The impact of common 'specific' therapeutic factors on treatment outcomes of mood and anxiety disorders

Impatto dei fattori terapeutici specifici comuni sugli esiti del trattamento del disturbo d'ansia e d'umore

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Summary

Objectives

Clinical work involves psychological-relational factors that make up the background and framework for the development of therapeutic relationships. We used a novel assessment to examine the impact of patient-therapist relationship factors on treatment outcomes.

Methods

This study was conducted on patients with mood and/or anxiety disorders, seeking treatment at public and private outpatient settings. Patients received treatment as usual, including psychotherapy, pharmacotherapy, or their combination. The diagnostic assessment was carried out by therapists using the MINI Neuropsychiatric Interview. At baseline and after 3 and 9 weeks patients and therapists filled out the Work Alliance Inventory (WAI) and the Common Specific Therapeutic Factor (CSTF) Questionnaire, an instrument designed to assess therapist's communication style, focus on patient history, supportive feedback/information, construction of the setting and therapist's recall of patient.

At the same time points, patients filled out the Work and Social Adjustment Scale. Linear regression models were used to examine the relation between CSTF- and WAI scores and treatment outcomes.

Linear regression was used to analyze the relation between change in functioning and change in CSTF and WAI scores (both patient and therapist versions). Two separate models were fitted for the patient and therapist versions of the instruments. Age, gender and drug treatment (coded as yes/no) were forced into the model to adjust for their potential confounding effect and CSTF factors and WAI scores were entered using a stepwise procedure.

Results

The mean decrease in functional impairment from baseline to endpoint, measured using the WSAS, was 5.3 points (SD 8.7). Sixty-one percent (61%) of the participants rated their satisfaction with treatment as being "very good" to "excellent" (N = 57); a further 33% reported that it was "good" (N = 31). Forty-six point nine percent (46.9%) of the participants achieved remission.

In a linear regression model using scores from the patient versions of the instruments, improvement in communication skills was significantly associated with functional improvement after adjusting for the effects of gender, age and drug treatment (Table II). When the analyses were replicated in patients stratified by diagnosis (mood or anxiety/other diagnosis), changes in communication skills proved to be associated with functional improvement only in patients with mood disorders ($b = 5.107$, $p = 0.026$).

In a second model, using scores from the therapist versions of the instruments, increased focus on patient history was the only factor associated with functional improvement after controlling for gender, age and drug treatment. Changes in supportive feedback/information, recall, and in WAI scores (patient and therapist versions) were unrelated to changes in functioning in both models. Analyses carried out in diagnostic strata identified different CSFT predictors of functional improvement. In patients with mood disorders, changes in recall ($b = 7.322$, $p = 0.019$) and in patients with anxiety/bulimia changes in communication skills ($b = 9.833$, $p < 0.001$) were associated with functional improvement from baseline.

Increase in therapeutic alliance was significantly associated with higher levels of satisfaction in the patient model (Table III). No CSTF was associated with satisfaction with treatment. In the therapist model, no predictor of satisfaction with treatment was identified.

Conclusions

Communication style, focus on patient history, therapist's recall of patients and therapeutic alliance were related to study outcomes. Further research involving therapists with different levels of experience is needed to shed light on whether and to what extent clinical experience mediates the CSTF-treatment outcome relation.

Key words

Therapeutic factors • Therapeutic alliance • Depression • Anxiety

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Riassunto

Obiettivo
L'attività clinica implica fattori psicologico-relazionali che fanno da cornice e da sfondo per lo sviluppo di relazioni terapeutiche. In questo articolo si esamina l'impatto dei fattori relazionali medico-paziente sugli esiti del trattamento utilizzando un nuovo strumento di valutazione.

Metodi
Lo studio è stato condotto in un campione di pazienti con disturbi d'ansia o depressione che si erano rivolti a centri pubblici o terapeuti privati. Nel corso dello studio non è stato adottato uno specifico protocollo terapeutico, ed i pazienti sono stati trattati con psicoterapia, farmacoterapia o con un terapia combinata. La valutazione diagnostica è stata condotta dai terapeuti con la *MINI Neuropsychiatric Interview*. All'inizio del trattamento e dopo 3 e 9 settimane i pazienti e i terapeuti compilavano il *Work Alliance Inventory* (WAI) e il questionario sui fattori terapeutici specifici comuni (FTSC), uno strumento sviluppato per valutare la stile comunicativo del terapeuta, l'attenzione alla storia del paziente, l'informazione e il feedback supportivo, la costruzione del setting e la presenza nella memoria del paziente. Agli stessi tempi, i pazienti compilavano la *Work and Social Adjustment Scale* per la valutazione del funzionamento. La relazione tra gli esiti del trattamento ed i punteggi al questionario FTSC e WAI è stata esaminata utilizzando modelli di regressione lineare. In particolare, la variazione del funzionamento tra l'inizio e la fine del trattamento è stata messa in relazione con le variazioni dei punteggi FTSC e WAI. Sono stati creati modelli distinti per le versioni paziente e terapeuta degli strumenti. Nei modelli sono stati inclusi come possibili confondenti il sesso, l'età e la presenza/assenza di terapie farmacologiche e poi aggiunti i punteggi FTSC e WAI mediante una procedura stepwise (per passi).

