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# The State of Therapeutic Alliance Training in Clinical and Counseling Psychology Graduate Programs

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The State of Therapeutic Alliance Training in Clinical and Counseling Psychology  
Graduate Programs

A Thesis Presented

by

NICHOLAS R. MORRISON

Submitted to the Graduate School of the  
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Clinical Psychology

The State of Therapeutic Alliance Training in Clinical and Counseling Psychology  
Graduate Programs

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## ABSTRACT

### THE STATE OF THERAPEUTIC ALLIANCE TRAINING IN CLINICAL AND COUNSELING PSYCHOLOGY GRADUATE PROGRAMS

FEBRUARY 2015

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The therapeutic alliance is an empirically-supported element of successful psychotherapy. However, the degree to which training programs incorporate alliance-centered components into their curricula and clinical practica remains unclear. The aims of this study were to (a) examine training programs' awareness of alliance research; (b) determine the extent to which programs incorporate formal, evidence-based alliance training into their pedagogy; (c) determine whether there are differences in evidence-based alliance training practices between programs with different foci/terminal degrees and programs with different training models; and (d) cultivate an understanding of what training programs would consider ideal alliance training practices and the barriers that may interfere with them. Data derived from a quantitative survey of directors (or their designates) of APA-accredited clinical and counseling doctoral programs in the United States and Canada and a follow-up qualitative survey that examined participant reactions to the initial survey results. Generally, respondents indicated that their programs were aware of alliance research trends. However, respondents also largely indicated they do not incorporate systematic, evidence-based alliance training into their programs despite believing that such systematic elements would contribute to ideal alliance training practices. There were no statistically significant differences between graduate program

degree type and training model in terms of awareness of alliance research or current alliance training practices. However, differences in views on gold-standard training emerged for training model; practitioner-scholar programs endorsed greater preferences for systematic alliance training relative to clinical scientist and scientist-practitioner programs. Qualitative responses to the findings provide additional context, and implications for training and future research directions are discussed.

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# CHAPTER 1

## INTRODUCTION

Treatment factors that cut across different theoretical orientations and patient populations have received growing attention in the psychotherapy literature (Imel & Wampold, 2008). Empirically, these common factors appear to have a greater influence on patient outcomes than theory-specific treatment techniques (Duncan, Miller, Wampold, & Hubble, 2010); thus, they represent an important element of evidence-based practice (Norcross, 2011). The therapeutic alliance, which reflects the patient-therapist collaborative and affective bond (Bordin, 1979), may be the quintessential common factor given its long conceptual history and robust empirical relation to treatment outcome (Castonguay, Constantino, & Holtforth, 2006; Constantino, Castonguay, & Schut, 2002; Muran & Barber, 2010). The alliance has consistently correlated with positive outcomes across diverse treatments and clinical conditions; in the most recent meta-analysis of 190 studies, the weighted  $r$  effect size for the alliance-outcome correlation was .275, accounting for approximately 7.5% of outcome variance (Horvath, Del Re, Flückiger, & Symonds, 2011). No major moderators of this effect were evidenced, suggesting that alliance quality relates to outcome irrespective of the treatment type, the presenting problems being treated, the outcome rated, when the alliance is measured, and who rates it. Thus, the evidence is compelling that providers can improve psychotherapy outcomes by establishing quality alliances with their patients.

Given the established association between alliance and treatment outcome, a second wave of alliance research has focused on variables that relate to its development or demise, including both patient and therapist contributions. The vast literature on

patient variables illuminates prognostic indicators of patients for whom it will be more or less likely to establish or maintain an alliance. For example, characteristics such as secure attachment style and high expectation for improvement correlate positively with alliance quality, while characteristics like interpersonal problems and low self-affiliation relate negatively with alliance quality (see Castonguay et al., 2006; Constantino, Castonguay, Zack, & DeGeorge, 2010). Therapists also influence the alliance. Various therapist attributes (e.g., warmth, patience) and behaviors (e.g., communicating empathy, facilitating affect expression) have been shown to relate positively to alliance quality (see Ackerman & Hilsenroth, 2003), while other attributes (e.g., rigidity, defensiveness) and behaviors (e.g., using premature interpretations, maintaining directiveness in the face of a patient's desire to control the session) relate negatively to the alliance (see Ackerman & Hilsenroth, 2001). Research has also statistically modeled therapist effects, showing that between-therapist variability in alliance quality predicts outcome, while patient-level variability does not; that is, therapists who form strong alliances tend to do so with most of their patients, which relates to positive treatment outcomes (the opposite is true for therapists who form poor alliances; Baldwin, Wampold, & Imel, 2007). Although therapists can certainly contribute to problems in the alliance, which are commonly termed *ruptures*, research also suggests that therapists can take steps to repair such ruptures (Eubanks-Carter, Muran, & Safran, 2010). Moreover, addressing an alliance rupture can actually provide a clinical change opportunity, and successfully repaired ruptures have indeed been related to positive outcomes (Safran, Muran, & Eubanks-Carter, 2011).

Drawing on first- and second-wave research on the alliance, researchers have begun to test the effectiveness of both alliance-fostering and alliance-repairing strategies. Regarding alliance-fostering strategies, Crits-Christoph et al. (2006) employed a pilot-scale manipulated training design to test their manualized alliance-fostering therapy, a 16-session treatment combining psychodynamic-interpersonal strategies with alliance strengthening strategies culled from the literature. The trainees treated cases before, during, and after training on the alliance manual, and moderate-to-large improvements on alliance ratings were demonstrated from their pre- to post-training cases. There were also small-to-moderate pre- to post-training effects for their patients' decreased depression and increased quality of life ratings. In another training study, Hilsenroth, Ackerman, Clemence, Strassle, and Handler (2002) administered a structured clinical training (SCT) to 13 advanced doctoral students. Among numerous components, SCT included strategies for fostering the patient-therapist bond and coordinated collaboration. Compared to a group of 15 doctoral students who received supervision-as-usual while delivering treatment-as-usual to a matched group of patients, the SCT therapists produced higher patient and therapist alliance ratings after the fourth session.

In terms of alliance-repair strategies, a pilot-scale clinical trial compared the efficacy of traditional cognitive therapy (CT) versus an integrative cognitive therapy (ICT) that assimilated manualized interpersonal techniques for noticing and responding to alliance ruptures. ICT patients, relative to standard CT patients, reported better alliance qualities and higher perceived therapist empathy, as well as evidenced greater post-treatment improvement on depression and global distress indices (Constantino et al., 2008). In another research program testing a stand-alone, relational treatment (i.e., brief

relational therapy; BRT) focused primarily on negotiating the alliance and its ruptures, BRT had lower dropout rates than cognitive-behavioral therapy and short-term dynamic therapy for patients with personality disorders (Muran, Safran, Samstag, & Winston, 2005) and for those at risk for treatment failure (Safran, Muran, Samstag, & Winston, 2005).

Another training study tested the efficacy of a brief continuing education workshop for community clinicians that incorporated both alliance fostering and repair elements (Smith-Hansen, Constantino, Piselli, & Remen, 2011). Although there were no differences in outcomes for patients treated by therapists in the training versus delayed training condition, the therapists in both groups reported using more alliance strategies in their post-training work. Furthermore, the use of such strategies correlated positively with alliance quality and the number of sessions attended across the two conditions. In another naturalistic study, patients regularly completed two brief scales that measured their experiences of the therapy relationship and treatment process. Having clinicians address patients' responses to these measures of alliance and therapy process doubled the effect size of treatment-as-usual (Miller, Duncan, Brown, Sorrell, & Chalk, 2006).

The aforementioned findings suggest that alliance cultivation and negotiation are capacities that therapists can and should be trained to develop just as they are trained to attend to other areas of their clinical work (Horvath et al., 2011). As an evidence-backed construct, the alliance and related strategies fall squarely within the realm of evidence-based practice. Thus, it would follow that training programs aspiring toward evidence-based best practices must consider the most effective ways to train their students on alliance development, maintenance, and repair (Constantino, Overtree, & Bernecker,

2014; Hershenberg, Drabick, & Vivian, 2012). However, it remains unknown how much clinical training programs incorporate specific alliance-focused elements into their curricula and clinical practica and, if they do, on what such trainings are based (Castonguay et al., 2006). More specifically, it is unclear whether clinicians receive training that incorporates the above scientific information to help them strengthen their alliances with their patients.

In fact, if one extrapolates from survey data focused on training on empirically-supported treatment packages, it seems unlikely that they do. Such survey data has revealed that graduate and internship clinical training programs place insufficient emphasis on empirically-supported therapies. In a survey of 221 directors (or their designates) from various training programs in psychiatry, psychology, and social work, the percentage of psychology programs that did not require a didactic and supervision component in at least one evidence-based therapy ranged from 43.8% to 67.3% (Weissman et al., 2006). In a similar survey of how frequently programs incorporated empirically-supported psychological treatments into their training approaches (based on a list of treatments that the researchers categorized as *well established*, *probably efficacious*, and *experimental*), results indicated that “only one doctoral program in five covers 25% or less of the validated treatments in didactic courses,” and that “internship programs were unlikely to require that students be competent in even one empirically valid treatment by the end of the internship year” (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995, p. 520).

