Early psychotherapeutic empathy, alliance, and client outcome: Preliminary evidence of indirect effects

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Abstract
The association between psychotherapeutic empathy and client outcome is well established, yet the mechanisms underlying this association remain poorly understood. We hypothesized that early experiences of empathy influence outcome through the working alliance. To test this hypothesis, we used archival data collected from 56 clients (mean [M] age = 19.5 years, 83.9% female, 76.8% White) who reported mild, moderate, or severe depressive symptoms at screening and pretreatment assessments and then received five sessions of evidence-based psychotherapy. Therapists (M age = 26.0 years, 50% female, 100% White) were six students in a clinical psychology PhD program. Results of bootstrap analyses were consistent with the idea that early experiences of empathy strengthen the alliance (specifically the goals and tasks facets), which in turn facilitates improvements in depressive symptoms and psychological well-being. While preliminary, these results implicate a specific pathway of change in the treatment of depression.

KEYWORDS
alliance, empathy, indirect effect, mechanism

1 | INTRODUCTION

Empathy is a complex, multifaceted process that operates in various forms of psychotherapy (Wampold & Imel, 2015). According to Rogers (1975), psychotherapeutic empathy entails (1) accurate attunement to the client’s frame of reference, in terms of both conceptual and emotional meanings, and (2) effective communication of that understanding to the client. Barrett-Lennard (1981) highlighted the client’s role in the empathic process by adding a third component to Rogers’ model: the client’s receipt and experience of the therapist’s communication. The client’s experience may be particularly important for treatment success, as there is evidence that client ratings of empathy may predict outcome (r = .32) better than therapist (r = 0.20) and observer (r = .25) ratings (Elliott, Bohart, Watson, & Greenberg, 2011).

Several hypotheses have emerged to explain the empathy–outcome link. Watson (2002) stated that empathy may "assist clients in deconstructing their world views so that they can become aware of the subjectivity of their J. Clin. Psychol. 2018;74:839–848. wileyonlinelibrary.com/journal/jclp © 2018 Wiley Periodicals, Inc. 839
perceptions” (p. 462). Greenberg, Watson, Elliott, and Bohart (2001) claimed that empathy might initiate a corrective emotional experience, wherein clients learn that they are worthy of attention, positive regard, and respect. It has also been suggested that empathy facilitates self-discovery (Rogers, 1975), emotional reprocessing (Greenberg & Paivio, 1997), positive outcome expectations (Angus & Kagan, 2007), and changes in attachment style (Watson, Steckley, & McMullen, 2014).

One aspect of therapy that may be integral to empathy’s effects is the collaborative, purposive relationship between client and therapist, known as the working alliance. According to Bordin (1979), the alliance consists of three facets: goals, tasks, and bond. Goals refers to client–therapist agreement on the aims of therapy (e.g., increased social engagement), tasks refers to client–therapist agreement on the strategies used to achieve therapy goals (e.g., behavioral activation), and bond refers to the emotional connection (e.g., trust, liking, acceptance) between client and therapist. Like empathy, alliance is regarded as a common factor across psychotherapy approaches (Wampold & Imel, 2015). In contrast to empathy, which can be conceptualized as a process occurring in a single session or in a single exchange (Duan & Hill, 1996), the alliance spans multiple sessions and provides the broader context for the work of therapy (Crits-Christoph, Connolly Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Horvath & Greenberg, 1989).

In the current research, we hypothesized that empathy facilitates the development of a strong alliance. This hypothesis is grounded in the vast literature on persuasion, particularly the technique of pacing and leading (e.g., see Wong, 2016). Pacing and leading is designed to obtain agreement from a conversational partner on an idea or suggestion. Pacing, which is the first step in this technique, involves mirroring the conversational partner’s preexisting point of view, for instance, by reflecting that an angry person is in fact angry. This demonstrates a shared point of view and, in doing so, can erode resistance and foster openness and receptivity in the conversational partner, increasing the likelihood that a leading statement will be accepted. The leading statement is an idea for which one is seeking agreement and may be a shift from the conversational partner’s point of view. For instance, after generating receptivity through mirroring the partner’s anger (i.e., pacing), one might lead by recommending a self-help book on anger management.

