 clients participated in the study. Inclusion criteria for selection consisted of clients between the ages of 20 and 55 who were being seen in individual therapy on an outpatient basis. The presenting

problem was restricted to anxiety and/or depression, and these problems had to be in some way related to relationships with other people. Exclusion criteria consisted of those clients currently taking psychoactive medication, possessing psychotic or borderline features, presenting with problems relating to situational life stress (e.g., bereavement or job loss), or being treated primarily for a focal problem (e.g., simple phobia) with clearly delineated interventions (e.g., desensitization). The mean age for clients in the entire sample was 34.5. Of the 31 clients, 28 identified themselves as White, two as Black, and one as Hispanic. None of the clients had less than one year of college education; 32% had four years of college, and 32% had some graduate education. There were 4 male and 14 female clients in the cognitive-behavioral group and 7 male and 6 female clients in the psychodynamic-interpersonal group. The mean Global Severity Index of the Symptom Checklist (SCL-90) was 77.4 (SD = 44.5) and 80.9 (SD = 46.9) for cognitive-behavioral and psychodynamic-interpersonal clients, respectively. The mean Global Assessment of Functioning (GAF) scores were 65.1 (SD = 6.2) and 59.5 (SD = 10.1) for clients in each of these conditions. Inasmuch as the study was conducted in a naturalistic setting with the intent of being as unobtrusive as possible, both of the above scores were obtained approximately one to two weeks after the significant session had been identified.

INSTRUMENT

The Working Alliance Inventory–Observer Form (WAI-O) is divided into three subscales: the bond, the tasks, and the goals (Horvath & Greenberg, 1989). Each subscale consists of 12 items rated on a 7-point Likert scale (1 = "never" and 7 = "always"). An example from the bond scale is: "There is a mutual liking between the client and the therapist"; from the tasks scale: "There is agreement about the steps taken to help improve the client's situation"; and from the goals scale: "The client and therapist are working on mutually agreed-upon goals." Nine bond items, seven task items, and six goal items are positively valenced. The remaining three bond items, five task items, and six goal items are negatively valenced.

Inasmuch as the tasks, goals, and nature of the bond may differ between the two orientations, we developed a set of criteria for coding by independent observers based on Bordin's model of the alliance.[1] The therapeutic bond was defined as the mutual liking, attachment, and trust between the client and therapist and was assessed through such means as tone of voice, empathy, and comfort in exploring intimate issues. The tasks consisted of global strategies (e.g., exploration, confrontation, reality testing, homework assignments). Coders assessed agreement according to how responsive the participants were to each other's focus or need. The goals were the objectives of the client and therapist, or those areas specifically targeted for change (e.g., decrease in symptomatology, improvement in interpersonal relationships, increase in self-esteem). Coders assessed agreement according to the extent to which both participants interacted in ways that suggested the goals were important, mutual, and capable of being accomplished. It should be noted that the tasks and goals need not have been explicit; concordance between client and therapist was judged to be high as long as the general focus and topics of discussion were mutually followed.

[1]These guidelines are available on request.

TRANSCRIPTS

For each therapist and client pair, a single session was chosen by the therapist from the middle course of therapy (anywhere after the first five and before the last five sessions). Sessions were chosen on the basis of significance or importance in terms of facilitation of therapeutic change. To meet the criteria for significance, the issue dealt with must have reflected an interpersonal theme central to the client's problem, there must have been some observable impact on the client during the session as noted by the therapist, and the therapist must have noticed a change in the client during the subsequent session or two that was not clearly attributable to external factors. Cognitive-behavioral therapists chose sessions ranging from the 6th to the 80th, the average number being the 24th. Psychodynamic-interpersonal therapists chose sessions ranging from the 7th to th 98th, the average number being the 26th.