As these surveys indicate, despite a growing emphasis on empirically-supported therapies in the age of managed care, a relatively low percentage of training programs

have what would be considered a gold-standard protocol for training their students on empirically-supported psychotherapies. We suspect that even fewer programs implement formal and systematic protocols for training their students on central empirically-supported common factors, such as the therapeutic alliance. However, this is speculation, and there is a need to understand much more fully current alliance-training practices.

To date, we are aware of only one small study that has explored alliance-training practices in any kind of depth. This study explored qualitatively alliance researchers' views as to what would constitute gold-standard alliance training (Constantino, Morrison, MacEwan, & Boswell, 2013). The participants in this study, all of whom were well versed in and who had contributed to the alliance literature, did not reach a consensus in terms of ideal alliance training practices. However, findings did suggest that current alliance training is largely unstructured, and that a more structured approach (e.g., incorporating greater focus on the alliance in supervision, involving alliance-based coursework) is needed. Although structured approaches to training may be an ideal standard, the participants in this study posited differing ideas about the nature of such approaches. Further uncertainty and disagreement emerged concerning potential barriers to gold-standard alliance training. Thus, the study had limited clarifying yield. It also had methodological limitations in that it included a small sample, making it difficult to generalize results across training programs, and although the participants were all alliance experts or burgeoning experts, their perspectives were likely constrained to one or a few training programs to which they had been exposed or affiliated (again limiting generalizability).

Considering the disparate opinions of experts in the field, it is likely that graduate training programs vary significantly in their approaches to alliance training. Thus, it seems important to examine alliance training practices more systematically and inclusively in an effort to understand better the ways in which clinicians develop the capacity for promoting positive alliances with their patients, and the gaps that may currently exist (e.g., Boswell & Castonguay, 2007; Constantino et al., 2013). Thus, the aims of the present study were to (a) examine training programs' awareness of alliance research; (b) determine the extent to which programs incorporate formal, evidence-based alliance training into their pedagogy (e.g., didactic instruction, workshops, specific emphases on alliance supervision, personnel decisions); (c) determine whether there are differences in evidence-based alliance training practices between programs with different foci/terminal degrees (i.e., clinical Ph.D., counseling Ph.D., and clinical Psy.D.) and programs with different training models (i.e., clinical scientist, scientist-practitioner, and practitioner-scholar); and (d) cultivate an understanding of what training programs consider ideal alliance training practices and the barriers that may interfere with them.

In light of the broad extant literature on evidence-based training, we hypothesized that graduate training programs place little emphasis on *formal* alliance training. If programs are, in fact, incorporating alliance-related elements, we expected they are likely doing so informally (e.g., leaving clinical supervisors to discuss the therapeutic alliance at their discretion rather than incorporating science-based didactic training and practica). We also hypothesized that Psy.D. and more clinically-oriented Ph.D. programs engage in less formal, evidence-based alliance instruction than research-oriented Ph.D. programs given that the former two program types place relatively less emphasis on research.

Lastly, we predicted that the primary barriers to implementing evidence-based alliance training center on logistical concerns, including financial burdens and time constraints on faculty and students.



## **CHAPTER 2**

### **METHOD**

#### **2.1 Participants**

Participants were recruited from a pool of 305 directors of clinical training (DCTs), or their designates, across the United States and Canada, including 236 directors of American Psychological Association (APA)-accredited Ph.D. and Psy.D. graduate training programs in clinical psychology and 69 directors of APA-accredited Ph.D. programs in counseling psychology. We believed that training directors were the best-suited participants for this study, as they oversee the majority of training operations in their respective programs. However, the directors were invited to enlist the help of, or have serve as their proxy, the director of a training clinic/in-house practicum or one or more faculty member clinical supervisors when completing the survey. If a DCT declined participation, the research team invited a second person to participate based on our review of program websites (either an associate/assistant DCT, in-house practicum director, clinical supervisor, or other clinical faculty member familiar with the department's clinical training). Eighty-seven of the 305 APA-accredited programs responded to the survey for an overall response rate of 28.5%.

#### **2.2 Primary Survey**

Participants completed a multi-part survey through Qualtrics, a secure, web-based survey platform. The questions were crafted to be answerable by training directors (i.e., related to program, policy, attitude, and pedagogical implementation) and free of excess jargon. This study-specific survey was comprised of four domains (each is discussed in

greater detail below): (1) respondent and program information (12 items), (2) awareness of alliance research (5 items), (3) current alliance pedagogy (18 items), and (4) perspectives on gold-standard alliance training (14 items). The questions were answered on various forced-choice scales.

The survey was refined via *cognitive interviewing methodology*, a paradigm that elicits participant feedback about readability, comprehensibility, relevance, and ambiguity of the survey items (Beatty & Willis, 2007). This methodology seeks to reduce potential sources of response error by identifying areas of confusion and problematic items on the survey before it is administered to all participants. Adhering to this method, the survey was administered to two representative participants (in this case, one former DCT of a clinical psychology program and one current DCT of a school psychology program) while the principal investigator simultaneously interviewed the participants in person. We used a standardized probe-based approach to the cognitive interviews (Willis, 2005). The probes, developed in advance, consisted of two types: (1) “anticipated probes,” which are scripted probes that forestall specific problems with survey items, and (2) “conditional probes,” which are probes triggered by participant behavior in the moment. Examples of scripted probes (which were adapted for each item in the survey) include:

*Does your program engage in alliance pedagogy in a way that is not covered by questions in this section (i.e., domain 3 of the survey)?*

*Do you find this question to be clear and easy to understand? If not, can you think of ways to make it easier to understand?*

Additionally, the interview concluded with a series of follow-up questions that asked the participant to comment on the overall make-up of the survey (e.g., length, flow, coverage, relevance). For example:

*Do you think that the survey can be completed in a reasonable amount of time?*

*Do you think that the flow of the survey makes sense in its current form, with the four different domains?*

Each cognitive interview took approximately 1 hr to complete. After obtaining participant permission, their narrative responses were electronically recorded to ensure accurate analysis. After a thorough review of both cognitive interviews, the survey was revised to address the concerns of the interviewees. See Appendix A for the final survey used in the study.

### **2.2.1 Domain 1: Respondent and Program Information**

This domain focused on demographic information about respondents (name, gender, age, email address, and role in program) and their program (degree type, training model, training emphasis, theoretical orientation, and training clinic information).

### **2.2.2 Domain 2: Awareness of Alliance Research**

This domain focused on programmatic awareness of the array of alliance-related research findings.

### **2.2.3 Domain 3: Current Alliance Pedagogy**

This domain focused on current alliance-training practices in the program, including didactics, clinical practica, programmatic evaluation of and responses to student-based alliance evidence and trainee characteristics, and programmatic plans to implement evidence-based best practices in alliance training. The questions in this section were informed by the authoritative alliance resource in the field—an edited book entitled, *The Therapeutic Alliance: An Evidence-Based Guide to Practice* (Muran & Barber, 2010). This book includes a comprehensive compendium on alliance research, including an entire section on research-based training programs, as well as recommendations for practice and training based on the current knowledge base (Sharpless, Muran, & Barber, 2010). The five primary recommendations for therapists and/or training programs include: (1) becoming familiar with at least one established manual focused on alliance ruptures and their repair; (2) being knowledgeable of the literature on patient characteristics that relate positively and negatively to alliance quality, so that clinicians can be responsive to patients with protective factors or “warning signs;” (3) regularly measuring and assessing the alliance, and having such data be a key element in any rigorous 360-degree assessment of clinical skills; (4) using demonstrations of empirically-rated good and bad alliance moments in training; and (5) being knowledgeable of the literature on therapist actions and characteristics that relate positively and negatively to alliance quality, so that therapists can become more self-aware, interpersonally sensitive, and responsive, and so that programs can use such information to help make admission and programmatic advancement decisions.

#### **2.2.4 Domain 4: Perspectives on Gold-Standard Alliance Training**

This domain focused on what participants believe would constitute elements of a gold-standard alliance training program, with the questions again based on current best-practice recommendations (Sharpless et al., 2010), such as including an alliance course, training on at least one alliance manual, and so forth.

### **2.3 Follow-up Survey**

Participants who completed the survey and provided their email addresses were contacted with concise results of the survey and several open-ended follow-up questions (see Appendix B for the results presented and the specific open-ended questions). This allowed the participants to expand freely on their vision of a gold-standard alliance training program, potential barriers to their vision, and whether their program has any plans to implement any changes related to alliance training within the next five years.