Applying these concepts to psychotherapy process, we can see that pacing is roughly akin to empathic communication; the client is likely to infer from an empathic communication that the therapist shares her point of view and will thus, according to persuasion theory, be more open, receptive, and suggestible. Accordingly, when the therapist provides a theoretical formulation of the client’s problems (e.g., dysphoria is due to irrational beliefs) and offers technical methods for alleviating these problems (e.g., evaluating and restructuring the irrational beliefs), the client might embrace these ideas to a greater extent, creating a stronger working alliance. Of note, we are not claiming that therapists intentionally use empathy to increase client agreement on therapeutic goals/tasks. Rather, our argument is that empathy merely has this effect.

To test the alliance as an intervening variable in the empathy–outcome association (i.e., an indirect effect), associations must first be established between the independent variable (empathy) and proposed intervening variable (alliance) as well as between the proposed intervening variable and the dependent variable (client improvement) (see Kazdin, 2007; Shroft & Bolger, 2002).¹ There is extensive documentation that empathy is correlated with the alliance (Nienhuis et al., 2016)—supporting the former condition—and that the alliance is correlated with client improvement (Horvath, Del Re, Flickiger, & Symonds, 2011)—supporting the latter condition.

Although these simple associations have been confirmed, little research has tested whether the alliance mediates the empathy–outcome link. Watson and Geller (2005) studied 66 clients receiving cognitive-behavioral or process-experiential therapy for depression and found that the alliance mediated the link between client-rated relationship conditions (includes empathy, unconditional positive regard, and congruence) and outcome. This supports the view that therapists who are empathic, accepting, and genuine may reach strong agreements with their clients on therapeutic goals and tasks, thereby increasing the likelihood of good outcomes. It should be noted that Watson and Geller (2005) did not assess for mediation with each individual relationship condition, and so definitive conclusions cannot be drawn from their results about how empathy exerts its effects on outcome.

Malin and Pos (2015) investigated the links between empathic communication (as rated by observers of first session), alliance quality (as reported by clients after first session), and depressive symptom reduction (as reported by clients) in short-term experiential therapy. Clients in this study were 30 depressed clients with relatively high or low
alliance scores who were drawn from a larger client pool (n = 74). Communicated empathy was found to have an indirect effect on depressive symptom reduction via the alliance. Although this study provides support for the empathy–alliance–outcome model, it is limited by small sample size, the exclusion of clients with typical alliances, and its focus on only one treatment approach. Further, Malin and Pos (2015) used alliance scores from a single session, which can yield an unreliable index of alliance quality (Crits-Christoph et al., 2011), and analyzed total alliance scores only, potentially obscuring the specific facet(s) of the alliance (i.e., goals, tasks, bond) that are most central to empathy's effects.

In the present research, we tested the hypothesis that empathy (reported by clients after first session) has an indirect effect on depressive symptoms and psychological well-being (reported by clients) via the alliance (client ratings averaged over sessions two through five). The present research builds on Malin and Pos's (2015) study by (1) using a larger sample, (2) including the full range of alliance scores, (3) studying an array of treatment approaches, (4) employing a dependable alliance index (i.e., aggregating alliance scores over four sessions; see Crits-Christoph et al., 2011), and (5) examining individual facets of the alliance.

In contrast to Malin and Pos's (2015) study, we utilized client ratings of empathy because we deemed the experience of empathy (Barrett-Lennard, 1981) to be more relevant in this context than therapist-rated attunement (Rogers, 1975) or observer-rated communication (Rogers, 1975). In particular, we surmised that the effect of attunement/communication might be contingent on the client's perception of that attunement/communication; if a client is unaware of an empathic communication, then we would expect that she would be no more receptive (Wong, 2016) to therapeutic goals/tasks. This notion that the effect of empathy is dependent on the client's awareness is supported by qualitative data (MacFarlane, Anderson, & McClintock, 2017) and evidence that client ratings of empathy are better predictors of outcome than therapist or observer ratings (Bohart, Elliott, Greenberg, & Watson, 2002; Elliott et al., 2011).

2 METHOD

The present study used archival data from a recently conducted randomized clinical trial (see McClintock, Perlman, McCarrick, Anderson, & Himawan, 2017).