Risultati
La diminuzione media nella compromissione funzionale, misurata utilizzando la WSAS, è stata di 5,3 (DS 8,7). La soddisfazione nei confronti del trattamento ricevuto era molto buona o eccellente nel 61% dei partecipanti e buona nel 33% dei partecipanti. 46,9% dei partecipanti avevano raggiunto la remissione a fine trattamento. Nel modello che comprendeva come predittori di esito i punteggi FTSC e WAI delle versioni 'paziente', il miglioramento nelle abilità comunicative del medico è risultato associato ad una riduzione significativa della compromissione funzionale, al netto dell'effetto del sesso, dell'età e della terapia farmacologica (Tab. II). Replicando il modello di regressione nei pazienti stratificati per diagnosi (depressione e ansia), la relazione significativa tra miglioramento nelle abilità comunicative del medico e riduzione della compromissione funzionale era confermata solo nel gruppo con depressione (b = 5,107, p = 0,026).
Nel modello che utilizzava come predittori di esito i punteggi delle versioni 'terapeuta' dei questionari, l'aumento dell'attenzione alla storia del paziente era l'unico fattore associato al miglioramento funzionale al netto dei fattori di confondimento. Le variazioni nell'informazione/feedback supportivo, presenza nella memoria e alleanza terapeutica non sono risultate correlate al miglioramento funzionale. Tuttavia, nelle analisi stratificate per diagnosi, il miglioramento funzionale era associato ad un aumento della presenza nella memoria del paziente (b = 7,322, p = 0,019) nel gruppo con depressione e all'aumento delle abilità comunicative del medico (b = 9,833, p < 0,001) nel gruppo con disturbi d'ansia. L'alleanza terapeutica valutata dal paziente è risultata positivamente correlata alla soddisfazione per il trattamento ricevuto (Tab. III). Non sono stati identificati altri predittori della soddisfazione.

Conclusioni
Lo stile comunicativo, l'attenzione alla storia del paziente, la presenza nella memoria del paziente e l'alleanza terapeutica sono risultati aspetti legati agli esiti dello studio. Sono necessari ulteriori studi che coinvolgano terapeuti con diversi livelli di esperienza clinica per chiarire se e in che misura l'esperienza clinica agisca da mediatore della relazione tra fattori terapeutici ed esiti.

Parole chiave
Fattori terapeutici • Alleanza terapeutica • Depressione • Ansia

Introduction

Clinical work implies psychological-relational factors that make up the background and framework for the development of therapeutic relationships. Frank [1] distinguished between non-specific and specific aspects of therapy producing change and identified 'common' factors of psychotherapy, which constitute the core of all therapies and include emotional arousal, an understanding and empathic therapist, a specific treatment setting, success experiences and provision of therapeutic hope and optimism [2].
To elucidate the mechanisms of change underlying successful treatment, research in the field has begun focusing on the issue of therapeutic alliance [3-5] i.e. on the collaborative nature of the patient-therapist relationship, their agreement on goals and the personal bond that emerges in treatment. More recently, a group of Italian psychiatrists and psychotherapists recently used a broader approach, based on a systematic literature review and on their own clinical experience, to identify several other therapeutic relationship factors, in addition to therapeutic alliance: 1) supportive feedback/information; 2) focus on patient history; 3) construction of the setting; 4) therapist's recall of the patient; and 5) therapist's communication style [6].
The research group denoted these factors as Common Specific Therapeutic Factors (CSTFs, 7) to reflect the view that they are common to all activities of care [7-10] and that they make up a key ingredient thereof. This perspective is in contrast to that of the usual "nonspecific" denomination.
These CSTF factors were subsequently operationalized (see appendix) in a questionnaire that was developed and validated in two versions – one for therapists and one for patients [11] – with the aim of developing measurable constructs to be used in outcome studies.