### **2.4 Procedure**

The study involved two phases. In phase 1, the survey was emailed to the primary contact DCTs. The DCTs that did not respond were contacted with email reminders at 2 weeks and again, if necessary, at 4 weeks. We repeated this process for the secondary contact if the DCT failed to respond to the original email or reminders. Consent was obtained via the survey website. As part of the consent process, participants were assured that their responses would be kept confidential, and that any data would be published only in aggregated form. Participants were encouraged to answer all questions, and it took most participants approximately 15 min to complete the survey. Upon completion, participants had the option to enter to win one of six \$50 Amazon.com gift cards as

compensation. Participants were also debriefed via the website. The University of Massachusetts Amherst Institutional Review Board approved all study components.

In phase 2, participants who submitted the survey and included their email addresses were provided with concise results of the survey and the follow-up questions designed to allow participants to react to the results and elaborate on their visions of gold-standard alliance training. The results and questions also were presented/administered via Qualtrics.

## CHAPTER 3

### RESULTS

#### 3.1 Quantitative Analysis

The primary analyses included both descriptive and inferential statistics. Descriptive statistics revealed the percentage of programs that embody various demographic characteristics (domain 1), the percentage of programs that endorse awareness of various aspects of alliance-related research findings (domain 2), the percentage of programs that engage in various types of alliance pedagogy (domain 3), and the percentage of programs endorsing various aspects of a gold standard alliance training (domain 4). Inferential statistics (i.e., chi-square and Kruskal-Wallis analyses) were used to investigate differences between program types (i.e., foci/degree type and training models) for responses across the latter three domains.

##### 3.1.1 Domain 1: Respondent and Program Information

The mean age of respondents was 49.17 years ( $SD = 10.20$  years). Representation from training program types included: clinical Ph.D. (47.1%), clinical Psy.D. (23.0%), and counseling psychology Ph.D. (29.9%). Representation from training model types included: clinical scientist (12.6%), scientist-practitioner (59.8%), and practitioner-scholar (27.6%). Respondents were also asked to indicate the degree to which clinical training and research training are goals for their respective programs. On both items, participants were asked to rate their goals on a scale from 1 (major goal for our program) to 7 (not a goal for our program). The mean response for clinical training was 1.69 ( $SD =$

1.27) and the mean response for research training was 2.21 ( $SD = 1.48$ ). See Table 1 for additional respondent and program information.

### **3.1.2 Domain 2: Awareness of Alliance Research**

Across all programs, respondents reported a high degree of awareness of research on the alliance. The following percentages reflect affirmative responses to “completely or somewhat true” for the five research areas queried: alliance-outcome correlation (90%), patient characteristics that relate to alliance (78%), therapist actions and characteristics that relate to alliance (90%), alliance ruptures and repairs and their relation to outcome (88%), and alliance measurement (74%; see Table B1, which represents the data presented to respondents in the follow-up survey). Because the small cell sizes were in violation of the assumptions to run chi-square analyses, items were consolidated into three options (true, untrue, and don’t know) and analyzed between program type (clinical Ph.D. vs. counseling Ph.D. vs. clinical Psy.D.) and training model (clinical scientist vs. scientist-practitioner vs. practitioner-scholar). No significant differences were found between program types on awareness of research on the alliance-outcome correlation,  $\chi^2(4) = 2.106, p = .776$ ; research on patient characteristics that relate to alliance,  $\chi^2(4) = 0.753, p = .950$ ; research on therapist characteristics that relate to alliance,  $\chi^2(4) = 1.496, p = .861$ ; alliance rupture and repair research,  $\chi^2(4) = 2.904, p = .633$ ; or alliance measurement,  $\chi^2(4) = 5.368, p = .476$ .

No significant differences were found between training models on awareness of research on the alliance-outcome correlation,  $\chi^2(4) = .701, p = 1.000$ ; research on patient characteristics that relate to alliance,  $\chi^2(4) = 2.763, p = .620$ ; research on therapist



characteristics that relate to alliance,  $\chi^2(4) = 2.564, p = .699$ ; alliance rupture and repair research,  $\chi^2(4) = 1.454, p = .887$ ; or alliance measurement,  $\chi^2(4) = 5.029, p = .277$ .

### **3.1.3 Domain 3: Current Alliance Pedagogy**

Descriptive data for domain 3 are presented across groups and by program type in Table 2 and across groups and by training model in Table 3. Generally speaking, the majority of programs are not incorporating systematic alliance-training elements into their curricula. Percentages for implementation are notably low (< 20%) for offering an elective alliance-focused course (13%), training all trainees on an alliance-focused manual (8%), and archiving videos of good/poor alliance segments for subsequent training demonstrations (11%). However, 17% of the programs do require students to take at least one alliance-related course, and 35% reported that *some* of their students are training on alliance-focused manuals. Percentages are notably higher (> 50%) for programs taking remedial action in cases where trainees have consistently demonstrated an inability to forge quality alliances with their patients (58%) or possess personal characteristics known empirically to interfere with alliance development (53%; this finding was especially pronounced among practitioner-scholar programs). Additionally, 89% of all responding programs indicated that they rely, at least in part, on informal alliance training, which was true of virtually all practitioner-scholar (96%) and clinical scientist programs (100%).

In order to reduce the number of inferential analyses and, thus, the likelihood of committing a Type I error, we created an index of current alliance training. Programs received a higher index score for the greater number of statements endorsed “true” in

domain 3 (possible range = 0 to 18). Because assumptions for a one-way ANOVA were violated (i.e., the data were not normally distributed), two Kruskal-Wallis H tests were conducted on this index of current alliance pedagogy. Mean ranks were used in place of median index scores because the distributions between groups were dissimilar. The first test was conducted to determine if there were differences in index scores between the three program types: clinical Ph.D. ( $n = 39$ ), counseling Ph.D. ( $n = 25$ ), and clinical Psy.D. ( $n = 19$ ). Current alliance training index scores increased from counseling Ph.D. programs (mean rank = 39.34), to clinical Ph.D. programs (mean rank = 40.90), to clinical Psy.D. programs (mean rank = 47.76), but the differences were not statistically significant,  $\chi^2(2) = 1.485, p = .476$ .

The second Kruskal-Wallis H test was conducted to determine if there were differences in index scores between the three different training models: clinical scientist ( $n = 10$ ), scientist-practitioner ( $n = 50$ ), and practitioner-scholar ( $n = 23$ ). Current alliance training index scores increased from scientist-practitioner models (mean rank = 37.67), to clinical scientist models (mean rank = 40.35), to practitioner-scholar models (mean rank = 52.13), and the differences between the three groups trended toward significance,  $\chi^2(2) = 5.775, p = .056$ .

#### **3.1.4 Domain 4: Perspectives on Gold-Standard Alliance Training**

As was done for the previous domain, descriptive data for domain 4 are presented across groups and by program type in Table 4 and across groups and by training model in Table 5. In contrast to the current alliance training practices that programs are not incorporating in domain 3, many programs indicated that they would like to incorporate

additional alliance-training elements into their curricula. For example, over half of all programs across program type and training model reported that at least some trainees should be trained on an alliance manual, contrasted with current alliance practices in which less than half of all programs (except clinical scientist at 50%) currently train students on an alliance manual. However, over half of the programs also disagreed that their students should take at least one alliance-focused course, thus seemingly privileging manual training over additional coursework in this case. Additionally, despite relatively low current implementation of systematic alliance-training practices as revealed in domain 3, over 80% of all respondents indicated that graduate programs should not rely solely on informal alliance training.

In order to reduce the number of analyses and, thus, the likelihood of committing a Type I error, we created an index of gold-standard alliance training based on responses to domain 4 questions (possible range = 0 to 6). This index reflected the overall attitudes of respondents regarding systematic, gold-standard alliance training (responses to individual items that comprised the index ranged from strongly disagree to strongly agree as outlined in Appendix A). Because assumptions for a one-way ANOVA were violated (i.e., the data were not normally distributed), two Kruskal-Wallis H tests were conducted on this index of gold-standard alliance training. Mean ranks were again used in place of median index scores because the distributions between groups were dissimilar. The first test was conducted to determine if there were differences in index scores between the three program types: clinical Ph.D. ( $n = 38$ ), counseling Ph.D. ( $n = 24$ ), and clinical Psy.D. ( $n = 19$ ). Gold-standard alliance training index scores increased from counseling Ph.D. programs (mean rank = 38.15), to clinical Ph.D. programs (mean rank = 40.93), to

clinical Psy.D. programs (mean rank = 44.74), but the differences were not statistically significant,  $\chi^2(2) = 0.834, p = .659$ .

The second Kruskal-Wallis H test was conducted to determine if there were differences in index scores between training models: clinical scientist ( $n = 9$ ), scientist-practitioner ( $n = 49$ ), and practitioner-scholar ( $n = 23$ ). Gold-standard alliance training index scores were significantly different between the levels of training model,  $\chi^2(2) = 10.774, p = .005$ . Post hoc pairwise comparisons using the Mann-Whitney U test revealed statistically significant differences in index scores between the scientist-practitioner (mean rank = 31.76) and practitioner-scholar (mean rank = 46.61;  $p = .005$ ), and practitioner-scholar and clinical scientist (mean rank = 9.39;  $p = .007$ ) training models, but not between the scientist-practitioner and clinical scientist training models ( $p = .278$ ).

