The Perceived Importance of Alliance and Technique Adherence within Cognitive Behavioural Therapy: A Comparison of Patients' and Therapists' Beliefs

Ian Johnson*, Glenn Waller

Department of Psychology, The University of Sheffield, Sheffield, UK

**Corresponding author, ian.m.joh@gmail.com*

Abbreviations: CBT – Cognitive Behavioural Therapy

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Abstract

Alliance and adherence to therapeutic techniques are key elements of Cognitive Behavioural Therapy (CBT). Therapists' beliefs about how important alliance and technique adherence are throughout CBT might impact how they deliver therapy. Furthermore, these beliefs might or might not be congruent with patients' therapy-related beliefs. This research investigated whether therapists hold similar beliefs to patients regarding the importance of alliance and technique adherence throughout CBT and whether therapists could accurately predict patients' beliefs. CBT therapists (n=103) and CBT patients (n=181) rated the importance of alliance and technique adherence to CBT outcomes in early, mid and late therapy. Therapists also predicted patients' responses. Mann-Whitney U tests compared therapists' responses and therapists' predictions with patients' responses at each stage of therapy. Therapists rated alliance and technique adherence as more important than patients did throughout therapy, with the largest discrepancy for alliance in early therapy. Therapists accurately predicted patients' alliance importance ratings but underestimated patients' technique adherence importance ratings for early and mid-therapy. Therapists are encouraged to challenge their assumptions about patients' therapy-related beliefs by having open discussions with patients. Therapists are encouraged to prioritise technique adherence as well as alliance in early CBT.

Keywords

Cognitive Behaviour Therapy; Psychotherapy; Client Attitudes; Therapist Attitudes; Therapeutic Alliance; Treatment Compliance

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The therapeutic alliance is one factor that is necessary for positive cognitive behavioural therapy (CBT) outcomes (Beck et al., 1979), accounting for 5-8% of outcomes across psychotherapies (Flückiger et al., 2018; Horvath & Symonds, 1991; Martin et al., 2000). Adherence to specific techniques is also associated with positive CBT outcomes (Bennett-Levy, 2003; Rees et al., 2005; Westra et al., 2007). Lambert and Barley (2001) have estimated that specific therapy techniques account for 15% of therapeutic outcomes. However, other research linking adherence and outcomes is mixed, with a meta-analysis failing to find a significant correlation between the two (Webb, DeRubeis, & Barber, 2010). In response, researchers have theorised a curvilinear relationship between adherence and outcomes (Barber, 2009; Hogue et al., 2008). Additionally, the results of Webb et al.'s (2010) meta-analysis revealed significant heterogeneity, suggesting the results represented differences in underlying populations. Therefore, the adherence-outcome association might by impacted by differences across therapy models and stages of therapy.

Some research indicates that adherence is be especially important within the early part of CBT (Feeley et al., 1999; Folke et al., 2017; Haug et al., 2015; Strunk et al., 2010), possibly driving the early symptom improvement that predicts positive therapy outcomes (Delgadillo et al., 2014), with alliance more important later in CBT (Gaston et al., 1991; Haug et al., 2015; Horvath et al., 2011; Weiss et al., 2014). This might be due to Tang and DeRubeis's (1999) "upward spiral". However, other research suggests that alliance is a precondition for adherence (Weck et al., 2015) Regarding this discrepancy, the condition being treated might be an important factor. For example, the interaction of alliance and adherence might differ within CBT for generalised anxiety disorder compared with CBT for depression (Roussos et al., 2018).

While there might be times in CBT that an early focus on adherence to techniques is more important than an early focus on the alliance, it is not clear whether this is appreciated by CBT therapists. It is possible that CBT therapists commonly focus on early alliance at the expense of early adherence, seeing the two as conflicting, and assuming that working on the alliance is needed prior to symptom change, despite evidence to the contrary (Brown et al., 2013, 2014; Mulkens et al., 2018). For example, therapists express beliefs that adherence to techniques such as exposure, treatment manuals and homework can negatively impact the therapeutic relationship (Addis et al., 2006; Addis & Krasnow, 2000; Deacon, Farrell, et al., 2013; Kazantzis et al., 2005).

If CBT therapists view adherence as harmful to the alliance, or hold beliefs that patients cannot tolerate certain techniques, they might try to 'protect' patients from CBT techniques by non-adherence (Meyer et al., 2014). In other words, when therapists "drift" away from adherence to evidence-based therapies and techniques (Waller, 2009; Waller & Turner, 2016), this might be driven by therapists' assumptions that patients do not value adherence in therapy. However, therapists might be underestimating patients' preferences for adherence to techniques. For example, therapists show concerns about exposure and under-utilise it in therapy, which is at odds with patients' preferences for exposure-based therapy (Becker et al., 2004, 2007, 2009; Deacon, Lickel, et al., 2013; Hipol & Deacon, 2013). However, such clinician concern might be driven by a desire to protect their patients from what clinicians believe will be 'challenging' aspects of CBT, though that belief is based on 'mind-reading' what their patients would find more or less valuable and acceptable.