Hence, the aim of the present paper was to examine the predictive validity of CSTFs in patients with mood and anxiety disorders, treated in Italian community mental health services and private practices. We hypothesized that CSTF baseline-to-endpoint score increases would be associated with better treatment outcomes.

Methods

This longitudinal observational study was conducted between October 2005 and August 2006. Seventeen mental health professionals, including 8 psychiatrists and 9 psychologists working in community mental health services located in the cities of Bologna and Imola (Italy) or in private practices, agreed to participate in the study and to consecutively recruit at least 7 patients each with mood or anxiety disorders seeking treatment. Psychiatrists and psychologists were experienced clinicians, with an average of at least seven years of clinical activity each. Patients seeking treatment for mood and anxiety disorders were screened at their first visit for potential participation in the study.

After giving a complete description of the study to the potential patients, written informed consent was obtained. Inclusion criteria were: 1) Age ≥ 18; 2) both genders; 3) mood or anxiety disorders diagnosed with the MINI Neuropsychiatric Interview using DSM-IV criteria; 4) ≥ 8 years of education. Exclusion criteria were: a) active suicidal ideation; b) current psychosis or mental organic disorder; c) substance abuse or dependence in the last 6 months; d) ongoing treatment for the current disorder.

Diagnostic assessment was carried out at baseline by therapists using the MINI Neuropsychiatric Interview version 5.0 [12 13], which allows to make diagnoses according to DSM-IV criteria. Therapists were trained to conduct the diagnostic interview by one of the authors (EF) and an experienced interviewer not involved in the study.

At the end of the first session, both patients and therapists completed self-report questionnaires. Patients' forms were returned to the administrative staff in a sealed envelope. This procedure was chosen to ensure that the therapists were blind to the patients' self-reports.

Two subsequent follow-up visits were scheduled flexibly, according to the patients' treatment needs: at 2-4 weeks and at 8-10 weeks. Patients not presenting for the second follow-up visit were scheduled for a new appointment.

Baseline and follow-up assessments included the Common Specific Therapeutic Factors (CSTFs) questionnaire, which was developed in Italian and validated by Gallo et al. [11]; the Working Alliance Inventory – Short form (WAI [14]), translated into Italian by Lingiardi and Filippucci and the Work and Social Adjustment Scale to measure functional impairment (WSAS [15]).

At endpoint, patients rated their satisfaction with treatment on a Likert scale (1 = excellent and 8 = terrible).

The common specific therapeutic factors (CSTF) questionnaire

The CSTF questionnaire was designed to assess the degree and the quality of supportive feedback/information, focus on patient history, construction of the setting, therapist's recall of patient, and the therapist's communication style. It was developed in 4 versions (patient baseline, therapist baseline, patient follow-up and therapist follow-up). See Appendix for the patient baseline version. The baseline version explores supportive feedback/information, focus on patient history, construction of the setting, and therapist's communication style. The follow-up version includes an additional part exploring the therapist's recall of patient, and several items referring to setting stability and flexibility.

The CSTF items are statements rated on a Likert scale ranging from 1 to 6, according to degree of agreement with the statement (1 = not at all, 2 = a bit, 3 = moderately, 4 = sufficiently, 5 = much, 6 = very much).

Individual CSTF scores are obtained as the average of items comprising the factor. The instrument has been shown to have sound psychometric properties [11], and both the patient- and therapist versions yielded satisfactory internal consistency values (Cronbach's alfa > 0.70 for 4 out of 5 CSTFs). Correlations between patient- and therapist-rated factor scores were moderate (r = 0.30-0.50).

For reasons of brevity, the terms *supportive feedback/information, history, recall, setting and communication* will be used to denote the CSTF factors throughout the paper.

Work Alliance Inventory

The WAI scale measures therapeutic alliance and consists of 12 items – 10 positively worded and 2 negatively worded – rated on a 7-point Likert scale, with 1 = never and 7 = always. The total score was calculated as the sum of the positively worded items and the inverted score of the negatively worded items. The psychometric properties of the observer version had been examined in previous work [16]. Interrater reliability, estimated by Pearson correlation coefficient, was found to be 0.67; and item-by-item interrater reliabilities ranged from a low of 0.14 to a high of 0.65, with a median of 0.42.

Work and Social Adjustment Scale (WSAS)

The WSAS consists of 5 items rated on an 8-point ordinal scale. The total score is obtained as the sum of the 5 item scores, and ranges from 0 to 40. Higher scores denote higher levels of functional impairment. Internal consistency was found to range from 0.70 to 0.94, and the test-

retest correlation was 0.73 [15]. Interactive voice response administration of this scale yielded correlations of 0.81 to 0.86 with clinician interviews. The WSAS correlation with severity of depression was 0.76. Scores were sensitive to patient differences, in terms of disorder severity and treatment-related change [15].