CODING

Three advanced female graduate students in clinical psychology, coming from a cognitive-behavioral background but having some general familiarity with dynamically-based interventions, served as raters. Before coding, they were trained to reliability on a mix of cognitive-behavioral and psychodynamic-interpersonal therapy sessions (separate from those of the study). During coding, the order of sessions was randomized to control for possible biasing effects related to order of receipt from the therapist. After listening to the audiotape and reading the transcript, all three raters independently coded every session. To maintain calibration, raters met after every three sessions to discuss any discrepancies.

RESULTS

Using the intraclass correlation coefficient, the coders achieved a reliability of .71 for the bond subscale, .81 for the task subscale, .74 for the goal subscale, and .78 for the total alliance score.

As can be seen in Table 1, the mean total alliance score was 6.39 for the cognitive-behavioral group, and 5.82 for the psychodynamic-interpersonal group.

Table 1. Comparison of Psychodynamic-Interpersonal and Cognitive-Behavioral Alliance Scores

Score	Psychodynamic-Interpersonal (n = 13)		Cognitive-Behavioral (n = 18)		t
	Mean	*SD*	*Mean*	*SD*	
Total	5.82	.87	6.39	.51	2.31*
Bond	5.85	.90	6.47	.50	2.46*
Task	5.75	1.00	6.32	.63	1.97+
Goal	5.85	.88	6.39	.46	2.21*

*Significant at the .05 level.
+Significant at the .10 level.

Although both of these averages are quite high (e.g., 7.00 indicates that a good alliance was always present, 6.00 that it was very often present, and 5.00 that it was often present), a *t*-test comparing them indicates significantly higher scores for the cognitive-behavioral group as a whole ($t(29) = 2.31$, $p = .028$). Table 1 also summarizes the results of *t*-tests conducted using the three subscales, indicating comparable findings for bond and goal, and marginal significance for task. Consistent with past research (Horvath & Greenberg, 1989), the subscales were all highly intercorrelated (.81 for bond and task, .82 for bond and goal, and .93 for task and goal). A comparison of the standard deviations for the total scores of the two groups (.51 and .87, respectively) revealed significantly higher variability in the alliance scores of the psychodynamic-interpersonal group ($F(1,30) = 2.92$, $p = .043$).

T-tests were conducted to assess possible differences in symptomatology and level of functioning between the two therapy groups. The variables included the Global Severity Index of the Symptom Checklist as rated by clients approximately one to two weeks after the selected session, and the Global Assessment of Functioning Scale as rated by therapists approximately one to two weeks after the selected session. The means and standard deviations for these scores have been summarized in the Methods section. No differences were found between client SCL-90 scores ($t(29) = .21$, $p = .84$). The other comparison, although not significant, suggests a higher Global Assessment of Functioning score in the cognitive-behavioral group ($t(29) = 1.93$, $p = .06$).

Further analyses were performed to assess the relationship of these client characteristics to alliance scores (see Table 2). A negative correlation was obtained between the SCL-90 and total alliance scores for all participants ($r = -.46$, $p = .01$), suggesting that the more symptomatic clients presented themselves, the lower the alliance tended to be. Interestingly, when the two orientations were separated in the analysis, the correlation did not hold up for the cognitive-behavioral group ($r = -.32$, $p = .20$). For the psychodynamic-interpersonal group, however, the negative correlation did hold up, and even increased to $-.64$ ($p = .02$). When the only outlier was removed from the analysis in the psychodynamic-interpersonal condition, the correlation jumped to $-.92$ ($p = .001$). The scatterplots for these correlations are presented in Figure 1. The correlation between GAF and alliance score with the total sample only approached significance ($r = .31$, $p = .09$), suggesting that the higher the client's level of functioning, the higher the alliance score may be.

Table 2. Correlations Between Client Characteristics and Total Alliance Scores

	Correlations with Total Alliance Scores		
Variable	Combined	Psychodynamic-Interpersonal	Cognitive-Behavioral
	($n = 31$)	($n = 13$)	($n = 18$)
SCL-90	−.46**	−.64*	−.32
Global Assessment of Functioning	.31+	.18	.24

*Significant at the .05 level.
**Significant at the .01 level.
+Significant at the .10 level.