### **3.2 Qualitative Analysis**

Thirteen of the 87 APA-accredited programs that completed the initial alliance-training survey responded to the follow-up qualitative survey (15% response rate). Representation from training program types included: clinical Ph.D. (46%), clinical Psy.D. (38%), and counseling Ph.D. (15%). Representation from training model types included: clinical scientist (8%), scientist-practitioner (46%), and practitioner-scholar (46%). See Table 6 for additional respondent and program information.

The open-ended follow-up questions were analyzed using thematic analysis (see Braun & Clarke, 2006) by the principal investigator and an advanced undergraduate research assistant. This inductive method allows investigators to gain a rich understanding of participants' perceptions of the target phenomena. Both analysts

independently reviewed the qualitative data across the five question domains and generated initial categories before coming together to discuss emerging themes. Any discrepancies in the open coding were settled via discussion and consensus decisions. Table 7 provides a summary of the results, which are elaborated below. Although some participants greatly elaborated on their views, others wrote only a few words in response to some of the questions. The qualitative analysis sought to balance these two approaches.

The first question, which asked about participants' reactions to the survey results, yielded distinct differences. Generally, participants indicated that they were either surprised or unsurprised by the findings. One participant indicated, "it is surprising that although most respondents seem to favor including alliance training, so few actually provide that in their program," while another contrasted this viewpoint by stating "I'm not surprised that there is a discrepancy between what we know we should do and what we actually do; we are currently making significant changes to our clinic because of this." Additionally, some participants commented on the importance of the findings. While one participant reported that the results of the survey "sensitize us to the importance of bringing more attention to explicit training in alliance training," another stated "you [the principal investigator] think that the alliance and specific training in forming, maintaining, and repairing the alliance is much more important than is felt in the trenches."

The second follow-up question, which asked if the survey results lead respondents to think about their current alliance training practices any differently, also yielded dichotomous results. Some respondents indicated a change in how they thought about the

alliance with responses including, “I am now more mindful and intentional about explicit focus on alliance training” and “we are one of the programs that needs to do better in this area.” In terms of respondents who did not think differently, there were two themes that emerged. Some participants simply indicated that the results did not lead them to think differently; for example, one participant acknowledged a specific training area and stated, “I’m not a fan of manualized treatments, so I would not be inclined to include that option in the current training model.” Others indicated that although their thoughts regarding alliance training did not change, they were previously concerned about this issue: one participant specifically stated, “we are one of the rare programs that exposes all trainees to an empirically-supported alliance manual,” while another more broadly indicated that “it [alliance training] was something that I feel our program should do more formally before this survey.”

In terms of the third follow-up question, which asked about visions of a gold-standard evidence-based alliance-training curriculum, three distinct categories emerged from the data (i.e., improvements for students, faculty, and administration). Additionally, two respondents were unsure of what a gold-standard alliance-training program would look like. Although a variety of ideas were posited, respondents vacillated between structured suggestions, such as “training and implementation for using session measures evaluating the relationship” or “incorporating a lot more work on nondefensive metacommunication,” and unstructured considerations such as “lots of reading and discussion to familiarize students with the literature.” When asked about a gold-standard program, one respondent indicated that it is “probably unnecessary except for train-as-you-go supervision.”

The fourth follow-up question, which asked about perceived barriers to alliance training, also yielded varied responses that focused on issues related to students, faculty, and logistical demands. The thematic analysis indicated that the greatest barrier was a lack of interest on the part of faculty to modify training. Multiple participants addressed this area. For example, one participant stated, “my faculty do not always cooperate with ideas such as these; they seem stuck in how they were trained and unwilling to try innovative ideas based on current thinking in the field, which is frustrating.” Another participant described a barrier as “faculty unwilling to move from how they were trained and who are resistant to innovation and current best practice.” Yet another respondent stated, “we have many faculty who are opposed to anything related to evidence-based or empirically-validated practice, although we have been APA accredited a very long time.” Conversely, one participant dissented with the aforementioned opinions: “You should be able to see the apathy in the results of your survey. If one were inclined, overcoming that apathy would be a barrier. Finding that something isn’t considered important does not mean it should be considered important.”

Lastly, participants were asked if they had any plans to implement changes in their alliance training practices in the next five years. Although the majority of respondents did not endorse any formal changes, some indicated an interest in revising practices. For example, one participant stated, “I might add some more discussion on alliance in my supervision class; we could talk about how this research might be used differently across different approaches to treatment.” Another indicated, “I would like to focus on more routine use of alliance inventories; we use them now but they are not

routine across all faculty seminar leaders.” Still others indicated an interest in raising these issues at faculty meetings.



## CHAPTER 4

### DISCUSSION

This study evaluated the current state of alliance training in APA-accredited training programs. The main findings are as follows: (a) a large majority of respondents indicated that clinical trainers (e.g., instructors, clinical supervisors) in their programs are aware of alliance research findings, with no differences on such awareness between program types and training models; (b) Across most areas, and as predicted, the majority of respondents reported that their programs are not incorporating formal alliance training into their curricula; (c) in most (but not all) areas, the majority of respondents indicated that programs *should* be incorporating elements of systematic alliance training into their curricula; (d) although no statistically significant differences emerged between program types and training models on current alliance-training practices (which ran counter to our prediction), significant training model differences emerged on perceived gold-standard practices—practitioner-scholar programs endorsed the most systematic alliance-training preferences; (e) respondents who completed the qualitative follow-up survey were polarized regarding the importance of alliance training and whether the results of the original survey changed their thoughts or opinions on training; (f) the majority of follow-up respondents indicated that a lack of interest in improving alliance training was the greatest barrier to implementing gold-standard, evidence-based alliance-training practices (counter to our expectation that logistical concerns would be the most prominent barriers); and (g) most respondents did not have any plans to change alliance training in their programs in the next five years.

A number of trends characterize the descriptive data provided by participants. The faculty across training programs appear to be aware of the alliance research literature and the evidence-based nature of the construct. This suggests that, at least at a broad brushstroke level, alliance research dissemination is reaching those responsible for training graduate students. The sheer volume of alliance research, as well as the construct's central place in our conceptualizations of psychotherapy as an interpersonal endeavor, has seemed to enter the consciousness of clinicians and educators. Yet, despite this high level of awareness, the majority of participants across all programs indicated that they are currently not incorporating formal, evidence-based alliance practices into their training curricula. In some areas, alliance practices were notably minimal.

For example, few programs offer an elective course on the alliance. Although the reason for this remains unclear, the qualitative responses suggest that a lack of curriculum space may be one deterrent. This is not surprising considering the number of required classes that clinical graduate students must take for programs to be compliant with APA accreditation. Other qualitative responses suggest that general apathy toward the alliance construct could be a factor in restricted course offerings. Although this opinion was not unanimous, it raises the question of just how universal is the belief that alliance training is essential for good, evidence-based clinical practice.

Another minimally endorsed alliance practice was training students on an alliance-focused treatment manual. Qualitative results hinted at possible reasons for this, including faculty resistance to changing traditional training foci and some general disdain for manualized treatment. It is also possible that alliance findings, while broadly well

disseminated, may not be reaching trainers in a more specific format that is easily translated into training action.

Finally, few programs are archiving video examples of reliably rated good and poor alliance segments. It is possible that this reflects logistical barriers, or possibly fears of negative evaluation on the part of supervisors who might share their own “poor” work. Collectively, these findings point to the need for more research to better understand determinants of limited implementation of evidence-based alliance practices that do exist and can be disseminated. One additional determinant that may be gleaned more directly from the present findings is the degree to which an alliance-training element is required versus available. Programs indicated greater implementation of alliance practices for some vs. all students (e.g., some trainees routinely completing alliance assessments with their patients).

Although implementation of evidenced-based alliance training practices is generally lacking, the majority of participants indicated that most elements of alliance training posited in the survey *should* be incorporated into a gold-standard training program (although more likely as a training option vs. requirement). Moreover, a large percentage of respondents disagreed with the statement that training programs should rely solely on informal alliance training within the context of supervision-as-usual. However, an overwhelming majority of participants indicated that their programs rely, at least in part, on informal alliance training within the context of supervision-as-usual, with no other current alliance-training element receiving the same level of implementation. These findings suggest a clear disconnect between what clinical faculty are aware of and regard

as important training principles, and what is being done to train clinical students in best alliance practices.

The discrepancy between what is currently being executed in graduate training programs and respondents' perspectives on ideal alliance training practices may be unsurprising given similar trends in the field of psychotherapy. For example, many psychotherapists recognize the utility of routine outcomes monitoring (ROM; another common treatment factor) and ROM-based clinical feedback, yet fewer than half of practitioners actually incorporate ROM into their practice (Bickman et al., 2000; Hatfield & Ogles, 2004). This highlights a discrepancy between clinicians' purported values and their clinical behavior. In a survey of researcher-clinicians, investigators also demonstrated that while clinicians value empirical evidence, they find it to be less helpful to them as practitioners than other information sources, including ongoing experience with their patients and supervision or consultation with others (Safran, Abreu, Ogilvie, & DeMaria, 2011). Research on the alliance may be falling in line with this attitude.