Outcomes

Our primary outcomes were functional change, defined as the difference between WSAS scores at baseline and at the second follow-up, and satisfaction with treatment, measured at endpoint.

Our secondary outcome was remission, defined by the absence of the primary diagnosis at the second follow-up assessment, assessed by the therapist using the MINI Interview.

Statistical analyses

Box-and-whiskers plots were used to summarize the CSTF and WAI score distribution (Fig. 1). In this graphical representation, the box includes values between the 25th and the 75th percentile. The line across the box indicates the median. The "whiskers" are lines extending from the box to the highest and lowest values, excluding outliers. The dots above and below the whiskers represent the outliers.

Linear regression was used to analyze the relation between change in functioning and change in CSTF and WAI scores (both patients and therapists' versions). Two separate models were fitted for the patient and therapist versions of the instruments. Age, gender and drug treatment (coded as yes/no) were forced into the model to adjust for their potential confounding effect and CSTF factors and WAI scores were entered using a stepwise procedure. Secondary analyses were carried out in patients stratified by diagnosis (mood disorders *vs.* anxiety disorder, including the two patients with bulimia).

The *setting* factor was not used in the analyses because it explores different items at baseline and follow-up and change from baseline cannot be determined.

Similarly, two linear regression models were used to analyse the relationship between satisfaction with treatment and changes in CSTF and WAI scores.

Results

One hundred and fourteen patients were assessed for potential participation in the study. Two patients meeting criteria for psychotic disorders and one with vascular encephalopathy were excluded; one refused to participate. Ten patients dropped out at the first follow-up, and four others did so at the second follow-up.

Ninety-six patients (84.2%) completed the three study assessments and were included in the analyses. The 96 completers showed no significant differences from the 14 non-completers in terms of age, education, gender distribution, diagnostic distribution, and functional impairment. Baseline CSTF factor scores did not differ significantly between completers and non completers. The only exception was that non-completers had lower scores on supportive feedback/information (patient version) than completers did. This difference, however, was not significant (mean = 3.6, SD = 0.8 *vs.* mean = 4.1, SD = 0.8, t-test = -1.84, p = 0.068).

Among the patients dropping out, two discontinued treatment; one moved to another town; one sought treatment with a private mental health specialist; and two were non-compliant with the treatment schedule and did not return the questionnaires; no protocol discontinuation reasons were recorded for the remaining eight drop-out patients.

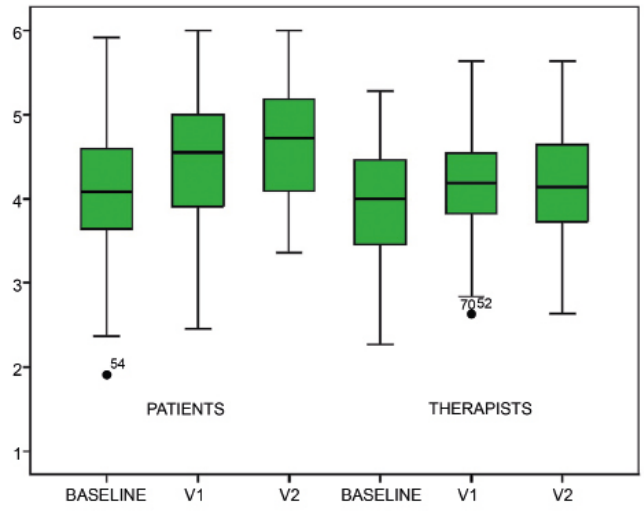
Table I shows completers' characteristics. Participants were mostly female, with a mean age of 38 years and an educational level of 12 years, corresponding to a high school diploma. More than 50% were single, divorced, or widowed. The WSAS score at baseline was 19.7 (SD = 9.6). During the study period, patients received treatment as usual, which was pharmacotherapy for 42 patients, psychotherapy (individual or family-focused) for 32 patients, and a combination of pharmacotherapy and psychotherapy for 22 patients. Patients treated with psychotherapy alone and the majority of those in combined treatment were seen once a week; patients with pharmacotherapy alone were usually seen once a week for the first three or four times, and then once every two-three weeks. On average, the follow-up phase lasted 67.3 days (SD 17.5, range 25-129), i.e., approximately 9 weeks.