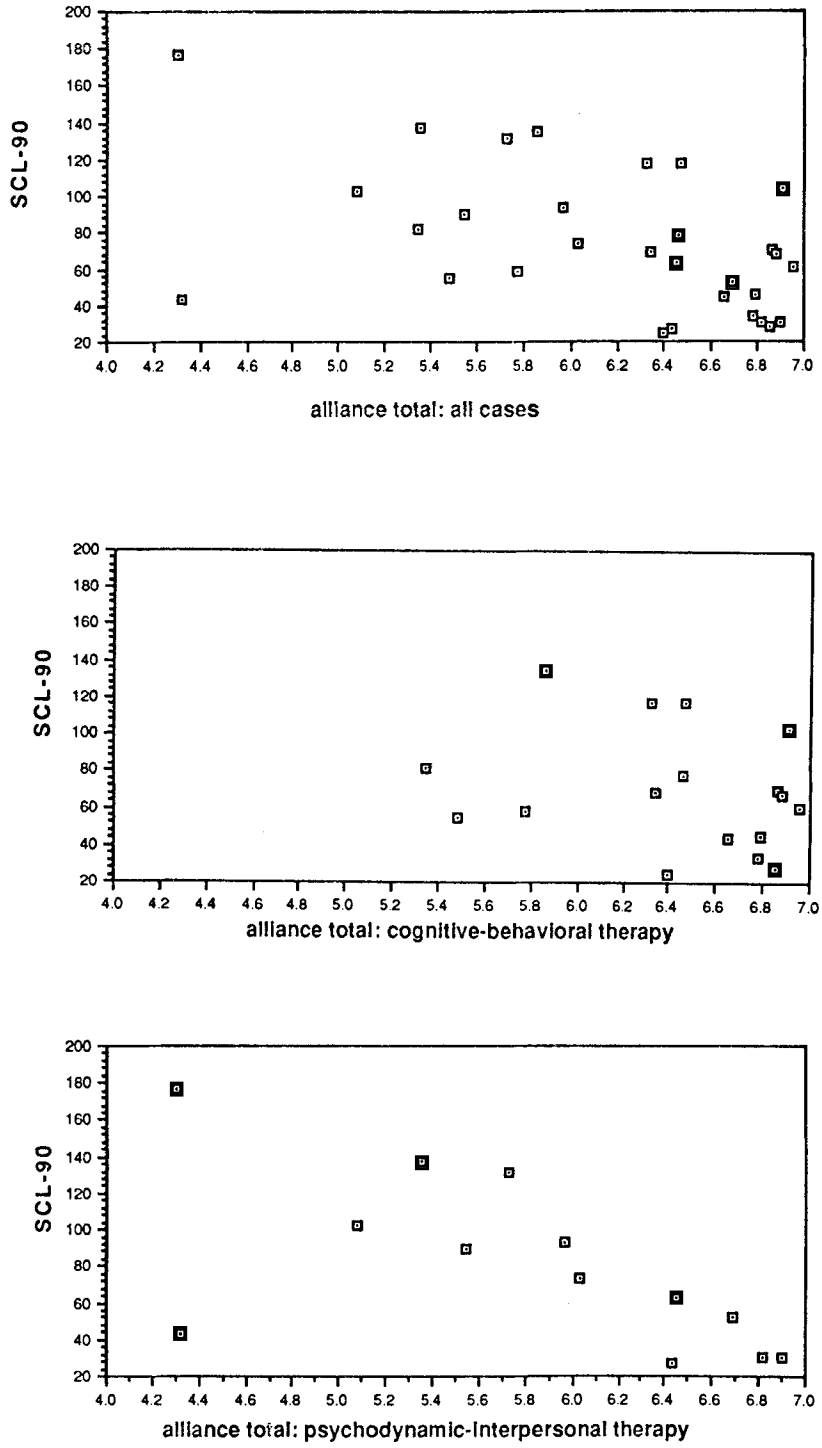

Figure 1. Relationship of SCL-90 score and total alliance score for all cases (n = 31), for cognitive-behavioral cases (n = 18), and for psychodynamic-interpersonal cases (n = 13).