Our qualitative results, though decidedly preliminary, helped shed some light on the actual-ideal disconnect. Multiple participants recognized the difficulty of changing current training practices due to lack of faculty interest, which may derive from hesitation to depart from traditional training approaches or reluctance to embrace empirically-supported constructs (perhaps especially common factors). Historically, the field of psychotherapy has grappled with the issues inherent in empirically-supported constructs and treatments, and it is unsurprising to see similar trends emerge in training related to the alliance construct (Persons, 1995; Wampold, Lichtenberg, & Waehler, 2002). As trainers in the field (especially program leaders) hesitate to adopt empirically-supported

and systematic approaches to training, programs will maintain status-quo training practices. With relevance to this study, trainees, then, may be robbed of the opportunity to receive formal, high quality training on research-informed practices related to what is perhaps the flagship common factor in psychotherapy (Constantino et al., 2002). As alliance research advances, it seems vital that training programs evolve with such research in mind. However, the onus is not solely on programs. As noted above, researchers may need to do a better job of disseminating not just statistical results, but also clear and easily adopted training products. Moreover, greater direct collaboration between researchers and clinicians (some of whom are also supervisors in training programs), may promote greater integration of alliance science and alliance practice (Castonguay, Barkham, Lutz, & McAleavey, 2013).

Contrary to our hypothesis, it appears that practitioner-scholar programs currently have the most interest in adopting systematic alliance-training practices into their curricula and clinical practica. This may be due in part to the heavily emphasized role of clinical practice in these programs and their interest in training practitioners in a construct so well regarded in the field. It might also suggest that research-oriented programs value different types of research to different degrees. For example, with its interpersonal and somewhat latent nature, it is possible that research-heavy programs give alliance research a lower relative “weight” than say research on basic science constructs and/or neuroscience. Future research should examine such attitudes as they bear on training in evidence-based practices.

One final trend in the data worth noting is that a large number of participants responded “don’t know” across domains 2 and 3, which suggests that the program leaders

are not always familiar with their colleagues' awareness of alliance literature and/or current alliance training practices in their programs. For example, one in four participants did not know if some of their clinical trainees are trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures. As over half of all respondents were DCTs, and other respondents were designates of these DCTs or other full-time faculty members, the lack of familiarity with colleagues' awareness of alliance research and current alliance training practices in their respective programs is concerning given that the alliance is one of the most intensely researched subjects in the extant psychotherapy literature (Horvath et al., 2011). This disconnect squares with other research (Crits-Christoph et al., 1995; Weissman et al., 2006) that suggests that attention to, knowledge of, and training on evidence-based therapeutic practices remains remarkably underdeveloped, including in programs that explicitly promote the importance of clinical science in their training missions.

Several limitations characterize this study. First, the most important consideration is the relatively low response rate. The major issue here is the possibility of a non-representative sampling of APA-accredited training programs, particularly in terms of the number of clinical scientist and practitioner-scholar programs represented. This consideration is especially important when interpreting the results of the smaller sample of respondents that completed the qualitative follow-up survey. Respondents to both study surveys may have had particular biases regarding the therapeutic alliance and/or issues regarding clinical training. Second, not all DCTs are intimately familiar with the nuanced training practices of their programs' supervision teams or didactic coursework, and may not have responded to the survey items accurately. This limitation was mitigated

by the option for DCTs to delegate survey participation to other clinical faculty, but it is still possible that programmatic attitudes and policies may have been misrepresented. Lastly, the surveys focused on trainee exposure to alliance material and content across specific areas, but did not evaluate the quality of alliance training or explicitly ask about other ways in which trainees might be exposed to the alliance construct. It is possible that clinical faculty may incorporate varying degrees of alliance training that were not addressed by the surveys.

The above limitations notwithstanding, the current study sheds some light on the current and ideal alliance-based training practices in graduate training programs. Generally, faculty across training programs appear to be aware of the alliance literature, and while they recognize the utility of incorporating systematic alliance-training elements into their curricula and clinical practica, they are currently not doing so. Future efforts should focus on a number of objectives. First, it would be worth incorporating some of the less intensive alliance-training elements into clinical training programs, such as familiarizing trainees with an alliance-repair manual or archiving alliance video footage to be used in conjunction with supervision-as-usual (Muran & Barber, 2010). This may be more effective, at least in the short-term, than incorporating mandatory coursework or clinical practica related to the alliance, especially for faculty of programs most resistant to change. Second, the field should consider systematic approaches related to evidence-based training in alliance-centered approaches. Preliminary work has shown the benefits of these methods (e.g., Eubanks-Carter, Muran, & Safran, 2014; Safran et al., 2014; Smith-Hansen et al., 2011), and other areas of psychotherapy have called for the development of systematic trainings in evidence-based approaches (Rakovshik &

McManus, 2010). Third, it would behoove the field to obtain trainee perspectives on alliance-training practices. Although initiatives have been undertaken to evaluate trainee perspectives on evidence-based practice more broadly (Luebbe, Radcliffe, Callands, Green, & Thorn, 2007), it would be beneficial to evaluate perspectives on alliance-related elements specifically.

This study has provided an overview of current and ideal alliance-focused training practices from the perspective of APA-accredited doctoral programs. Despite its illumination of various trends, attitudes, and attitude/behavior chasms, there is clearly much research that remains to be conducted in this area. Our hope is that this work helps stimulate such research in order to help trainees capitalize even more systematically and frequently on the seeming power of the patient-therapist relationship.



Table 1

*Respondent and Program Information (N = 87)*

Area	Category	Respondents (N)	Respondents (%)
Respondent's Role in Program	Director of Clinical Training (DCT)	45	52%
	Assistant DCT	5	6%
	Director of In-House Training Clinic	12	14%
	Faculty Member (Provides In-House Supervision)	35	40%
	Other Programmatic Role	18	21%
Respondent's Gender	Male	38	44%
	Female	49	56%
Type of Doctoral Training Program	Ph.D. Clinical Psychology	41	47%
	Psy.D. Clinical Psychology	20	23%
	Ph.D. Counseling Psychology	26	30%
Program Training Model	Scientist-Practitioner	52	60%
	Practitioner-Scholar	24	28%
	Clinical Scientist	11	13%
Does Program Have In-House Training Clinic?	Yes	69	79%
	No	18	21%
Program's Theoretical Orientation	No Primary Orientation	23	26%
	Multiple/Equally Emphasized Orientations	33	38%
	Psychoanalytic/Psychodynamic	2	2%
	Behavioral	1	1%
	Cognitive/Cognitive-Behavioral	16	18%
	Integrative	7	8%
	Other	5	6%

*Note.* 87 programs of 305 eligible clinical and counseling psychology programs participated (29% response rate). Percentages above are rounded to nearest whole number.

Table 2

*Current Alliance Pedagogy Percentages by Program Type*

	<u>Ph.D. Clinical</u> (n = 41)			<u>Psy.D. Clinical</u> (n = 20)			<u>Ph.D. Counseling</u> (n = 26)			<u>Total</u> (N = 87)		
Current Training Practice	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)
<b>Program requires that trainees:</b>												
Take at least 1 alliance course	13	85	3	35	60	5	8	89	4	17	80	4
Attend at least 1 evidence-based alliance training	28	64	7	25	60	15	20	80	0	25	68	7
Engage in an alliance practicum	23	69	7	25	60	15	23	69	8	24	67	9
<b>Program offers following electives:</b>												
An alliance-focused course	18	80	3	15	75	10	4	92	4	13	82	5
An alliance-focused training	35	62	3	20	70	10	27	69	4	29	66	5
An alliance-focused practicum	18	71	11	20	80	0	19	73	8	19	74	7
<b>All trainees:</b>												
Trained on alliance manual	13	77	10	0	90	10	8	85	8	8	82	9
Routinely complete alliance	11	79	3 n/a=8	16	42	11 n/a=32	36	44	0 n/a=20	20	60	4 n/a=17

assessments												
<b>Some trainees:</b>												
Trained on alliance manual	44	28	28	35	50	15	23	54	23	35	41	24
Routinely complete alliance assessments	43	24	24 n/a=8	42	16	11 n/a=32	52	16	12 n/a=20	46	20	17 n/a=17
<b>Program takes remedial action against:</b>												
Trainees unable to forge alliances	57	27	16	79	21	0	42	38	21	58	29	14
Trainee characteristics interfering with alliance	53	33	14	67	28	6	44	35	22	53	33	14
<b>Program has archived video sessions of good/poor alliance segments</b>	16	76	8	11	78	11	4	92	4	11	81	8
<b>Program faculty:</b>												
Devoted meeting time in last 3 years to alliance training best practices	11	84	5	37	63	0	17	74	9	19	76	5
Will devote meeting time in next year to alliance training best practices	11	60	30	42	37	21	13	57	30	19	53	28

Assess prospective trainees on characteristics correlated with alliance	19	78	3	42	53	5	25	71	4	26	70	4
<b>Program relies in part on informal alliance training</b>	90	8	3	90	11	0	87	9	4	89	9	3

*Note.* All values are listed as percentages of responses to each item, as some representatives did not answer every item. Percentages above are rounded to nearest whole number. Items coded not applicable (n/a) reflect programs that did not have internal practicum sites.