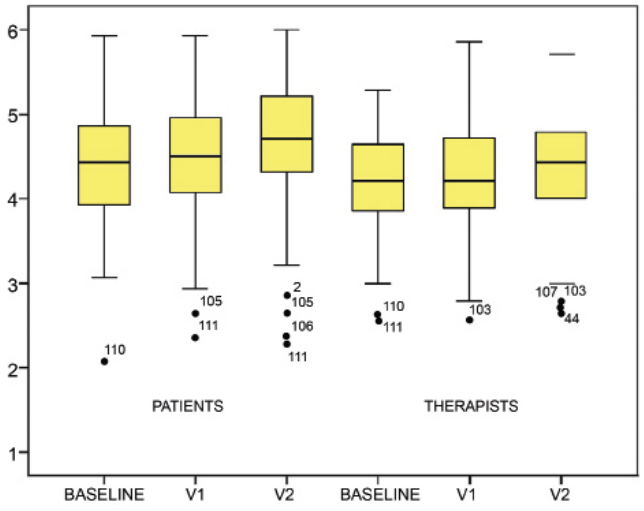
Outcomes

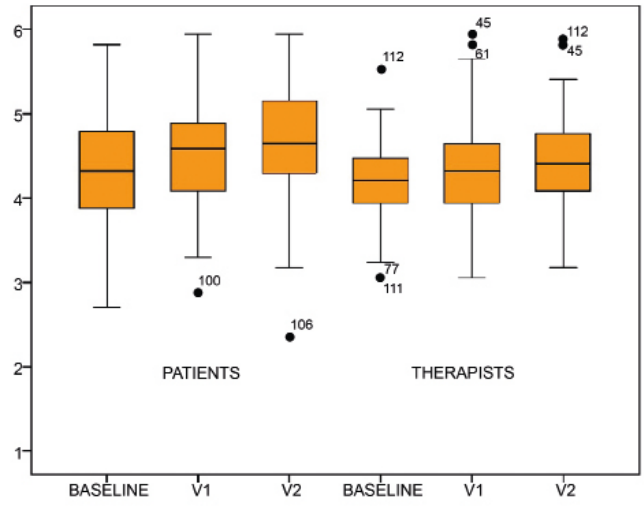
The mean decrease in functional impairment from baseline to endpoint, measured using the WSAS, was 5.3 points (SD 8.7). Sixty-one percent (61%) of the participants rated their satisfaction with treatment as being "very good" to "excellent" (N = 57); a further 33% reported that it was "good" (N = 31). Forty-six point nine percent (46.9%) of the participants achieved remission.

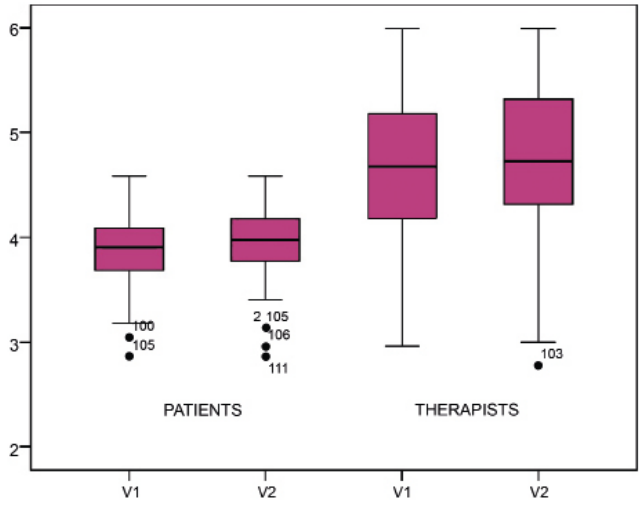
CSTF and WAI scores over treatment

Patients and therapists showed moderate-to-high ratings on the CSTF and WAI at baseline and during treatment. The box plots in Figure 1 show that scores clearly clustered in the distribution's upper range, with medians ranging from 4 to 5. Supportive feedback/information, communication, and history scores increased over time for patients, and remained fairly stable for therapists. Therapists gave higher ratings to the recall factor than patients did at each time point.









