

THE RELATIONSHIP AMONG PATIENT CONTEMPLATION, EARLY ALLIANCE, AND CONTINUATION IN PSYCHOTHERAPY

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The present study examined the relationship among contemplation stage of readiness to change, formation of an early therapeutic alliance, and psychological distress following the first session of psychotherapy. Significant correlations between the contemplation scores and the therapeutic alliance were found for patients in the contemplation stage. Although contemplation scores were not a factor in return for a second session of psychotherapy, the bond subscale of the alliance inventory did significantly contribute to whether patients returned for therapy. Patient psychological distress was not a significant factor in predicting the early alliance. Results indicate a need for further focus on contemplation with its inherent ambivalence, its relationship to alliance, and continuation in early psychotherapy.

Keywords: therapeutic alliance, contemplation, readiness to change, psychological distress, continuation, ambivalence

Psychotherapy research over the last few decades suggests that both a strong therapeutic alliance (Bordin, 1979; Crits-Christoph & Connolly, 2003) and a patient's readiness to change (Prochaska, Norcross, & DiClemente, 1994) influence therapeutic effectiveness and continuation of psychotherapy. Other factors important to treatment success include the level of psychological distress (a common motivation for referral to treatment; Eurelings-Bontekoe, Diekstra, & Verschuur, 1995), and patient retention early in therapy. The main purpose of the present study was to investigate how the patients in the *contemplation* stage of readiness to change and their psychological distress affect the establishment of the therapeutic alliance and continuation of treatment following the first session of psychotherapy.

The alliance¹ has been shown to play a significant role in successful outcome across many theoretical modalities, including psychodynamic

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¹ The terms, "therapeutic alliance," "working alliance," and "helping alliance" have been used throughout the literature to delineate specific aspects of the therapeutic relationship or to describe the relationship as a whole between patient and therapist (Horvath, Gaston, & Luborsky, 1993). Although each expression is intended to emphasize particular features that are associated with that term, a particular theoretical orientation, or a particular research instrument, the use of these terms in the research literature is neither consistent nor specific. In this study, the terms, "therapeutic alliance" or "alliance" are used generally in the introduction and thereafter specifically to refer to the WAI, except in those instances when a different theory or researcher necessitates a different or specific use of a term.

(Crits-Christoph & Connolly, 2003), cognitive-behavioral (Constantino, Arnow, Blasey, & Agras, 2005), interpersonal (Krupnick, Sotsky, Elkin, Watkins, & Pilkonis, 1996), and eclectic (Sexton, 1996). Empirical research on the therapeutic alliance has demonstrated that the alliance forms relatively early in treatment and is predictive of later positive therapeutic outcome (Hartley & Strupp, 1983; Henry & Strupp, 1994; Horvath, 1993, 2000). The initial phase of development of the alliance is thought to occur during the first five sessions with a peak most often by the third session and variability thereafter (Horvath, 1993). Thus, the first session is considered critical for developing a therapeutic alliance (Hartley & Strupp, 1983). However, despite the recent findings that patient contributions to the alliance (rather than therapist) are associated with a positive therapeutic outcome (Blatt, 1999; Hubble, Duncan, & Miller, 1999; Shahar & Blatt, 2005), few studies have focused on the patient perspective of the first session of therapy.

Patient readiness to change is another key factor in psychotherapy outcome. The Transtheoretical Stages of Change Model, developed to operationalize intention to change behavior (McConaughy, Prochaska, & Velicer, 1983), consists of four specific elements: *Precontemplation*, *contemplation*, *action*, and *maintenance* (McConaughy, DiClemente, Prochaska, & Velicer, 1989). Patients in the *action* stage are more likely to participate in a process of self-change, engage with the therapist, and stay in treatment; while patients in the *precontemplation* stage are hesitant even to initiate therapy; and patients in the *contemplation* stage are ambivalent about change and thus at high risk for dropping out of therapy (Brogan, Prochaska, & Prochaska, 1999; Prochaska, Norcross, & DiClemente, 1994). Derisley and Reynolds (2000) found that low *contemplation* stage scores were associated with an increased risk of premature termination, while high *contemplation* stage scores were significantly associated with the formation of the early therapeutic alliance. In addition to *contemplation*, another important and infrequently examined factor in the Transtheoretical Model is psychological distress. However, the few available studies relating psychological distress and patient readiness to change with the alliance have shown inconsistent findings (Derisley & Reynolds, 2000; Multon, Heppner, Gysbers, Zook, & Ellis-Kalton, 2001; Ryan, 2001).