1.1 Archival study design

McClintock et al. (2017) investigated the effects of a common factors feedback (CFF) system on treatment process and outcome. The CFF system was designed to provide ongoing feedback to clients and therapists about client ratings of three common factors: (1) outcome expectations, (2) empathy, and (3) alliance. Clients were undergraduate students who reported mild, moderate, or severe depressive symptoms on the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) at a screening assessment and a subsequent pretreatment assessment. Clients were randomized to either treatment-as-usual (TAU) or TAU plus the CFF system (TAU + CFF). Both conditions entailed five, weekly sessions of evidence-based therapy. Therapists had freedom to select evidence-based approaches (e.g., cognitive-behavioral, emotion-focused, mindfulness/acceptance-based, client-centered, interpersonal; see McClintock et al., 2017) based on their theoretical orientation, case conceptualization, and supervisor input. Clients completed process and outcome measures (see Measures) at each session, and client and therapists in TAU + CFF received feedback on client ratings of outcome expectations, empathy, and alliance at the beginning of sessions two through five. McClintock et al. (2016) found treatment condition effects on empathy and alliance ratings. Treatment effects were thus controlled for in the present analyses.

2.2 Participants

2.2.1 Clients

Clients in this study were 56 undergraduates (mean [M] age = 19.5, standard deviation [SD] = 2.5; 83.9% female) who completed TAU (n = 32) or TAU + CFF (n = 24). About 76.8% identified as White/Caucasian, 7.1% as Black or African
American, 5.4% as multiracial, 3.6% as American Indian or Alaska Native, 3.6% as Hispanic or Latino/Latina, 1.8% as Asian or Asian American, and 1.8% as Middle Eastern. Clients reported a mean BDI-II score at pretreatment (24.3; SD = 8.4) that fell in the moderate depression range (see Beck et al., 1996).

2.2.2 | Therapists
Therapists in this study were six students in a clinical psychology PhD program (M age = 26.0 years; SD = 2.2). All had completed graduate-level assessment and treatment courses and were involved in practicum/traineeship associated with the training program. Therapists had a mean of 313.2 face-to-face clinical hours (SD = 261.3) by the start of the study. Three therapists were male, three were female, and all identified as White/Caucasian. With regard to theoretical orientation, three therapists identified as cognitive-behavioral, two identified as integrative/eclectic, and one identified as humanistic.

2.3 | Measures

2.3.1 | Barrett–Lennard Relationship Inventory-Empathy subscale
The Barrett–Lennard Relationship Inventory-Empathy (BLRI-E; Barrett-Lennard, 2015) is a frequently used client-rated measure of empathy (Elliott et al., 2011). It consists of 16 items (example item: “My counselor usually senses or realizes what I am feeling.”) that are rated on a 6-point scale ranging from (–3) “No, I strongly feel that it is not true” to (3) “Yes, I strongly feel that it is true.” A total BLRI-E score is derived by taking the mean of all items (after reverse-scoring six items). Past research has established the internal consistency, test-retest reliability, convergent/divergent validity, and predictive validity of the BLRI-E (see Barrett-Lennard, 2015). The BLRI-E had acceptable internal consistency in the current study (Cronbach 𝛼 = 0.73 after Session 1).

2.3.2 | Working Alliance Inventory-Short Form Revised
The Working Alliance Inventory-Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006) is a widely used 12-item measure of the working alliance. Each item (example item: “I feel that the things I do in therapy will help me to accomplish the changes that I want.”) is rated on a 5-point scale ranging from “1 – seldom” to “5 – always.” The WAI-SR has three subscales: Goals (i.e., agreement on goals of therapy), Tasks (i.e., agreement on tasks of therapy), and Bond (i.e., the emotional connection between client and therapist). This measure has excellent reliability, convergent validity, and predictive validity (Hatcher & Gillaspy, 2006; McClintock, Anderson, & Petrarca, 2015). Subscale and total scores were calculated by summing the relevant items. The WAI-SR and its subscales demonstrated acceptable levels of internal consistency (all Cronbach 𝛼s > 0.70 over Sessions 2–5).

