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Relational Virtues and Alliance Correspondence in Psychodynamic Psychotherapy

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Study Overview

The routine outcome monitoring of treatment progress typically emphasizes tracking mental health symptoms. In contrast, McWilliams (2021) formulated indicators of progress in psychodynamic psychotherapy, labeled *psychological vital signs*. These vital signs go beyond symptom reduction and signal growth in "overall psychological wellness" (p. 67). McWilliams identified the virtues of gratitude and forgiveness as two vital signs with a "focus on what simply *is* rather than on the constant striving for what *might* be" (p. 65). We responded to the call for "alternative ways of establishing [psychodynamic] psychotherapy as 'evidence-based'" (Fonagy, 2015, p. 137) by employing longitudinal mixture modeling, or trajectory-based analysis, to evaluate treatment effectiveness (e.g., Berlin et al., 2014; Jankowski et al., 2019).

Method

Between fall 2020 and fall 2022, data were collected from clients receiving outpatient mental health treatment at a psychodynamic training clinic in the northeastern United States. Clients received long-term spiritually-integrated contemporary relational psychotherapy (CRP), based on the spiritual-existential-religion-theology (SERT) model used at the clinic (Rupert et al., 2019; Sandage et al., 2020). CRP utilizes the alliance as a key mechanism of change, informed by (a) safe haven and secure base attachment functions, (b) emotional co- and self-regulation and balanced autonomy-closeness relational functioning, (c) intersubjective recognition of self and other, and (d) repairing alliance ruptures (Sandage et al., 2020). We created a modified intent-to-treat sample using clients (N = 185; M_{age} = 40.12; SD = 16.10; range = 18 – 81) who had at least two assessment dates, with an average length of treatment over the five assessments of 14.45 months. Most participants identified as White (74.1%; 7% Asian, 5.4% Black, 2.2% Hispanic, 8.6% multiple races, 2.7% other), cisgender female (60%; 33% cisgender male, 1.6% transgender, 4.9% other), and heterosexual (69.4%; 7.3% gay/lesbian; 9.7% bisexual, 6.5% multiple sexual identities, 7.2% other). A majority identified as religious (68.1%; 31.9% non-religious, i.e., agnostic, atheist, and/or none).

Measures

1. **Gratitude.** We used two items (α = 0.74 at time 1; α = 0.76 at time 2; α = 0.69 at time 3; α = 0.77 at time 4; α = 0.79 at time 5; e.g., "I expressed gratitude to others;" Choe et al., 2023). We used an "over the past month" prompt, asking how often participants "engaged in the following behaviors if they were appropriate to the situation." Items were rated from 1 (*Never*) to 5 (*Almost always*), with higher scores indicating greater gratitude engagement.
2. **Forgiveness.** We used two items (α = 0.78 at time 1; α = 0.74 at time 2; α = 0.76 at time 3; α = 0.76 at time 4; α = 0.79 at time 5; e.g., ''I tried to see an offense from a different perspective;'' Choe et al., 2023), and an "over the past month" prompt about participants' level of forgiveness behaviors "if they were appropriate to the situation." Items were rated from 1 (*Never*) to 5 (*Almost always*). Higher scores indicated greater forgiveness engagement.
3. **Depression.** We used the 9-item Patient Health Questionnaire (PHQ-9; Kroene & Spitzer, 2002; ω = 0.87 at time 1; ω = 0.93 at time 5; e.g., "Little interest or pleasure in doing things"). Participants rated the items on a scale from 0 (e.g., *Not at all*) to 3 (e.g., *Nearly every day*) with higher scores indicating greater depression symptoms.
4. **Well-being.** We used the 14-item Mental Health Continuum—Short Form (MHC-SF; Lamers et al. 2011; e.g., "When I look at my life, I feel happy"). Items (ω = 0.92 at time 1; ω = 0.95 at time 5) were rated from 1 (*Never*) to 6 (*Every day*). Higher scores indicated greater well-being.
5. **Alliance.** We used the 12-item Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) to assess clinicians' (e.g., "client and I respect each other;" ω = 0.93 at time 2) and clients' perceptions of the alliance (e.g., "individual therapist and I respect each other;" ω = 0.92 at time 2). Items were rated from 1 (*Seldom*) to 5 (*Always*) with higher scores indicating stronger alliance.