DISCUSSION

The primary purpose of this study was to conduct a comparative analysis of the therapeutic alliance within significant change sessions, as identified by experienced, expert-nominated therapists. Although the overall alliance scores for both orientations were high, the cognitive-behavioral group had uniformly higher scores than the psychodynamic-interpersonal group.

Our results recall those of Sloane, Staples, Cristol, Yorkston, and Whipple (1975), who found that behavior therapists, although not differing in degree of warmth or unconditional positive regard, were rated as demonstrating higher level of empathy, congruence, and interpersonal contact than psychoanalytic therapists. In another study, Brunink and Schroeder (1979) found that expert psychoanalytic and behavior therapists were rated similarly in their communication of empathy, but that behavior therapists used significantly more supportive communications.

One possible explanation for our findings is that cognitive-behavioral therapists may put a greater emphasis on providing structure in the session, thereby making the therapeutic tasks and goals explicit and clear to the clients. However, the difference in task subscores for the two orientations only approached significance. Alternately, it may reflect the emphasis in cognitive-behavioral therapy on establishing and maintaining a good, collaborative relationship, which is consistent with the fact that this orientation obtained higher bond subscores. In cognitive-behavioral therapy, the relationship is used by the therapist as a tool to encourage the client to engage in within-session therapeutic activities and between session risk-taking. In contrast, in psychodynamic-interpersonal therapy, where the proposed mechanism of change requires a focus on the transferential aspects of the relationship itself, negative relationship issues are likely brought up and dealt with. Perhaps creating a strong emotional reaction within psychodynamic-interpersonal therapy, by confronting patients about their maladaptive ways of relating within the therapeutic relationship, may be important for creating long-range change—even if it may temporarily strain the alliance. For example, Luborsky (1984) suggests that the repetition and working through of patients' relationship problems with their therapists leads to greater self-understanding and increased control and mastery. This, in turn, allows patients to be more tolerant of relationship problems and to explore more adaptive ways of behaving.

The particular sessions that therapists chose may reflect the above conceptualizations, with cognitive-behavioral therapists submitting sessions in which the alliance was relatively intact and some clearly articulated and agreed-upon task was successfully engaged in, and psychodynamic-interpersonal therapists submitting sessions in which some aspects of the alliance was strained. Based on our finding of greater variability of alliance scores within psychodynamic-interpersonal sessions, we might hypothesize that either (1) only some therapists of this orientation selected sessions based on an endangered alliance, with other therapists using some other criteria for significance, or (2) for some sessions, this strain was resolved within the same session, and for others, within subsequent sessions.

An informal inspection of psychodynamic sessions with a total alliance score under 6.00 (n = 7) seemed to confirm the former hypothesis. In these sessions, there was a high focus on the client's perception of the therapist and the therapeutic relationship. The following major issues were dealt with: client frustrated with therapist unhelpfulness/nondirectiveness; client defensive and not sharing emotions in and out of session; client feeling hopeless and not helped by the therapist or the

therapy; client inability to see self as changing; client discomfort with and distrust of therapist; client defiance in and out of session; client not feeling intimate with others in past, currently, and with therapist. These issues were brought up by both the therapist and the client and were often willingly explored by both. The participants were working with a rupture in the alliance, and observable resolutions did not necessarily take place within the session. Interestingly, in higher-rated psychodynamic sessions, there was very little of a focus on the therapeutic relationship.