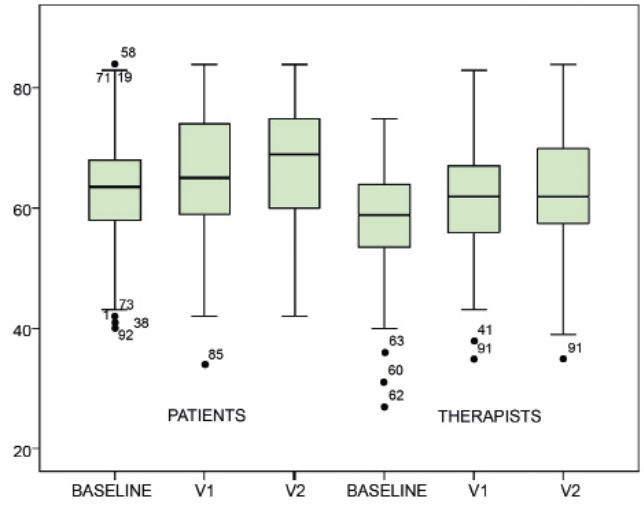


FIGURE 1.
Box plots for CSTF and WAI scores: lines in boxes indicate medians, and dots represent outliers. *Grafici a scatola per i punteggi CSFT e WAI: le linee all'interno della scatola indicano la mediana e i punti rappresentano i valori anomali.*

TABLE I.
Demographic and clinical characteristics of the sample. *Caratteristiche demografiche e cliniche del campione.*

	Mean	SD
Age (years)	38	10
	N	%
Gender		
Male	30	31.3
Female	66	68.7
Marital Status		
Single	44	45.8
Separated/divorced	6	6.3
Widowed	1	1.1
Married / living with a partner	45	46.8
Education		
Illiterate	0	0
Primary school	3	3.1
secondary school	25	26.0
High school	51	53.1
University	17	17.7
Occupational status		
Currently unemployed	7	7.3
Full or part-time work	68	70.8
Supported employment	1	1.1
Other (housewife, student, retired)	20	20.8
Primary diagnosis		
Major depression (current)	43	44.8
Major depression (lifetime)	1	1.0
Dysthymia	13	13.6
Panic disorder	23	23.9
Generalized anxiety disorder	10	10.4
Social phobia	2	2.1
Post-traumatic stress disorder	1	1.0
Bulimia nervosa	2	2.1
Obsessive – compulsive disorder	1	1.0

Outliers, represented as dots in Figure 1, were found at the bottom part of the setting – and history factor distributions – for both the patient and therapist versions of the questionnaire. This result indicates that some patients and therapists gave low ratings to the 'setting' factor with respect to the index visit and were not satisfied with the degree of 'focus on patient history'. Conversely, the outliers at the top of the communication distribution indicate that some therapists were extremely satisfied with the level of communication achieved during the session. Therapeutic alliance scores increased in patients from the first to the second follow-up visit and remained constant for therapists.

Functional improvement

Linear regression models were used to examine the relationship between functional improvement from baseline and changes in CSTF and WAI scores. In the first model, using scores from the patient versions of the instruments, improvement in communication skills was significantly associated with functional improvement after adjusting for the effects of gender, age and drug treatment (Table II). When the analyses were replicated in patients stratified by diagnosis (mood or anxiety/other diagnosis), changes in communication skills proved to be associated with functional improvement only in patients with mood disorders ($b = 5.107$, $p = 0.026$).
In the second model, using scores from the therapist versions of the instruments, increased focus on patient history was the only factor associated with functional improvement after controlling for gender, age and drug treatment. Changes in supportive feedback/information, recall, and in WAI scores (patient and therapist versions) were unrelated to changes in functioning in both models.
Of note, analyses carried out in diagnostic strata identified different CSFT predictors of functional improvement. In patients with mood disorders, changes in recall ($b = 7.322$, $p = 0.019$) and in patients with anxiety/bulimia changes in communication skills ($b = 9.833$, $p < 0.001$) were associated with functional improvement from baseline.

Satisfaction with treatment

Increase in therapeutic alliance was significantly associated with higher levels of satisfaction in the patient model (Table III). No CSTF was associated with satisfaction with treatment.
In the therapist model, no predictor of satisfaction with treatment was identified.

Discussion

The present study used CSTF assessment to examine the impact of patient-therapist relationship factors on the treatment outcomes of patients recruited in public and private settings and treated for an average of 9 weeks by experienced mental health specialists.
Similarly to the WAI and to a recently developed 12-item scale assessing the therapeutic relationship in commu-

TABLE II.
Predictors of functional improvement (patient and therapist models). *Predittori del miglioramento funzionale (modelli paziente e terapeuta)*.