Table 3

*Current Alliance Pedagogy Percentages by Training Model*

Current Training Practice	Clinical Scientist (n = 11)			Scientist-Practitioner (n = 52)			Practitioner-Scholar (n = 24)			Total (N = 87)		
	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)	True (%)	Untrue (%)	Don't Know (%)
<b>Program requires that trainees:</b>												
Take at least 1 alliance course	10	90	0	14	82	4	25	71	4	17	80	4
Attend at least 1 evidence-based alliance training	30	70	0	18	74	8	38	54	8	25	68	7
Engage in an alliance practicum	20	80	0	20	69	12	33	58	8	24	67	9
<b>Program offers following electives:</b>												
An alliance-focused course	10	90	0	12	84	4	17	75	8	13	82	5
An alliance-focused training	30	70	0	26	70	4	35	57	9	29	66	5
An alliance-focused practicum	20	80	0	16	73	12	26	74	0	19	74	7
<b>All trainees:</b>												
Trained on alliance manual	0	90	10	14	78	8	0	88	13	8	82	9
Routinely complete alliance	0	100	0	26	58	2	14	46	9	20	60	4
						n/a=14			n/a=32			n/a=17

assessments													
<b>Some trainees:</b>													
Trained on alliance manual	50	30	20	28	45	28	46	38	17	35	41	24	
Routinely complete alliance assessments	60	40	0	41	20	25 n/a=14	50	9	9 n/a=32	46	20	17 n/a=17	
<b>Program takes remedial action against:</b>													
Trainees unable to forge alliances	50	25	25	43	39	18	91	9	0	58	29	14	
Trainee characteristics interfering with alliance	50	38	13	46	35	19	71	24	5	53	33	14	
<b>Program has archived video sessions of good/poor alliance segments</b>	11	89	0	8	88	4	19	62	19	11	81	8	
<b>Program faculty:</b>													
Devoted meeting time in last 3 years to alliance training best practices	0	100	0	17	75	8	32	68	0	19	76	5	
Will devote meeting time in next year to alliance training best practices	11	67	22	15	58	27	32	36	32	19	53	28	

Assess prospective trainees on characteristics correlated with alliance	11	89	0	22	74	4	41	55	5	26	70	4
<b>Program relies in part on informal alliance training</b>	100	0	0	83	13	4	96	4	0	89	9	3

*Note.* All values are listed as percentages of responses to each item, as some representatives did not answer every item. Percentages above are rounded to nearest whole number. Items coded not applicable (n/a) reflect programs that did not have internal practicum sites.

Table 4

*Perspectives on Gold-Standard Alliance Training Percentages by Program Type*

Gold-Standard Training Practice	<u>Ph.D. Clinical</u> (n = 41)				<u>Psy.D. Clinical</u> (n = 20)				<u>Ph.D. Counseling</u> (n = 26)				<u>Total</u> (N = 87)			
	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)
<b>Programs should require trainees to:</b>																
Take at least 1 alliance course	54	8	19	19	28	22	22	28	50	17	13	21	47	14	18	22
Attend at least 1 evidence-based alliance training	13	5	24	58	32	16	16	37	26	4	26	44	21	8	23	49
Engage in an alliance practicum	43	16	16	24	21	32	26	21	42	4	33	21	38	16	24	23
<b>Program faculty should:</b>																
Archive video sessions of good/poor alliance segments	16	5	30	49	16	5	47	32	29	17	21	33	20	9	31	40
Assess prospective trainees on characteristics correlated with alliance	30	11	30	30	5	5	5	84	17	4	29	50	20	8	24	49
Meet regularly to implement alliance	11	0	41	49	0	16	26	58	8	13	33	46	8	8	35	50



practices Programs should take remedial action against:																	
Trainees unable to forge alliances	3	0	13	84	0	11	11	79	0	0	13	88	1	3	12	84	
Trainee characteristics interfering with alliance	3	8	14	76	11	5	11	74	4	8	8	79	5	8	11	76	
<u>All</u> trainees should be trained on an alliance manual	8	14	35	43	26	26	16	32	29	17	25	29	19	18	28	36	
<u>Some</u> trainees should be trained on an alliance manual	11	6	31	53	21	11	32	37	29	13	21	38	19	9	28	44	
Clients/ Therapists should routinely complete alliance assessments	5	11	27	57	0	11	32	58	4	21	29	46	4	14	29	54	
Supervisors should review literature on:																	
Client characteristics correlated with alliance	0	0	19	81	5	5	5	84	4	0	8	88	3	1	13	84	
Therapist characteristics correlated with alliance	0	0	16	84	5	11	5	79	4	4	0	92	2	4	9	85	
Programs should rely solely on informal alliance training	57	27	5	11	63	26	0	11	57	22	0	22	58	25	3	14	

*Note.* All values are listed as percentages of responses to each item, as some representatives did not answer every item. Percentages above are rounded to nearest whole number.

Table 5

*Perspectives on Gold-Standard Alliance Training Percentages by Training Model*

Gold-Standard Training Practice	Clinical Scientist (n = 11)				Scientist-Practitioner (n = 52)				Practitioner-Scholar (n = 24)				Total (N = 87)			
	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)	Strong/ Moderate Disagree (%)	Slight Disagree (%)	Slight Agree (%)	Strong/ Moderate Agree (%)
<b>Programs should require trainees to:</b>																
Take at least 1 alliance course	78	11	0	11	51	14	18	16	24	14	24	38	47	14	18	22
Attend at least 1 evidence-based alliance training	44	0	0	56	19	6	33	42	17	13	9	61	21	8	23	49
Engage in an alliance practicum	56	22	22	0	43	10	25	23	18	27	23	32	38	16	24	23
<b>Program faculty should:</b>																
Archive video sessions of good/poor alliance segments	22	0	33	44	20	12	29	39	18	5	36	41	20	9	31	40
Assess prospective trainees on characteristics correlated with alliance	56	0	33	11	22	8	31	39	0	9	5	86	20	8	24	49
Meet regularly to implement alliance	22	11	33	33	6	6	42	46	4	9	22	65	8	8	35	50

practices																	
<b>Programs should take remedial action against:</b>																	
Trainees unable to forge alliances	0	11	11	78	2	2	14	82	0	0	9	91	1	3	12	84	
Trainee characteristics interfering with alliance	11	22	0	67	4	8	14	74	5	0	9	86	5	8	11	76	
<b>All trainees should be trained on an alliance manual</b>	11	11	56	22	16	20	29	35	27	14	14	45	19	18	28	36	
<b>Some trainees should be trained on an alliance manual</b>	11	0	44	44	17	13	25	46	27	5	27	41	19	9	28	44	
<b>Clients/ Therapists should routinely complete alliance assessments</b>	0	22	44	33	6	14	27	53	0	9	27	64	4	14	29	54	
<b>Supervisors should review literature on:</b>																	
Client characteristics correlated with alliance	0	0	22	78	4	0	17	79	0	5	0	95	3	1	13	84	
Therapist characteristics correlated with alliance	0	0	11	89	4	4	10	82	0	5	5	91	2	4	9	85	
<b>Programs should rely solely on informal alliance training</b>	78	11	0	11	52	29	4	15	64	23	0	14	58	25	3	14	

*Note.* All values are listed as percentages of responses to each item, as some representatives did not answer every item. Percentages above are rounded to nearest whole number.

Table 6

*Qualitative Follow-Up Program Information*

Area	Category	Respondents (N)	Respondents (%)
Type of Doctoral Training Program	Ph.D. Clinical Psychology	6	46%
	Psy.D. Clinical Psychology	5	38%
	Ph.D. Counseling Psychology	2	15%
Program Training Model	Scientist-Practitioner	6	46%
	Practitioner-Scholar	6	46%
	Clinical Scientist	1	8%
Respondent's Role in Program	Director of Clinical Training (DCT)	8	62%
	Assistant DCT	1	8%
	Director of In-House Training Clinic	1	8%
	Faculty Member (Provides In-House Supervision)	5	38%
	Other Programmatic Role	3	23%

*Note.* 13 programs of the 87 that completed the original survey participated (15% response rate). Respondents consisted of directors of clinical training, their designates, or clinical faculty, and may have served multiple roles within their respective programs. Percentages above are rounded to the nearest whole number.