Given these competing priorities in how clinicians deliver CBT, it would be valuable to understand therapists' beliefs about the importance of alliance and adherence to techniques throughout therapy, and to understand their beliefs about what patients will find acceptable. Therefore, it is important to determine whether patients' beliefs do or do not reflect the

therapists' predictions as to what those beliefs are, to determine whether therapists' 'mind-reading' is accurate.

The aim of this study was to determine whether CBT therapists' ratings of the importance of alliance and technique adherence reflect those of CBT patients, across early, mid and late therapy. It was hypothesised that therapists would view the alliance as more important and technique adherence as less important relative to patients' ratings, particularly early in therapy. Also, it was hypothesised that therapists would make 'mind reading' errors, overestimating the importance of the alliance and underestimating the importance of technique adherence to patients, relative to patients' own ratings, particularly early in therapy.

Method

Ethics

Ethical approval was granted by the Sheffield University Ethics Committee. All participants gave informed consent.

Design

A mixed, cross-sectional design was used. Online questionnaires were employed to measure participants' demographics and therapy-related beliefs. Independent variables were participant type (CBT therapist or CBT patient) and stage of therapy (early, mid, late). Early, mid and late therapy were defined as the first, second and final third of therapy respectively, as the length of CBT can vary. Dependent variables were ratings of alliance and technique adherence importance (all participants) and predictions of patients' ratings of alliance and technique adherence importance (therapists only).

Participants

There were two groups of participants – CBT therapists and CBT patients. Therapists needed to have a qualification or accreditation in CBT and to have routinely delivered individual CBT within the previous two years. Patients needed to have completed individual

CBT within the previous two years. The recruitment information gave a short description of CBT to clarify what this therapy entails, for potential participants.

An a priori power calculation indicated 64 participants per group were needed to detect a medium effect size at power .80 and an alpha level of .05 (Cohen 1992). In total 103 therapists (75 completers) and 181 patients were recruited (140 completers). See Figure 1 for dropout rates and Table 1 for participant demographics.

Therapists were recruited by email from the British Association for Behavioural and Cognitive Psychotherapies. Patients were recruited by email from the University of Sheffield student population and the online recruitment tools Survey Circle and Survey Swap, which allow researchers to participate in each other's research. Participants were also recruited via email and social media from local and national mental health services and charities.

Procedure

Questionnaires were created and hosted online using Qualtrics survey software. Online adverts for the study contained a link to the study information, consent form and screening questionnaires. Screened and consenting participants were directed to the appropriate questionnaire. Data were collected and stored via the Qualtrics system.

Measures

CBT Component Importance Questionnaires

Using a measure designed for this study, participants rated the importance of six CBT components for therapy outcomes. Importance ratings were on a seven-point Likert scale. Three items represented therapeutic alliance - agreement on goals, agreement on tasks, and the affective bond (Bordin, 1979). These items were aggregated together to create an overall alliance score. Three items represented adherence to CBT techniques - behavioural techniques, cognitive techniques, and homework tasks. These items were aggregated together to create an overall technique adherence score.

Participants rated the importance of each component within early, mid and late therapy, defined as the first, second and final thirds of therapy respectively. Therapists also predicted patients' importance ratings. To aid consistency in understanding the concepts measured, each item was accompanied by a short description, based on the Working Alliance Inventory (Horvath & Greenberg, 1989) for alliance items and the Cognitive Therapy Scale – Revised (Blackburn et al., 2001) for technique adherence items. The questionnaires were also piloted with two therapists and two patients, to ensure the concepts were well and consistently understood. Some wording changes to aid clarity were suggested by the patients at this pilot phase. See supplementary material for copies of the questionnaires.

Data Analysis

Non-parametric analyses were applied as the data were non-normal in their distribution and normality could not be achieved using data transformation. Mean importance ratings for alliance items and for technique adherence items were calculated for each participant, at each therapy stage (early, mid, late). Therapists' predictions of patients' alliance and technique adherence importance ratings were also averaged for each therapy stage. At each therapy stage four Mann-Whitney U tests were completed. These tests compared mean scores of: therapists' alliance ratings with patients' alliance ratings; therapists' technique adherence ratings with patients' technique adherence ratings; therapists' predictions of patients' alliance ratings with patients' actual alliance ratings; and therapists' predictions of patients' technique adherence ratings with patients' actual technique adherence ratings. Effect size estimates for Mann-Whitney U tests were calculated using the formula $r = z / \sqrt{N}$ (Field 2018).