A corresponding inspection of cognitive-behavioral sessions with a total alliance score under 6.00 ($n = 5$) revealed strikingly less of a focus on the client's perception of the therapist and the therapeutic relationship. The following major issues were dealt with: therapist highlighting past sexual abuse and its effect on the client's current functioning while client minimizes it; therapist focus on the client's contribution to interpersonal problems; therapist focus on own experience at the expense of the client's; therapist focus on client's tendency to switch topics; and client's fear of negative therapist reaction to client disclosure of past abuse. Thus, whereas low alliance sessions in psychodynamic-interpersonal therapy seemed to be due to negative issues within the therapeutic relationship, relatively lower alliance sessions in cognitive-behavioral therapy were due for the most part to nonrelationship issues.

How do we account for the finding that more symptomatic psychodynamic-interpersonal (but not cognitive-behavioral) patients had lower working alliances? As there were no differences in SCL-90 scores for clients in the two treatment conditions, this finding cannot be attributed to differences between the two orientations in clients' level of symptomatology, although the higher variability in alliance scores in the psychodynamic group may partially account for this higher correlation. Moreover, it might be that psychodynamic-interpersonal therapists, as their theory would suggest, are not symptom-oriented, and that more symptomatic patients would have greater reluctance and difficulty engaging in the work required in this kind of therapy. Clients experiencing less anxiety and depression may indeed be better able to explore emotional issues underlying their relations with themselves and with others. In contrast, one important goal of cognitive-behavioral therapists is symptom reduction, such that symptomatology would be unrelated to ability form an alliance.

Further, the findings may reflect a greater degree of structure provided by cognitive-behavioral therapists, which could serve to prevent significant pathology from becoming manifest within the therapeutic relationship. This could conceivably be beneficial to the process of therapy by keeping clients "healthy" and rational and enabling them to form stronger alliances. On the other hand, this may be characterized as a superficial control of problems that would prevent their manifestation within the relationship where they might be worked on.

Apart from this intervention, it may not be accurate to speak of symptomatology as a predictor in our study, as these measures of symptomatology were taken approximately one to two weeks after the targeted session. Because of this, it cannot be totally ruled out that something that occurred within the session (such as confrontation) could have contributed to an increase in self-reported symptomatology.

A somewhat related correlation, between Global Assessment of Functioning scores and alliance, suggested a nonsignificant trend for higher levels of client functioning (for the entire sample, but not for either orientation alone) to be associated with higher alliance scores. In all likelihood, therapists find it easier to

like and identify with better functioning clients, and have more optimistic expectations in their work with such individuals. Our results are consistent with past research that has found therapists to relate better to clients who are generally more similar to themselves (Garfield, 1986; Orlinsky & Howard, 1986).

In interpreting our findings, it should be kept in mind that we measured the alliance from an external vantage point. Had we used ratings from the therapist and the client for the same sessions, we might have obtained different findings, as some past research would suggest. For example, Gurman (1977) has concluded that therapists and clients do not agree on therapists' facilitative conditions, and judges and clients only inconsistently agree. Similarly, Tichenor and Hill (1989) found that the client and therapist version of the Working Alliance Inventory did not correlate with each other or with any other measure of the alliance. These findings suggest that ratings from different vantage points reflect somewhat different constructs, or aspects of the working alliance. Another limitation in interpreting our findings is that the coders themselves all came from a cognitive-behavioral background. It should be noted, however, that this methodological constraint is typical of virtually all process research that involves observer coding systems, and is therefore not unique to our study. Future research should look at both of these issues to determine whether the findings hold up when different perspectives and coders from other orientations are used.

Although there are different possible interpretations for our results, they nonetheless are intriguing and are based on a relatively unique data set, namely, single sessions chosen by therapists of two orientations on the basis of their therapeutic significance. The findings have raised a number of interesting questions that bear on the comparative nature of the alliance in the therapeutic change process and point to directions for future research.

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