Data Analysis

We analyzed the data using parallel longitudinal mixture modeling procedures in Mplus (version 8.4; Muthén & Muthén, 1998–2019; i.e., type = complex random mixture, cluster = provider (n = 35), to account for client data nested in provider; estimation = maximum likelihood estimation with robust standard errors). We used the TSCORES option to account for time-unstructured data (Muthén & Muthén, 1998–2019), with T1 at zero months and T2-T5 at individually varying times of assessment in months. We treated clinician and client ratings of the alliance as time-invariant covariates and examined their effect on class membership. We expanded the logistic regression by adding quadratic terms for the ratings of the alliance. We used the estimates produced by the regression model to examine *alliance correspondence* by testing the four slopes for the response surface analysis (Marmarosh & Kivlighan, 2012; Schönbrodt et al., 2022; Shanock et al., 2014; Whelen et al., 2023).

Results

We identified the 3-class model as best fit to the data. As depicted in Figure 1, Class 1 was characterized by highest gratitude and forgiveness, and reported no change in the virtues. Class 1 also reported the lowest depression and highest well-being, along with gains in well-being (Δ = 3.11, SE = 0.29, p < 0.001, d = 0.66). Higher initial well-being predicted a lesser rate of change in well-being (B = -0.80, SE = 0.10, p < 0.001). We labeled this subgroup the *stable flourishing*. Class 2 was depicted by mid-level scores on the virtues and no change in virtues. Members of class 2 also reported mid-levels of symptoms and well-being, and proportional latent change scores showed no change. We labeled this subgroup *moderately healthy*. Members of class 3 reported lower gratitude and forgiveness and exhibited significant growth in both virtues. Class 3 was also characterized by the lowest well-being and highest depression, and reported a decrease in symptoms (Δ = -0.13, SE = 0.05, p = 0.01, d = 0.31). Higher initial levels of depression predicted a lesser rate of change in depression (B = -0.14, SE = 0.03, p < 0.001). We labeled this subgroup *virtue growth*.

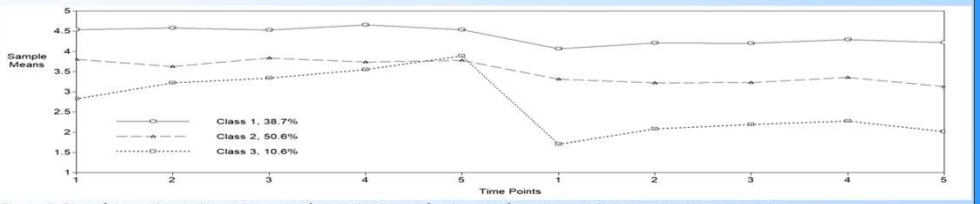

Figure 1. Plot of the estimated sample means for gratitude and forgiveness from the parallel growth mixture model.

Response surface analysis results showed a significant slope along the line of agreement (B = -2.59, SE = 1.09, p = 0.02; see Figure 2), suggesting that as the strength of the combined agreement about the alliance increased, the probability of membership in the *virtue growth* subgroup decreased, relative to the *stable flourishing*. Results predicting membership in the *moderately healthy* showed a significant slope (B = -2.73, SE = 0.77, p < 0.001) and curvature along the line of agreement (B = -1.54, SE = 0.78, p = 0.048) suggesting that as agreement about high alliance ratings increased and agreement about low ratings increased, clients were less likely to belong to the *moderately healthy* (see Figure 3). There was also a significant slope along the line of disagreement (B = -1.80, SE = 0.86, p = 0.03) suggesting that as client perceptions about the alliance increased and clinician perceptions decreased, belonging to the *moderately healthy* increased, and this effect was stronger relative to when client perceptions of the alliance decreased and clinician perceptions increased.

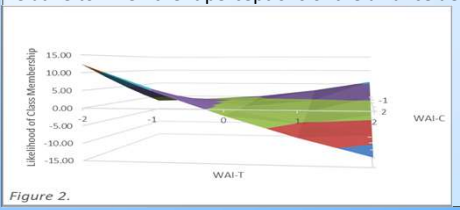

Figure 2.

Figure 3.

Conclusion

Results supported McWilliams' (2021) assertion that gratitude and forgiveness can be used to monitor progress in psychodynamic treatment, primarily in terms of symptom improvement, and to a lesser extent well-being. Results also supported contrasting perspectives for alliance correspondence. We found support for greater correspondence to indicate a positive therapeutic process (Nissen-Lie et al., 2021). Greater agreement predicted membership in the *stable flourishing*. On the other hand, greater disagreement increased the likelihood of belonging to the *stable flourishing* subgroup relative to the *moderately healthy*, when clinician rating were higher and client ratings lower, suggesting that dis-correspondent ratings could also indicate an effective process (Nissen-Lie et al., 2021), at least for some clients with mid-levels of virtues, well-being, and symptoms.