The primary goal of the present study was to examine the relationship between early formation of the therapeutic alliance, *contemplation* scores, degree of psychological distress, and patient continuation following the first session of psychotherapy in a general adult outpatient population. We proposed three specific hypotheses pertaining to individuals seeking outpatient psychotherapy: (1) *contemplation* scores would be positively correlated with the formation of an early alliance; (2) *contemplation* scores and alliance scores would predict return to the second session of psychotherapy; and (3) *contemplation* scores and level of psychological distress would predict a significant amount of variance in the early formation of the therapeutic alliance.

Methods

Participants

The 91 participants included 62 (68.2%) females and 29 (31.8%) males ranging in age from 18 to 58 with a mean age of 32.6 ($SD = 12.5$). The majority of the sample was single (58.2%) and Caucasian (91.2%), with the remaining population identified as 4.4% African American, 2.2% Asian, and 2.2% other. Most participants (61.5%) reported having engaged in psychotherapy at some point prior to the study but confirmed that they had no previous contact with their scheduled therapist. The most common self-reported diagnoses among participants were mood and anxiety disorders. Because the focus of the study was on the patient readiness to change and perception of the alliance, therapists were not included as participants.

Procedures

Participants were recruited at the time of their initial appointments at a northern New England community outpatient mental health center and a university counseling center between September 2003 and March 2004. Scheduled treatment was either a result of self-initiation, referral from employee assistance programs, or referral from another clinician. Of the 154 individuals approached for the study, 126 completed the study packets—a participation rate of 82%. Personal preference was the only reason identified for non-participation in the study. Because of the small numbers of participants in the remaining stages

of change, the focus of the analyses was on those participants who were categorized in the *contemplation* stage of change ($n = 91$).

Potential participants were not excluded based on diagnoses, but were excluded if court-ordered for treatment or showed symptoms of acute agitation, active psychoses, or other behaviors such as gross memory impairment that would compromise their ability to complete the questionnaires. Based on these criteria, no individuals were excluded by study staff trained to determine suitability for study participation. Thus, potential participants were informed that the clinic was participating in a research study designed to help improve psychotherapy services, handed sealed study packets, and told that they were in no way obliged to participate.

Following informed consent, participants completed a series of confidential questionnaires before the initial psychotherapy session and a second series of questionnaires immediately after the initial psychotherapy session. The study materials took approximately 15 minutes to complete and participants received \$5 for participating. Return for a second session of psychotherapy was assessed using a computerized search of completed visits from the clinic databases. Therapists included experienced community psychologists, social workers, and clinical counselors. Although the therapists were informed of the study, they were blind to whether their patients were participants. The appropriate human subjects committees approved all study procedures.

Measures Before Psychotherapy Session

Demographic data included self-report of age, gender, marital status, racial background, previous psychotherapy experience, and psychiatric diagnosis.

The Symptom Checklist (Brief Symptom Inventory—18; BSI-18; Derogatis, 2001), a short form of the Brief Symptom Inventory (BSI; Derogatis, 1993), is a self-report measure of psychological distress. The 18 items measure 3 primary symptom dimensions, and the Global Severity Index (GSI; Cronbach's alpha, 0.94) provides a single indicator of overall level of distress (Derogatis, 2001). The high internal consistency coefficient is consistent with previous studies (Derogatis, 2001).

The Stages of Change Scale (URICA; McConaughy et al., 1983) is a self-report measure

with four subscales used to identify four stages of change: (1) *precontemplation*, (2) *contemplation*, (3) *action*, and (4) *maintenance*. Responses to the 32 items allocates participants to one of the four stages based on the highest raw score obtained among the subscales; in the event of a tie, the participant was placed in the next stage (Derisley & Reynolds, 2000, 2002; Satterfield, Buelow, Lyddon, & Johnson, 1995). Internal consistency coefficients (Cronbach's alpha) were high: *precontemplation* (0.71); *contemplation* (0.80); *action* (0.87); and *maintenance* (0.82) and are consistent with prior studies (McConaughy et al., 1989).