		Unstandardized Coefficients		Standardized Coefficients	t	p
		B	SE(b)	Beta		
Patient model	(Constant)	4.816	4.858		.991	.324
	Drug treatment (yes/no)	1.309	1.988	.072	.658	.512
	age	-.034	.094	-.040	-.363	.718
	gender	-.464	1.945	-.025	-.239	.812
	Communication skills	4.663	1.503	.327	3.102	.003
Therapist model	(Constant)	11.294	4.640		2.434	.017
	Drug treatment (yes/no)	1.121	2.036	.062	.551	.583
	age	-.059	.096	-.069	-.613	.541
	gender	-2.831	1.996	-.152	-1.419	.160
	Focus on history	3.660	1.623	.241	2.255	.027

nity mental health centers [17], the CSTF incorporates both patients' and therapists' views. We found that, with only a few exceptions, both patients and their therapists gave moderate to high ratings on CSTF factors and therapeutic alliance, at baseline and during treatment. Therapeutic factors showed a higher increase over time for patients than for therapists.

The proportion of patients achieving symptomatic remission in 9 weeks was in line with RCT findings and outcome studies on mood and anxiety disorders [18-20]; our drop-out rate was 12.7%, which denotes a higher degree of compliance with treatment than is typically observed in studies lasting 8-12 weeks.

Notably, of the CSTF factors, only therapist's communication style and focus on patient history were associated with functional improvement. Previous studies conducted in primary care settings [21 22] have provided similar evidence of the positive impact of communication style on outcomes.

Psychotherapists usually focus on their patients' life stories, not only on their pathology, and in fact, there is a general consensus on the psychotherapeutic value of the search for an autobiographical narrative dimension [23-25].

In a study comparing case review with usual care in depression outcomes, Berti Ceroni et al. [26] found that primary care physicians are more likely to remember their patients' history than their symptoms. No instrument was available at the time, however, to measure focus on patient history. To our knowledge, the present study is the first to find the positive impact of this factor on patient outcomes.

Similarly to communication style and focus on patient history, the influence of the supportive feedback/information factor increased over time during treatment, although it was not related to functional impairment or satisfaction with treatment. Providing patients with supportive feedback is an important part of a therapist's management

TABLE III.
Predictors of satisfaction with treatment (patient model). *Predittori di soddisfazione per il trattamento ricevuto (modello paziente)*.

	Unstandardized Coefficients		Standardized Coefficients	t	p
	b	SE(b)	Beta		
(Constant)	1.500	.426		3.522	.001
Drug treatment (yes/no)	-.289	.184	-.167	-1.571	.120
age	.015	.009	.187	1.760	.082
gender	.299	.176	.168	1.696	.093
WAI score	-.021	.009	-.244	-2.457	.016

skills, and can play an important role in calibrating mutual expectations for patient recovery.
A secondary finding to be confirmed in larger samples is that the predictors of functional impairment vary according to the diagnosis. Communication skills retain their prominent role as a factor associated with good outcome in mood disorders according to the patients' view, and in anxiety disorders according to the therapists' view. Therapist's recall of patient seems to be related specifically to functional improvement in mood disorders. This indicates that keeping a depressed patient in mind and recalling details of his/her life and relationships has a beneficial effect on outcome.
The relation between therapeutic alliance and clinical outcome has been confirmed across diverse types of treatment [27]. Clinical trials employing cognitive, interpersonal, behavioral, psychodynamic therapies and pharmacotherapy have demonstrated the robust nature of this finding [28 29]. In line with Fuertes et al.'s results [30], our study showed an association between therapeutic alliance and satisfaction with treatment.
Our results should be interpreted, however, in light of the following limitations: Therapeutic factor scores were on average very high, and this restricted range of variability might have limited our ability to find a relation between factors and outcomes. Although in our analyses we controlled for the effect of drug treatment, the impact of individual types of treatment could not be determined, because of the wide range of strategies adopted by the therapists participating in the study. Evidence from the literature, however, suggests that alliance predicts outcome beyond symptom changes during treatment [31]. Hence, CSTF factors and alliance might affect outcome even when treatment effects are partialled out. Future research is needed to determine the mediating effect of CSTF factors on treatment outcomes. Moreover, we did not assess treatment adequacy in terms of drug dosage or minimum number of therapy sessions. All therapists were established clinicians with at least 7 years of experience, participating in the study on a voluntary basis. We were therefore unable to examine the effect of clinical experience on the CSTF-outcome relation.
The follow-up was on average relatively short to observe an effect of psychotherapy.