Table 7

*Qualitative Thematic Analysis*

<b>Domain</b>	<b>Category-Subcategory</b>	<b>No. of cases</b>
Reaction to alliance training survey (13/13 participants commented)	Unsurprised by survey results	5
	Somewhat surprised by survey results	3
	Considers survey results important	2
	Considers survey results unimportant	2
	Other comments	3
Change in thoughts on current alliance training (13/13 participants commented)	Yes	6
	Would like to incorporate more systematic alliance training	4
	No	7
	Would not implement alliance training	2
	Previously concerned about alliance training	3
Vision of gold-standard alliance training curriculum (11/13 participants commented)	Improvements for students	9
	Train to read effectiveness studies	1
	Read more literature on relationship	4
	Use more alliance inventories	4
	Exposure to interventions	5
	View videos or transcripts of sessions	3
	More discussion of the relationship	2
	Attend specialized clinical workshops	1
	Improvements for faculty	3
	Use train-as-you-go supervision	3
	Discuss and update practices together	2
	Learn more about therapeutic alliance	2
	Improvements for administration	2
	Provide course/practicum on alliance	1
	Assess traits of trainees for	1

admittance		
	Unsure	2
Potential barriers to gold-standard alliance training curriculum (11/13 participants commented)	Little diversity in faculty orientation	2
	Differences in faculty orientation	1
	Need access to necessary materials	1
	Lack of interest to improve techniques	6
	Faculty with poor supervisory training	1
	Faculty with poor social skills	1
	Demands on faculty and students' time	1
	Finding space within the curriculum	2
	Administrative issues	1
	Unsure	1
Plans to change alliance training in the next five years (13/13 participants commented)	More routine use of alliance inventories	2
	Diversity training on alliance factors	1
	Faculty discussions on alliance training	1
	More talks with students on the alliance	2
	Use of more evidence-based approaches	2
	None	6

## APPENDIX A

### EVIDENCE-BASED ALLIANCE TRAINING SURVEY

#### ALLIANCE TRAINING SURVEY CONSENT

You are invited to participate in a research study titled, “The State of Therapeutic Alliance Training in Clinical and Counseling Psychology Graduate Programs.” Nicholas Morrison from the Psychology Department at the University of Massachusetts Amherst is conducting this study (under the direction of Dr. Michael J. Constantino).

#### **Description of the Study**

This survey of training directors is part of a research effort to understand clinical training with a focus on the construct of the patient-therapist relationship (i.e., the therapeutic alliance). The therapeutic alliance involves the coordinated collaboration and affective bond between patient and therapist. We are interested in how programs train their doctoral students to foster and navigate effective alliances with their patients. We believe that training directors, or their designated program proxy, are in the best position to represent and to provide feedback on their programs’ philosophies and training practices. As a point of emphasis, all responses should reflect the training *program’s* philosophies, attitudes, and practices, as opposed to personal opinions on the matters queried.

**If you agree to take part in this study, you will be asked to complete an online survey.** This survey asks questions about: (1) director/representative and program information, (2) awareness of alliance research, (3) current alliance pedagogy, and (4) perspectives on gold-standard alliance training. **The survey should take no longer than 15 minutes to complete.** We will provide participating programs with the results of the survey, and give them an opportunity to react to/comment on the results in a brief follow-up survey.

#### **Benefits**

You might not directly benefit from this research; however, we hope that your participation in the study may help contribute to the body of knowledge about therapeutic alliance training and help us improve the quality of clinical training.

#### **Compensation**

If you submit a survey, **you will be entered into a raffle to win one of six \$50 gift cards to Amazon.com.** There is no other compensation for participating.

#### **Risks and Protections**

This study involves minimal to no emotional risk. However, as with any online related activity, the risk of a breach of privacy is always possible. To the best of our ability, your

answers in this study will remain confidential. The researchers will keep all study-specific, electronically collected data in the secure online database. Nobody else will have access to these identifying data or to your responses. If our research findings are ever presented in public, they will be in aggregated and anonymous form.

**Your participation is completely voluntary and you can stop at any time.** You also are free to skip any question that you are not comfortable answering.

### **Contact Information**

If you have questions about this project, or if you have a research-related problem, you may contact the primary researchers, Nicholas Morrison (413-345-2924; nmorriso@psych.umass.edu) or Dr. Michael Constantino (413-545-1388; mconstantino@psych.umass.edu). If you wish to speak to someone not directly related to the research, you can contact Dr. Melinda Novak, Chair of the Psychology Department at the University of Massachusetts Amherst (413-545-2387; mnovak@psych.umass.edu). If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO; 413-545-3428; humansubjects@ora.umass.edu).

### **Agreement to Participate**

By clicking “I agree,” you affirm (1) that you are at least 18 years of age, (2) that the purpose and nature of this research have been sufficiently explained, that you have read and understood this consent form, and that you agree to participate in this research study, and (3) that you understand that the survey must be completed and submitted to be entered into a raffle to win a gift card valued at \$50. You are free to withdraw at any time simply by closing this browser window (prior to submission of your responses). Please print a copy of this page for your records.

[I agree/I DO NOT agree]



ALLIANCE SURVEY ITEMS

DOMAIN 1 – DIRECTOR/REPRESENTATIVE AND PROGRAM INFORMATION

(Number of questions = 12)

Q. What is your name?

Q. What is your gender?

- Male
- Female
- Transgender

Q. What is your age?

Q. What is your email address? (Note: This address will only be used to provide you with concise results of the survey and follow-up with optional open-ended questions)

Q. What is the name of your program (e.g., University of Massachusetts Amherst Clinical Psychology Program)?

Q. What clinically relevant position(s) do you currently hold in your department (select all that apply)?

- Director of Clinical Training
- Assistant Director of Clinical Training
- Director of in-house, program-administered training clinic
- Assistant Director of in-house, program-administered training clinic
- Faculty member who provides clinical supervision for in-house, program-administered practicum
- Adjunct faculty member who provides clinical supervision for in-house, program-administered practicum
- Other (please specify)

Q. Please indicate the type of doctoral training program with which you are affiliated.

- Ph.D. Clinical Psychology
- Psy.D. Clinical Psychology
- Ph.D. Counseling Psychology
- Other (please specify)

Q. What is your program's primary training model or philosophy?

- Scientist-Practitioner
- Practitioner-Scholar
- Clinical Scientist
- Other (please specify)

Q. Please rate the extent to which training in clinical practice is a goal for your program.

1 = Major goal for our program

2

3

4 = Modest goal for our program

5

6

7 = Not a goal for our program

Don't know

Q. Please rate the extent to which training in research is a goal for your program.

1 = Major goal for our program

2

3

4 = Modest goal for our program

5

6

7 = Not a goal for our program

Don't know

Q. What is your program's primary theoretical orientation?

- No primary orientation
- Multiple primary and equally emphasized orientations
- Psychoanalytic/Psychodynamic
- Interpersonal
- Behavioral
- Cognitive/Cognitive-Behavioral
- Humanistic/Experiential
- Systems
- Integrative
- Other (please specify)

Q. Does your training program administer an in-house training clinic in which trainees provide direct clinical services under supervision?

- Yes

- No

## DOMAIN 2 –AWARENESS OF ALLIANCE RESEARCH

(Number of questions = 5)

**To the best of my knowledge, the trainers (e.g., faculty instructors, clinical supervisors) in our program are aware of the following:**

Q. Psychotherapy research points to alliance quality being a robust correlate of positive therapeutic change.

- Completely untrue
- Somewhat untrue
- Don't know
- Somewhat true
- Completely true

Q. There is an empirical literature on client characteristics that correlate either positively or negatively with alliance quality.

- Completely untrue
- Somewhat untrue
- Don't know
- Somewhat true
- Completely true

Q. There is an empirical literature on therapist actions and characteristics that correlate either positively or negatively with alliance quality.

- Completely untrue
- Somewhat untrue
- Don't know
- Somewhat true
- Completely true

Q. Problems in the therapeutic relationship (i.e., ruptures) have been shown empirically to relate to poorer treatment outcome, while successfully repairing such ruptures can be therapeutic.

- Completely untrue
- Somewhat untrue
- Don't know
- Somewhat true

- Completely true

Q. There are brief psychometrically sound measures of the alliance that can be incorporated into routine practice and clinical training/supervision.

- Completely untrue
- Somewhat untrue
- Don't know
- Somewhat true
- Completely true

DOMAIN 3 – CURRENT ALLIANCE PEDAGOGY  
(Number of questions = 18)

**In this section, please focus on your program's *current* functioning.**

**Our program requires that trainees:**

Q. Take at least one course (i.e., didactic instruction) that focuses solely on the alliance and surveys the relevant alliance-focused research literature.

- True
- Untrue
- Don't know

Q. Attend at least one specialized clinical workshop or training (either taught by a core faculty member or an invited speaker) devoted entirely to evidence-based alliance practices.

- True
- Untrue
- Don't know

Q. Engage in at least one clinical practicum (either internal or external) specifically on evidence-based alliance practices.