2.3.3 | Beck Depression Inventory-II
The BDI-II (Beck et al., 1996) is the most widely used measure of depressive symptoms. This measure features 21 items describing depressive symptoms. Respondents rate the presence of each symptom on a 4-point scale. An example item is “Sadness” with response options (0) “I do not feel sad,” (1) “I feel sad much of the time,” (2) “I am sad all of the time,” and (3) “I am so sad or unhappy that I can’t stand it.” BDI-II total scores (sum of all items) can be categorized in the following ranges: minimal (0–13), mild (14–19), moderate (20–28), and severe (29–63) depressive symptoms. The BDI-II has sound psychometric properties in both clinical and nonclinical samples (Beck et al., 1996). The BDI-II exhibited good internal consistency in the current study (Cronbach 𝛼 = 0.84 at pretreatment).

2.3.4 | Schwartz Outcome Scale-10
The Schwartz Outcome Scale-10 (SOS-10; Blais et al., 1999) is a 10-item self-report measure of psychological well-being. The SOS-10 was developed using classical test theory and Rasch item analysis and has been employed extensively to assess the effectiveness of mental health treatments. Each item features a 7-point scale ranging from “0 – never” to “6 – nearly all of the time.” Sample items include “I have confidence in my ability to sustain important
relationships" and "I am generally satisfied with my psychological health." The SOS-10 is scored by summing the 10 items (higher scores indicate better well-being). This measure has demonstrated good internal consistency, test-retest reliability, and convergent/discriminant validity (Haggerty, Blake, Naraine, Siefert, & Blais, 2010; Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003). The SOS-10 exhibited high internal consistency in the present research (Cronbach $\alpha = 0.84$ at pretreatment).

### 2.4 Procedures and statistical analyses

Client BLRI-E scores from Session 1 were used as an index of early psychotherapeutic empathy (hereafter referred to as BLRI-E First). To obtain a dependable index of alliance quality (Crits-Christoph et al., 2011), we averaged client WAI-SR scores over sessions two through five (hereafter referred to as WAI-SR-Total Avg, WAI-SR-Goals Avg, WAI-SR-Tasks Avg, WAI-SR-Bond Avg). Residualized change scores were calculated for the client-rated outcomes by regressing posttreatment scores on pretreatment scores (hereafter referred to as SOS-10 Change and BDI-II Change).

Two preconditions need to be met prior to testing for indirect effects (e.g., see Sholdt & Bolger, 2002): (1) the independent variable (BLRI-E First) must be related to the proposed intervening variable (WAI-SR-Total Avg) and (2) the proposed intervening variable must be related to the dependent variable (SOS-10 Change or BDI-II Change). These relationships were assessed with bivariate correlations.

The indirect effect was tested with Hayes’s (2013) PROCESS Macro. This macro generates bias-corrected bootstrap confidence intervals (CIs) for testing the statistical significance of the indirect effect. The 95% CI for the estimate of the indirect effect was obtained with 5,000 bootstrap resamples. If the CI does not include zero, it can be concluded that the indirect effect is statistically significant at the 0.05 level. The bias-corrected bootstrap method is considered the gold standard for testing an indirect effect because it has lower Type I error rates and more power than other methods (e.g., Baron and Kenny method) and does not require that variables be normally distributed (MacKinnon, Lockwood, & Williams, 2004; Sholdt & Bolger, 2002). Efron and Tibshirani (1993) found this method to be appropriate for samples as small as 20. BLRI-E First was entered as the independent variable, WAI-SR-Total Avg was entered as the proposed intervening variable, an outcome variable (SOS-10 Change or BDI-II Change) was entered as the dependent variable, and treatment condition (TAU vs. TAU + CFF) was entered as a covariate. Analyses yielding significant indirect effects were rerun without the covariate to calculate $R^2_{med}$, an index of the size of an indirect effect (see Fairchild, MacKinnon, Taborga, & Taylor, 2009, Hayes, 2013). Because of concerns about alpha inflation, we did not test indirect effects with the WAI-SR subscales (i.e., Goals, Tasks, Bond) unless the total WAI-SR index yielded significant effects.