Measures After Psychotherapy Session

The Working Alliance Inventory (WAI—Short Form Client; Horvath & Greenberg, 1989) consists of 12 items, developed from the 32-item WAI designed to assess Bordin's theory of goal agreement, task agreement, and bond development (Multon et al., 2001). The Client version correlates more highly with outcome than that of the Observer or Therapist (Horvath & Symonds, 1991). The *goal* subscale refers to mutual endorsement by the patient and therapist on the desired therapeutic outcomes; *task* to behavioral and cognitive processes that occur during sessions; and *bond* to the positive attachment formed between patient and therapist. The internal consistency coefficients (Cronbach's alpha) for this study's Client version were high: *Bond* (0.90); *goal* (0.90); and *task* (0.89) and are consistent with prior studies (Kokotovic & Tracey, 1989; Patton, Kivlighan, & Multon, 1997).

Results

Of the 126 participants who completed the readiness to change scale, the majority of participants ($n = 91$, 72.2%) were in the *contemplation* stage of change with an average *contemplation* stage score of 32.6 ± 4.7 (range 17–40). The remaining participants ($n = 35$, 27.7%) were in the *precontemplation*, *action*, or *maintenance* stages of change. Because of low power for other stages of change, only scores for participants in the *contemplation* stage ($n = 91$) were analyzed, consistent with prior studies that focused solely on the *contemplation* stage (Anatchkova, Velicer, & Prochaska, 2005), and a precedent for use as a continuous variable (Blanchard, 2003).

Our first hypothesis was that among outpatients, *contemplation* stage scores would be positively correlated with scores on the WAI. Pearson intercorrelations between the WAI subscales showed a large and significant positive correlation between *task* and *bond* ($r = .82, p < .001$), but lower correlations between *bond* and *goal* ($r = .66, p < .001$) and *task* and *goal* ($r = .62, p < .001$). These intercorrelations are consistent with prior studies (Horvath & Greenberg, 1989). Pearson partial correlation coefficients controlling for the age of the participants showed a significant positive relationship with a medium effect size (Cohen, 1988) between *contemplation* stage scores and patient-therapist goal ($r = .37, p < .01$), *task* ($r = .37, p < .01$), and *bond* ($r = .42, p < .01$), as well as total WAI score ($r = .44, p < .01$). All correlations suggested that the higher the *contemplation* score, the higher the *goal*, *task*, *bond*, and total scores of the working alliance.

Our second hypothesis was that the degree of contemplation and ability to form an alliance would predict return to psychotherapy. Logistic regression analysis revealed that the *contemplation* stage of change was not a significant independent predictor of return for a second session of psychotherapy ($\beta = 0.07, p > .05$). In addition, neither *goal* ($\beta = 0.03, p > .05$) nor *task* ($\beta = 0.21, p > .05$) on the WAI were significant predictors of return for a second session of psychotherapy. Only the *bond* subscale of the WAI was a significant predictor of actual return for a second session of psychotherapy ($\beta = 0.34, p < .05$).

Our third hypothesis examined the role of psychological distress (as measured by the GSI overall scale of the BSI-18), *contemplation* stage of change, and the formation of the early alliance. Multiple linear regression showed the total score for WAI was significant, $F(2, 88) = 12.11, p < .001$, and while *contemplation* scores predicted a high level of alliance ($\beta = 1.04, p < .01$), the overall level of psychological distress was not a significant predictor of the total WAI score ($\beta = 0.10, p = .10$). Similar to the findings in the total WAI score, the multiple regression analysis with the *bond* subscale was significant with about 20% (adjusted $R^2 = 0.199$) of the variance in the *bond* subscale of the WAI being predicted by *contemplation* stage and psychological distress scores. The multiple regressions on the *goal* and *task* subscales were also significant ($p < .01$), with

the estimated proportion of the variance for the *goal* and *task* subscales at 0.124 and 0.144, respectively.