Results

As hypothesised, therapists rated alliance importance significantly higher than patients did across all stages of therapy (see Table 2). This difference was largest early in therapy (r = -0.32), compared with mid (r = -0.25) and later in therapy (r = -0.26), however, analyses were not conducted to determine whether the differences in these effect sizes were significant.

Contrary to hypothesis, therapists also rated technique adherence importance significantly higher than patients did across all stages of therapy. These differences were associated with small to moderate effect sizes (r = -0.21 to -0.25).

Contrary to hypothesis, therapists accurately predicted patients' alliance importance scores across all stages of therapy (see Table 3). However, as hypothesised, therapists demonstrated 'mind reading' errors by underestimating patients' technique adherence importance scores in early and mid-therapy. The effect sizes for these differences were larger in early therapy (r = -0.32), than mid therapy (r = -0.14), although it is not known if these differences were significant.

Discussion

The first key finding of this study is that CBT therapists view technique adherence and alliance throughout therapy as more important that patients do. This suggests that therapists and patients might differ in how they value the different elements of therapy. For example, therapists might place more importance than patients on the therapy elements they can control, such as alliance and adherence, (D'Souza Walsh et al., 2019).

A second key finding of the study is that the largest discrepancy between patients' and therapists' beliefs occurs in early therapy, where therapists believed the alliance to be more important than patients did. This might be related to therapists' beliefs that early alliance is important for driving therapeutic change (Brown et al., 2014; Mulkens et al., 2018), with patients potentially not sharing these beliefs, given the discrepancy in scores.

A third key finding is that therapists accurately predicted the importance of alliance to patients but made 'mind reading' errors by underestimating the importance of technique adherence to patients. This underestimation might reflect therapists' concerns about technique adherence being received negatively by patients and leading to alliance ruptures (Addis et al., 2006; Addis & Krasnow, 2000; Deacon, Farrell, et al., 2013; Kazantzis et al., 2005). Therefore,

therapists' underestimation of the importance of technique adherence to patients might be greater in early therapy, due to the importance therapists place on early alliance.

Limitations and Future Research

A key limitation is the retrospective nature of the research. Participants who experienced CBT up to two years prior to recruitment might have retrospective recall biases when drawing on their therapy experiences to inform their beliefs. For example, they might be able to recall the ending and eventual outcome of therapy more accurately and depending on this outcome, ascribe greater or lesser importance to earlier therapy elements than if they were asked during therapy. The different frames of reference for the participants must also be considered, with therapists likely having experienced many courses of CBT and patients perhaps only one. Also, as participants were required to complete therapy, recruitment might have been biased towards selecting patients with more positive therapy experiences, as patients with very negative therapy experiences are potentially less likely to complete therapy. However, data collected on the patients' therapy experiences did show a range of outcomes, with 17.8% reporting that CBT did not impact their symptoms or made them worse (see supplementary material).

Other limitations include therapists and patients not being recruited as dyads and therefore potentially representing different underlying populations. Although a description of CBT was given in the recruitment information, it is possible that some patients did not receive CBT, especially if a different therapy was delivered under the label of CBT. Lack of information on the type of CBT or disorder patients experienced treatment for is also a limitation, especially as different disorders might require differential emphases on the alliance and technique adherence.

Other differences between groups which might have impacted results included differences in age and gender distribution of participants. For example, six patients (4.3%)

were under the age of 18, whereas the therapist sample contained no children. Lack of other demographic information, such as ethnicity and location of participants make it unclear how representative the samples are, raising questions about generalisability of findings. Online recruitment might have also impacted sample demographics, possibly skewing the sample away from older participants (Dodge & Chapman, 2018). Other limitations with using online surveys include the possibility of participants responding more quickly, which can be associated with lower quality of data (Heerwegh & Loosveldt, 2008; Zhang & Conrad, 2014).

Additionally, the questionnaires used were developed for this study, as they were specifically designed to ascertain beliefs about alliance and technique adherence, rather than to measure alliance and adherence per se. Although the wording of questionnaires was based on established measures (the Working Alliance Inventory and Cognitive Therapy Scale-Revised), the reliability and validity of these questionnaires themselves have not been established. Finally, regarding analyses, the larger sample collected allowed for detection of a small effect sizes (0.16) at power .80 and an alpha level of .05. However, use of twelve Mann-Whitney U tests increased the likelihood of a familywise type one error.