### 2.5 Results

WAI-SR scores at Sessions 2–5 and SOS-10 and BDI-II scores at pretreatment and posttreatment are presented in Table 1. Descriptive statistics and correlations for BLRI-E First, WAI-SR Avg, SOS-10 Change, and BDI-II Change are presented in Table 2. Regarding the first precondition for testing the indirect effect, BLRI-E First was significantly correlated with WAI-SR-Total Avg, WAI-SR-Goals Avg, and WAI-SR-Tasks Avg, but not WAI-SR-Bond Avg. Regarding the second precondition, WAI-SR-Total Avg, WAI-SR-Goals Avg, and WAI-SR-Tasks Avg were significantly correlated with both SOS-10 Change and BDI-II Change, whereas WAI-SR-Bond Avg was significantly correlated with SOS-10 Change only. Because WAI-SR-Bond Avg failed to satisfy the necessary preconditions, it was excluded from indirect effect analyses.

### 2.6 Bootstrap analyses were first conducted with WAI-SR-Total Avg as the intervening variable

The indirect effect of BLRI-E First on SOS-10 Change through WAI-SR-Total Avg was statistically significant ($B = 0.344$, 95% CI = 0.113 to 0.690, $R^2_{med} = 0.122$). The positive sign of this effect indicates that empathy’s influence on psychological well-being via the alliance was to improve well-being, as would be expected. The $R^2_{med}$ index suggests that the
### Table 1
Means (standard deviations) for alliance and outcome variables, N = 56

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WAI-SR-Total</strong></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>46.82 (7.92)</td>
</tr>
<tr>
<td>Session 3</td>
<td>49.51 (7.42)</td>
</tr>
<tr>
<td>Session 4</td>
<td>51.63 (7.29)</td>
</tr>
<tr>
<td>Session 5</td>
<td>52.62 (7.52)</td>
</tr>
<tr>
<td><strong>WAI-SR-Goals</strong></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>15.61 (2.97)</td>
</tr>
<tr>
<td>Session 3</td>
<td>16.47 (2.73)</td>
</tr>
<tr>
<td>Session 4</td>
<td>17.21 (2.47)</td>
</tr>
<tr>
<td>Session 5</td>
<td>17.59 (2.86)</td>
</tr>
<tr>
<td><strong>WAI-SR-Tasks</strong></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>15.36 (2.90)</td>
</tr>
<tr>
<td>Session 3</td>
<td>16.44 (2.72)</td>
</tr>
<tr>
<td>Session 4</td>
<td>16.91 (2.93)</td>
</tr>
<tr>
<td>Session 5</td>
<td>17.14 (3.18)</td>
</tr>
<tr>
<td><strong>WAI-SR-Bond</strong></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>15.86 (3.53)</td>
</tr>
<tr>
<td>Session 3</td>
<td>16.60 (3.51)</td>
</tr>
<tr>
<td>Session 4</td>
<td>17.50 (2.87)</td>
</tr>
<tr>
<td>Session 5</td>
<td>17.98 (2.35)</td>
</tr>
<tr>
<td><strong>SOS-10 Pre</strong></td>
<td>30.50 (8.61)</td>
</tr>
<tr>
<td><strong>SOS-10 Post</strong></td>
<td>41.32 (10.77)</td>
</tr>
<tr>
<td><strong>BDI-II Pre</strong></td>
<td>24.18 (8.45)</td>
</tr>
<tr>
<td><strong>BDI-II Post</strong></td>
<td>13.02 (9.98)</td>
</tr>
</tbody>
</table>

Note. WAI-SR = Working Alliance Inventory-Short Form Revised; SOS-10 = Schwartz Outcome Scale-10; BDI-II = Beck Depression Inventory-II; Pre = pretreatment; Post = posttreatment