Conclusions

Our results provide a helpful operationalization of the therapeutic factors, which identify in communication, focus on patient history and therapist's recall of patients the key aspects predicting clinical outcomes. Further research conducted with the participation of therapists presenting different levels of experience is warranted to elucidate whether (and if so, the extent to which) experience mediates the relation between CSTFs and treatment outcomes.
Future perspectives include the incorporation of recent findings in neurobiology and experimental psychology to refine these therapeutic factors. Understanding the mechanisms underlying clinical change, as Kazdin [32] emphasizes, is the path towards improved treatment.

Acknowledgements

This work was supported by a grant from Fondazione IDEA. The authors gratefully acknowledge the contribution of the psychiatrists and psychologists who collected the data and made this study possible (Antonella Alzani, Francesco Berti Ceroni, Lidia Borghi, Paolo Borghi, Caterina Bruschi, Patrizia Ciavarella, Roberto de Falco, Giovanni Giovannini, Marco Gorini, Maurizia Lenzi, Marco Monari, Danilo Pasotti, Nicola Rossi, Damiano Suzzi, Tiziana Toraldo, Simona Maria Veggetti).

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Common Specific Therapeutic Factors Questionnaire

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First visit - Patient version

Data:

In reference to the visit you have just had, say how true the following statements are for you. You may respond to each statement with one of the following choices:

1 = Not at all; 2 = A little; 3 = Moderately; 4 = Quite ; 5 = A lot; 6 = Very much

	During the visit I have just had:						
1	I felt at ease	1	2	3	4	5	6
2	I think that the therapist dedicated attention to me	1	2	3	4	5	6
3	The therapist asked me questions which helped me to express myself	1	2	3	4	5	6
4	The therapist gave me some useful information	1	2	3	4	5	6
5	I have been informed in detail about my illness	1	2	3	4	5	6
6	I have been informed about the treatment	1	2	3	4	5	6
7	I have taken stock of the situation together with the therapist	1	2	3	4	5	6
8	I did not conceal things that are important for me	1	2	3	4	5	6
9	I have spoken about my ailments	1	2	3	4	5	6
10	I have talked about questions regarding my personal life	1	2	3	4	5	6
11	I had positive feelings	1	2	3	4	5	6
12	On the whole I feel I have been helped to express myself	1	2	3	4	5	6
13	I would like to have some other meetings like this	1	2	3	4	5	6
14	I have spoken about the possibility of having other meetings with the therapist	1	2	3	4	5	6
15	I talked about the main events in my life	1	2	3	4	5	6
16	I talked about the problems or satisfactions that I get sometimes from people who are close to me	1	2	3	4	5	6
17	I talked about things that are important to me	1	2	3	4	5	6
18	I have spoken about the relationships I have with other people in general	1	2	3	4	5	6
19	I feel I managed to talk openly about moments in my life that I would not perhaps talk about with everybody	1	2	3	4	5	6
	My therapist:						
20	... showed interest in the events of my personal life	1	2	3	4	5	6
21	... encouraged me to talk about my illness	1	2	3	4	5	6
22	I think he/she wants to know me better, and find out about the things I do and my interests	1	2	3	4	5	6
23	I think he/she knows my personal history	1	2	3	4	5	6
24	... showed interest when I spoke about my feelings and my emotions	1	2	3	4	5	6
25	... showed interest in my ailments and illness	1	2	3	4	5	6
26	... asked me questions and explanations about certain events in my life	1	2	3	4	5	6
27	... encouraged me to speak about my life	1	2	3	4	5	6
28	… checked with me the course of my symptoms up to today	1	2	3	4	5	6
29	... informed me about the possible evolution of my disorder over the next few weeks	1	2	3	4	5	6
30	... made me understand that I will get better	1	2	3	4	5	6
31	... gave me the courage to go on	1	2	3	4	5	6
32	... described the possible side effects of the treatment	1	2	3	4	5	6
33	... reassured me that the treatment will not be harmful for me	1	2	3	4	5	6

34	... helped me to maintain reasonable expectations about the outcome of the treatment	1	2	3	4	5	6
35	I expect that I will get better with this treatment	1	2	3	4	5	6
36	I'm not afraid of possible side effects of the treatment	1	2	3	4	5	6
37	We had no interruptions during our session	1	2	3	4	5	6
38	Our meeting took place in a reserved and quiet atmosphere	1	2	3	4	5	6
39	We talked about the treatment programme	1	2	3	4	5	6
40	My therapist dedicates me enough time	1	2	3	4	5	6
41	He/she gave me enough time to express my thoughts and emotions	1	2	3	4	5	6
42	He/she gave me the possibility to contact him/her in between appointments if I feel the need	1	2	3	4	5	6
43	On the whole the meeting place and the time dedicated to me made me feel at ease	1	2	3	4	5	6