Future research could investigate similar beliefs within different therapeutic models, to see if a similar result emerges. Different components of the alliance and adherence (for example, affective bond, agreement on goals) could be separated within the analyses, examining these concepts in greater depth. Qualitative research could further investigate why therapists and patients hold their beliefs about the importance of therapy elements. Future research could also investigate how important it is for therapists to accurately predict patients' preferences and whether this leads to better therapy outcomes or higher patient satisfaction. Other factors which have been shown to impact alliance and adherence, such as attachment style and treatment expectation (Folke et al., 2016; Puls et al., 2019), could also be investigated, to determine whether therapists change their therapy-related beliefs when working with

patients with different presentations.

Clinical Implications

Therapists are encouraged to be aware they value elements of therapy differently to patients. Therapists are also encouraged to be aware they might be making 'mind reading' errors by assuming patients place less importance on technique adherence than they actually do. Therapists are encouraged to continue prioritising alliance, but also to ensure prioritisation of adherence to techniques especially within early and mid-therapy, to promote early symptom improvement. If therapists hold beliefs that alliance and adherence conflict, they might benefit from challenging these beliefs by considering research indicating positive associations between alliance and adherence (Addis et al., 2006; Brauhardt et al., 2014; Loeb et al., 2005; Puls et al., 2019), as well as research indicating that alliance ruptures can be repaired, leading to positive outcomes (Eubanks et al., 2018; Safran et al., 2011). Therapists might also benefit from challenging their assumptions about patients' preferences by discussing directly with patients, empowering patients in the process.

Conclusion

Alliance and technique adherence were both believed to be important for CBT outcomes by therapists and patients. However, therapists valued alliance and technique adherence more than patients did, whilst also underestimating the importance of technique adherence to patients. Awareness of this finding might help therapists to question and challenge their assumptions, hopefully aiding them to deliver therapy which is effective and in-line with patients' preferences.

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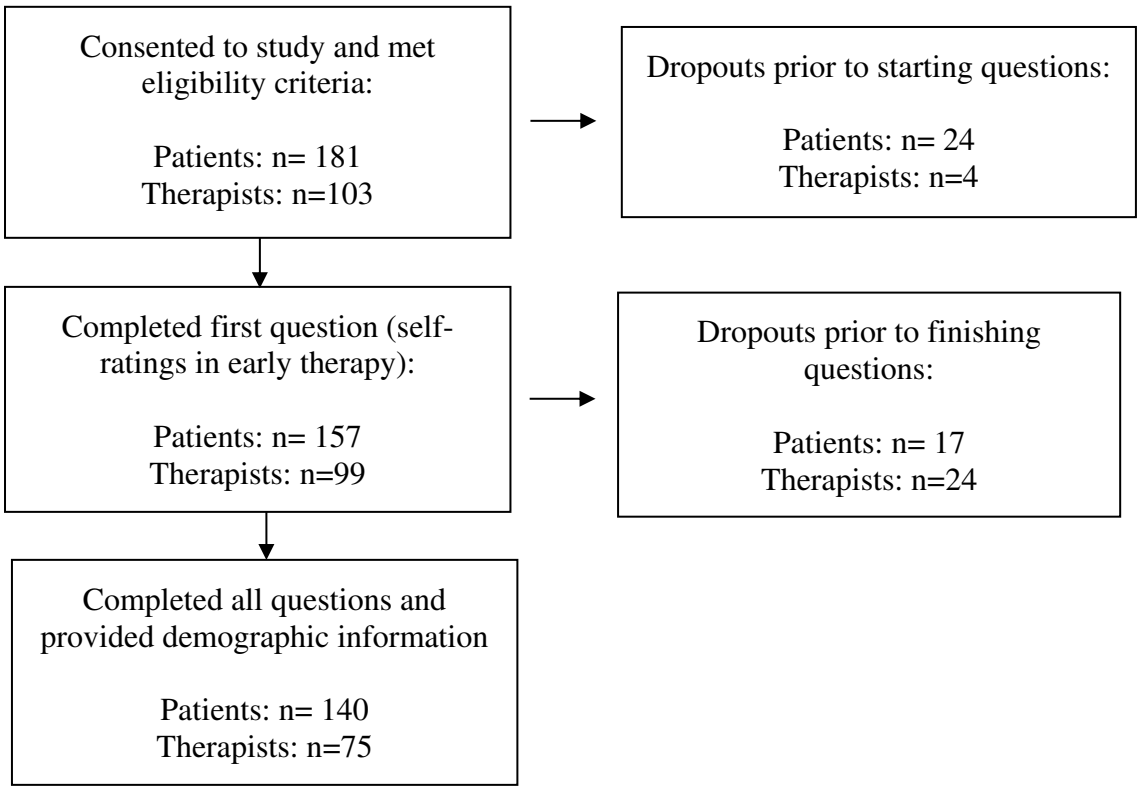

Figure 1. Dropout of participants during the study

Table 1.