### Table 2
Means (standard deviations) and correlations for study variables, N = 56

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
<th>BLRI-E First</th>
<th>WAI-SR-Total Avg</th>
<th>WAI-SR-Goals Avg</th>
<th>WAI-SR-Tasks Avg</th>
<th>WAI-SR-Bond Avg</th>
<th>SOS-10 Change</th>
<th>BDI-II Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLRI-E First</strong></td>
<td>1.59 (0.49)</td>
<td>—</td>
<td>0.32*</td>
<td>0.33*</td>
<td>0.27*</td>
<td>0.25</td>
<td>0.43*</td>
<td>−0.18</td>
</tr>
<tr>
<td><strong>WAI-SR-Total Avg</strong></td>
<td>50.16 (6.93)</td>
<td>—</td>
<td>0.93*</td>
<td>0.92*</td>
<td>0.81*</td>
<td>0.57*</td>
<td>−0.40*</td>
<td>−0.045*</td>
</tr>
<tr>
<td><strong>WAI-SR-Goals Avg</strong></td>
<td>16.75 (2.50)</td>
<td>—</td>
<td>0.89*</td>
<td>0.59*</td>
<td>0.56*</td>
<td>0.61*</td>
<td>−0.48*</td>
<td>−0.13*</td>
</tr>
<tr>
<td><strong>WAI-SR-Tasks Avg</strong></td>
<td>16.46 (2.65)</td>
<td>—</td>
<td>0.56*</td>
<td>0.61*</td>
<td>0.57*</td>
<td>0.61*</td>
<td>−0.48*</td>
<td>−0.045*</td>
</tr>
<tr>
<td><strong>WAI-SR-Bond Avg</strong></td>
<td>17.00 (2.64)</td>
<td>—</td>
<td>0.30*</td>
<td>−0.78*</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td><strong>SOS-10 Change</strong></td>
<td>—</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td><strong>BDI-II Change</strong></td>
<td>—</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
</tbody>
</table>

Note. BLRI-E First = Barrett-Lennard Relationship Inventory-Empathy Scale, first session ratings; WAI-SR Avg = Working Alliance Inventory-Short Form Revised, ratings averaged over sessions two through five; SOS-10 Change = Schwartz Outcome Scale-10, posttreatment ratings after partialling out first session ratings; BDI-II Change = Beck Depression Inventory-II, posttreatment ratings after partialling out first session ratings.

*p < .05
empathy-alliance indirect effect accounted for about 12% of the variability in well-being improvements. Regarding the second outcome variable, we found that the indirect effect of BLRI-E First on BDI-II Change through WAI-SR-Total Avg was statistically significant ($B = -0.251$, 95% CI = $-0.632$ to $-0.064$, $R^2_{med} = 0.037$). The negative sign of this effect indicates that empathy’s influence on depressive symptoms via the alliance was to reduce symptoms, as would be expected.

Given the significant effects with the total WAI-SR index, we followed with analyses of the relevant WAI-SR subscales; indirect effects of BLRI-E First through WAI-SR-Goals Avg were statistically significant with SOS-10 Change ($B = 0.333$, 95% CI = 0.123–0.670, $R^2_{med} = 0.122$) and BDI-II Change ($B = -0.290$, 95% CI = $-0.680$ to $-0.093$, $R^2_{med} = 0.039$), and indirect effects of BLRI-E First through WAI-SR-Tasks Avg were statistically significant with SOS-10 Change ($B = 0.302$, 95% CI = 0.054–0.685, $R^2_{med} = 0.111$) and BDI-II Change ($B = -0.256$, 95% CI = $-0.681$ to $-0.051$, $R^2_{med} = 0.037$).

3 | DISCUSSION

Study results were consistent with the hypothesis that early experiences of psychotherapeutic empathy serve to strengthen the alliance between client and therapist, which in turn facilitates improvements in the client’s symptoms and well-being. Specifically, the indirect effect of early empathy via the alliance accounted for about 4% of the variance in depressive symptom relief and 12% of the variance in well-being improvements. Because empathy accounts for, on average, about 9% of outcome variance (Elliott et al., 2011), it stands to reason that the alliance may be a key mechanism through which empathy operates.

When evaluating the facets of the alliance, we found that early empathy experiences were significantly associated with goals and tasks (but not bond). Large correlations have been reported between goals and tasks (e.g., Patterson, Uhlin, & Anderson, 2008), and some factor analyses have shown that goals and tasks items load on the same factor (e.g., Andrusyna, Tang, DeRubeis, & Luborsky, 2001; Falkenström, Hatcher, & Holmqvist, 2015), which has been labeled agreement (Webb et al., 2011). This potential link between empathy and agreement lends credence to the idea that empathy has pacing-like effects (see Wong, 2016). That is, the client—upon feeling understood by the therapist—might be more suggestible and inclined to agree with the provided goals/tasks. Although this interpretation is grounded in extant literature (e.g., MacFarlane, Anderson, & McClintock, 2015, 2017; Wong, 2016), it remains speculative and requires further scrutiny. Microanalytic sequential process research (see Elliott, 2010) and qualitative research that probes the client’s experience (e.g., MacFarlane et al., 2015, 2017) could help to illuminate the potential links between empathy, suggestibility, and agreement on goals/tasks.