- True
- Untrue
- Don't know

**Our program offers the following electives:**

Q. A course (i.e., didactic instruction) that focuses solely on the alliance construct and surveys the relevant alliance-focused research literature.

- True
- Untrue
- Don't know

Q. A specialized clinical workshop or training (either taught by a core faculty member or an invited speaker) devoted entirely to evidence-based alliance practices.

- True
- Untrue
- Don't know

Q. A clinical practicum (either internal or external) specifically on evidence-based alliance practices.

- True
- Untrue
- Don't know

**Please respond to the following items to the best of your knowledge about your trainers and trainees:**

Q. All of our trainees are trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.

- True
- Untrue
- Don't know

Q. Some of our trainees are trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.

- True
- Untrue
- Don't know

Q. In our internal practica, some trainers/supervisors review the empirical literature on therapist actions and characteristics that correlate with alliance quality.

- True
- Untrue
- Don't know
- Not applicable (i.e., no internal practica)

Q. In our internal practica, all clients and therapists routinely (i.e., at established intervals) complete formal alliance assessments to inform the quality of their relationship and clinical work.

- True
- Untrue
- Don't know
- Not applicable (i.e., no internal practica)

Q. In our internal practica, some clients and therapists routinely (i.e., at established intervals) complete formal alliance assessments to inform the quality of their relationship and clinical work.

- True
- Untrue
- Don't know
- Not applicable (i.e., no internal practica)

Q. To train our students to develop good alliances with their clients, our program relies on informal alliance training within the context of supervision-as-usual.

- True
- Untrue
- Don't know

Q. We have taken remedial action (i.e., additional alliance-focused trainings, probation, and/or dismissal) in cases where students have consistently demonstrated an inability to forge quality alliances with their clients.

- True
- Untrue
- Don't know

Q. We have taken remedial action (i.e., additional alliance-focused trainings, probation, and/or dismissal) in cases where students have consistently demonstrated personal characteristics known empirically to interfere with alliance development.

- True
- Untrue
- Don't know

Q. In our program, we have archived video recorded sessions of reliably rated good and poor alliance segments (with actual or analogue clients), which our trainers can use as an adjunct to their standard supervision.

- True
- Untrue
- Don't know

Q. We assess all prospective trainees on characteristics known empirically to correlate negatively with alliance quality to help determine whether they are admitted to our program.

- True
- Untrue
- Don't know

Q. Our faculty has devoted meeting time within the past 2-3 years to discuss implementing current best practices, based on research, for alliance training.

- True
- Untrue
- Don't know

Q. Our faculty will have one or more meetings in the next year to discuss ways in which we can implement current best practices, based on research, for alliance training.

- True
- Untrue
- Don't know

DOMAIN 4 – PERSPECTIVES ON GOLD-STANDARD ALLIANCE TRAINING  
(Number of questions = 14)

**In this section, please focus on YOUR PROGRAM'S PERSPECTIVE (rather than your personal perspective) on ideal functioning (even if something does not reflect current functioning).**

**To train students to develop good alliances with their clients, training programs SHOULD:**

Q. Rely solely on informal alliance training within the context of supervision-as-usual.

- Strongly disagree
- Moderately disagree
- Slightly disagree

- Slightly agree
- Moderately agree
- Strongly agree

Q. Require that trainees take at least one course (i.e., didactic instruction) that focuses solely on the therapeutic alliance construct and surveys the relevant alliance-focused research literature.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Require that trainees attend at least one specialized clinical workshop or training (either taught by a core faculty member or an invited speaker) devoted entirely to evidence-based alliance practices.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Require that trainees engage in at least one clinical practicum (either internal or external) specifically on evidence-based alliance practices.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Archive video recorded sessions of reliably rated good and poor alliance segments (with actual or analogue clients), to be used as an adjunct to standard supervision.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree



Q. Assess prospective trainees on characteristics known empirically to correlate negatively with alliance quality to help determine whether they are admitted to our program.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Take remedial action (i.e., additional alliance-focused trainings, probation, and/or dismissal) in cases where students who have consistently demonstrated an inability to forge quality alliances with their clients.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Take remedial action (i.e., additional alliance-focused trainings, probation, and/or dismissal) in cases where students have consistently demonstrated personal characteristics known empirically to interfere with alliance development.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. All clinical trainees should be trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Some clinical trainees should be trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Trainers/supervisors should review the literature on client characteristics that correlate either positively or negatively with alliance quality in the service of responding effectively to such markers.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Trainers/supervisors should review the literature on therapist actions and characteristics that correlate either positively or negatively with alliance quality.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Clients and therapists should routinely complete formal alliance assessments (either as a stand-alone measure or as part of a larger battery) as a means to informing the quality of their relationship and clinical work.

- Strongly disagree
- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Q. Training faculty should meet regularly to implement and update best practices, based on the research literature, for alliance training.

- Strongly disagree

- Moderately disagree
- Slightly disagree
- Slightly agree
- Moderately agree
- Strongly agree

Thank you for your time and effort. If you included your email address, concise results of the survey and optional open-ended questions will be emailed to you. We very much appreciate your help in studying alliance training practices.

## APPENDIX B

### EVIDENCE-BASED ALLIANCE TRAINING SURVEY FOLLOW-UP RESULTS AND QUESTIONS

Table B1

*Program Awareness of Alliance Research*

<b>Trainers (e.g., instructors, clinical supervisors) in our program are aware of the following:</b>	<b>Completely or somewhat true</b>	<b>Completely or somewhat untrue</b>	<b>Don't know</b>
Psychotherapy research points to alliance quality being a robust correlate of positive therapeutic change.	90%	7%	3%
There is an empirical literature on client characteristics that correlate either positively or negatively with alliance quality.	78%	7%	15%
There is an empirical literature on therapist actions and characteristics that correlate either positively or negatively with alliance quality.	90%	7%	3%
Problems in the therapeutic relationship (i.e., ruptures) have been shown empirically to relate to poorer treatment outcome, while successfully repairing such ruptures can be therapeutic.	88%	6%	6%
There are brief psychometrically sound measures of the alliance that can be incorporated into routine practice and clinical training/supervision.	74%	11%	15%

Table B2

*Current Alliance Pedagogy*

<b>Current alliance practices</b>	<b>True</b>	<b>Untrue</b>	<b>Don't know</b>	<b>N/A (no internal practica)</b>
<u>All</u> of our trainees are trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.	8%	81%	9%	-
<u>Some</u> of our trainees are trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.	35%	40%	24%	-
In our internal practica, <u>all</u> clients and therapists routinely complete formal alliance assessments to inform the quality of their relationship and clinical work.	18%	56%	3%	16%
In our internal practica, <u>some</u> clients and therapists routinely complete formal alliance assessments to inform the quality of their relationship and clinical work.	43%	18%	16%	16%
In our program, we have archived video recorded sessions of reliably rated good and poor alliance segments, which our trainers can use as an adjunct to their standard supervision.	10%	74%	7%	-
We assess all prospective trainees on characteristics known empirically to correlate negatively with alliance quality to help determine whether they are admitted to our program.	24%	64%	3%	-
Our faculty has devoted meeting time within the past 2-3 years to discuss implementing current best practices, based on research, for alliance training.	17%	69%	5%	-
Our faculty will have one or more meetings in the next year to discuss ways in which we can implement current best practices, based on research, for alliance training.	17%	48%	28%	-

*Note.* Percentages that do not total 100 reflect missing data.

Table B3

*Perspectives on Gold-Standard Alliance Training*

<b>Programs' perspectives on ideal functioning (irrespective of current functioning)</b>	<b>Strongly or Moderately Disagree</b>	<b>Slightly Disagree</b>	<b>Slightly Agree</b>	<b>Strongly or Moderately Agree</b>
Training programs should rely solely on informal alliance training within the context of supervision-as-usual.	53%	23%	2%	13%
Training programs should require that trainees attend at least one specialized clinical workshop or training devoted entirely to evidence-based alliance practices.	20%	7%	21%	45%
Training programs should archive video recorded sessions of reliably rated good and poor alliance segments, to be used as an adjunct to standard supervision.	20%	8%	29%	37%
Some clinical trainees should be trained on at least one empirically-supported manual focused on recognizing and repairing alliance ruptures.	17%	8%	25%	40%
Clients and therapists should routinely complete formal alliance assessments as a means to informing the quality of their relationship and clinical work.	3%	13%	26%	49%
Training faculty should meet regularly to implement and update best practices, based on the research literature, for alliance training.	7%	7%	32%	46%

*Note.* Percentages that do not total 100 reflect missing data.

ALLIANCE QUALITATIVE FOLLOW-UP ITEMS (OPEN-ENDED)

Q. What are your overall reactions to the results of the alliance training survey?

Q. Do these results make you think any differently about your program's current alliance training practices? If yes, how?

Q. What would be your vision of a gold standard evidence-based alliance-training curriculum?

Q. What are potential barriers to your vision?

Q. Do you have any plans to implement any changes related to alliance training within the next five years? If so, what are they?

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