*Participant demographics**

	Therapists N (%)	**Patients N (%)**	**Total N (%)**
Gender			
Female	52 (69.3)	112 (80)	164 (76.3)
Male	23 (30.7)	24 (17.1)	47 (21.9)
Other	0 (0)	3 (2.2)	3 (1.4)
Prefer not to say	0 (0)	1 (0.7)	1 (0.5)
Age (years)			
12-29	3 (4)	76 (54.3)	79 (36.7)
30-49	41 (54.7)	49 (35)	90 (41.9)
50-69	29 (38.7)	14 (10)	43 (20)
70-89	2 (2.7)	1 (0.7)	3 (1.4)
Mean ± SD	47.1 ±11.4	32.2 ±11.9	37.4 ±13.7
CBT qualifications**			
Doctorate in clinical psychology	16 (21.3)		
Doctorate or qualification in counselling psychology	4 (5.3)		
Improving Access to Psychological Therapies (IAPT) qualification	12 (16)		
Post-graduate diploma/certificate in CBT	52 (69.3)		
Other	17 (22.7)		
Years delivering CBT			
Mean ± SD	12.6 ± 7.6		

* Demographic data only available for completers

**Percentage values do not total to 100%, as participants could select more than one option

Table 2.

Mann-Whitney U tests comparing patients' and therapists' self-ratings of alliance and technique adherence importance across therapy

Stage of therapy	**Alliance / adherence**	**Type of importance ratings**	**N**	**Overall median**	**Standard deviation**	**Mann-Whitney U**	**Z value**	**Significance**	**Effect size (r)**
Early therapy	Alliance importance ratings	Patient self-ratings	158	5.83	1.07				
		Therapist self-ratings	99	6.33	0.64	4882.5	-5.11	**p < 0.001**	-0.32
	Adherence importance ratings	Patient self-ratings	158	5.33	1.16				
		Therapist self-ratings	99	6.00	0.80	5547	-3.95	**p < 0.001**	-0.25
Mid therapy	Alliance importance ratings	Patient self-ratings	145	5.67	1.16				
		Therapist self-ratings	92	6.00	0.78	4730	-3.8	**p < 0.001**	-0.25
	Adherence importance ratings	Patient self-ratings	145	5.67	1.16				
		Therapist self-ratings	92	6.00	0.86	4737	-3.78	**p < 0.001**	-0.25
Late therapy	Alliance importance ratings	Patient self-ratings	140	5.00	1.21				
		Therapist self-ratings	90	5.83	0.95	4349	-3.98	**p < 0.001**	-0.26
	Adherence importance ratings	Patient self-ratings	140	5.33	1.24				
		Therapist self-ratings	90	5.67	0.97	4721.5	-3.22	**p = 0.001**	-0.21

Table 3.

Mann-Whitney U tests comparing therapist-predicted patient ratings and actual patient self-ratings of alliance and technique adherence importance across therapy

Stage of therapy	**Alliance / adherence**	**Type of importance ratings**	**N**	**Overall median**	**Standard deviation**	**Mann-Whitney U**	**Z value**	**Significance**	**Effect size (r)**
Early	Alliance importance ratings	Patient self-ratings	158	5.83	1.07				
therapy		Therapist-predicted patient ratings	99	5.67	0.85	5749	-1.3	p = 0.195	-0.08
	Adherence importance ratings	Patient self-ratings	158	5.33	1.16				
		Therapist-predicted patient ratings	99	4.67	0.90	3944.5	-4.87	**p < 0.001**	-0.32
Mid	Alliance importance ratings	Patient self-ratings	145	5.67	1.16				
therapy		Therapist-predicted patient ratings	92	5.33	0.84	5496.5	-0.19	p = 0.849	-0.01
	Adherence importance ratings	Patient self-ratings	145	5.67	1.16				
		Therapist-predicted patient ratings	92	5.00	1.00	4625	-2.12	**p = 0.034**	-0.14
Late	Alliance importance ratings	Patient self-ratings	140	5.00	1.21				
therapy		Therapist-predicted patient ratings	90	5.33	0.91	4616.5	-1.76	p = 0.079	-0.12
	Adherence importance ratings	Patient self-ratings	140	5.33	1.24				
		Therapist-predicted patient ratings	90	5.00	1.09	5090.5	-0.68	p = 0.496	-0.05