Discussion

The present study examined the relationship among patients in the *contemplation* stage of readiness to change, formation of an early therapeutic alliance, and psychological distress following the first session of psychotherapy in a general adult outpatient population. The significant correlation between the *contemplation* scores and the total score on the WAI as well as the *goal*, *task*, and *bond* subscales suggest a relationship between patient *contemplation* scores and the formation of an early alliance with the therapist for patients in the *contemplation* stage. Although *contemplation* stage scores were not a factor in return for a second session of psychotherapy, the *bond* subscale of the WAI did significantly contribute to whether patients returned for therapy. Importantly, contrary to our hypothesis, patient psychological distress was not a significant factor in predicting the early alliance.

The findings of this study have several important implications for the study of early psychotherapy. Approximately 40% of patients in community mental health centers and 20% in independent practice settings terminate therapy within the first two visits (Richmond, 1992). However, the reasons for early termination of psychotherapy remain unclear. Given the fact that the majority of patients (61.5%) in the present study were in the *contemplation* stage of change, the finding that there is a significant relationship between their *contemplation* scores and therapeutic alliance builds on previous research suggesting the importance of understanding these concepts early in therapy (Derisley & Reynolds, 2000).

One possible link between *contemplation* scores and alliance scores may be the role of ambivalence—a concept inherent to the definition of the *contemplation* stage of change. Perhaps these patients are better able to connect with their therapists because they are aware that there is a problem (unlike in *precontemplation*), but are not yet directed toward changing it (unlike in *action*; Prochaska et al., 1994). The present finding that *contemplation* stage scores are significantly correlated with alliance scores supports the need for therapists to listen for and accept patient

expressions of ambivalence to treatment early in therapy in order to nurture the formation of a productive therapeutic alliance. Thus, it is important for therapists to recognize ambivalence, and to not take a strong position in one direction of a patient's ambivalence (Shaffer & Simoneau, 2001).

Although *contemplation* stage scores and *bond* scores were significantly correlated, only the *bond* scores of the alliance predicted return for a second session of therapy. In contrast to the *goal* and *task* subscales of the WAI, which focus more on the content and aims of the therapy, the *bond* subscale emphasizes the relational part of the alliance. Thus, the significant relationships among *contemplation* stage, the *bond* subscale, and return to therapy emphasize the essential role of the patient-therapist relationship early in psychotherapy.

The present study has several limitations. Although the study contained a large enough sample size to obtain significant findings in relation to patients in the *contemplation* stage, the population was not large enough to allow for analyses of the other stages of change. A larger, more ethnically diverse study population, stratified by stage of change, diagnoses, gender, and types of therapy may provide information about cultural and gender diversity. Data also were based on patient self-reports, which, although extensively validated (Kazdin, 1998), are always subject to participant bias. Future studies on the factors important to early psychotherapy should include measures of the alliance at multiple time points from multiple perspectives (e.g., observer), more data about the quantity and quality of past experiences with psychotherapy, and inclusion in the analyses of an assessment of therapeutic outcome.

It is also important to note that a significantly lower percentage of patients terminated therapy in our sample (14%) than has been reported in other community health center samples (approximately 40%; Richmond, 1992). Data cited from other centers often include dropouts after several sessions whereas our sample assessed return to therapy after the initial session. Because our sample included very few patients who did not return for a second session, the predictive power of our statistical analyses is limited. In light of this issue, however, the finding of statistically significant predictors of continuation is impressive.

Despite these limitations, the results support the importance of understanding patient pretreatment characteristics, including *contemplation* stage scores, and their effect on the formation of the therapeutic alliance as predictors of continuation as early as the first session of psychotherapy. The first session, therefore, should not be dismissed as a "history-taking" session (Horvath & Bedi, 2002). Future research could further investigate specific psychotherapy process variables designed to measure patient, therapist, and patient-therapist interactions during sessions for patients who ultimately continue versus those who prematurely terminate psychotherapy (Abalon & Marci, 2004). In addition, stages of change assessments could be used at the beginning of outpatient therapy to gauge patient readiness (McConaughy et al., 1983) and change in the psychotherapy process, while a better understanding of patient ambivalence at the beginning of treatment may help prevent premature termination.

The present study provides improved understanding of patient *contemplation* stage of change, the ability of patients to form an alliance with the therapist, and variables related to continuation after the first session of psychotherapy. More research is needed to better understand each of these variables as well as the relationships among them in the first few sessions of psychotherapy to help decrease early termination and improve psychotherapy outcomes.

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