Goals and tasks also yielded significant indirect effects; early empathy experiences had indirect effects on depressive symptoms and well-being through agreement on goals/tasks. In other words, agreement may be the specific component of the alliance that transmits the effects of early empathy experiences on outcome. Analysis of the importance of agreement relative to bond in therapeutic process and outcome should be a high priority of future research (see Webb et al., 2011).

Four limitations of the current research are worth highlighting. First, White females were disproportionately represented in our sample, and so caution should be taken when applying these findings to males and non-Whites. Second, our study was not powered for testing therapist effects. In light of the known therapist effects on process and outcome variables (Wampold & Imel, 2015), attempts should be made to replicate our indirect effects using multilevel models. Third, because we relied on passive observation, it would be premature to conclude that empathy, alliance, and outcome are causally related (see Kazdin, 2007). For example, the observed association between empathy and alliance could have been due to a third variable, like congruence (see Elliott et al., 2011). Passive observation also raises concerns about reverse causation. It is unclear, for instance, whether the alliance leads to—or is a by-product of—client improvement (for a recent review, see Zilcha-Mano, 2017). It may be that empathy, alliance, and client change influence each other, and thus our static measurement of these constructs (e.g., empathy scores from Session 1, alliance scores from Sessions 2–5) obscures the complex, multidirectional nature of the effects. Fourth, given that all
data were collected with client-rated instruments, shared method variance may have influenced study results. It is worth noting that we deliberately used client ratings of empathy so as to capture the client’s experience of empathy. The question of whether the effect emerges for therapist ratings, which might reflect empathic attunement (Rogers, 1975), or observer ratings, which might reflect empathic communication (Rogers, 1975), awaits future research (Duan & Hill, 1996; Elliott et al., 2011; Greenberg et al., 2001).

Strengths of this investigation include the study of multiple treatment approaches, the use of a dependable alliance index (i.e., aggregating alliance scores over four sessions; Crits-Christoph et al., 2011), and the staggering of empathy and alliance ratings to establish a timeline of change (Kazdin, 2007). A strength of our indirect effects model is that empathy and alliance operate in virtually all treatments and with virtually all clients (Wampold & Imel, 2015). We now have direct evidence for this model in short-term experiential psychotherapies for depression (Malin & Pos, 2015) and brief evidence-based psychotherapies for depression (present study), as well as indirect evidence in cognitive-behavioral and process-experiential therapies for depression (Watson & Geller, 2005). We can speculate from these findings that the empathy–alliance pathway might be a pantheoretical mechanism of change (see Barlow, Bullis, Comer, & Ametaj, 2013). Future research should attempt to replicate the observed effects in different settings, with different treatment modalities, with different client populations, and with empathy and alliance ratings collected at different time points in therapy. Research could also explore if the magnitude of the indirect effect is larger in some treatments and with some populations than others (see moderated mediation; Preacher, Rucker, & Hayes, 2007).

At present, there is little consensus about why psychotherapy works or how it produces change (Kazdin, 2007; Silberschatz, 2017). The findings generated in the current study support a common factors perspective of psychotherapy (Laska, Gurman, & Wampold, 2014; Wampold & Imel, 2015) and underscore the specific importance of early empathy experiences. Based on these results, we would recommend that therapists strive, early in treatment, to understand the client’s experience and communicate that understanding to the client. Upon feeling understood, the client might be more amenable to the theoretical formulation and enthusiastic about the treatment techniques, creating the conditions for a strong purposive relationship. In addition, our data suggest that, like other common factors (e.g., treatment/outcome expectations; see Constantino, Ametrano, & Greenberg, 2012; McClintock et al., 2015), early experiences of empathy may be therapeutic in part because they strengthen the working alliance. From this, we can speculate that the various ‘common factors’ may operate through common mechanisms. We hope the present results will spur efforts to refine common factors theory and to distill the predictors of outcome into a more parsimonious model of change mechanisms.

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NOTE
1 Baron and Kenny (1986) called for a third precondition for testing mediation: a demonstrated relationship between the independent variable and the dependent variable. This precondition is unnecessary, however, for testing indirect effects (Shrout & Bolger, 2002; MacKinnon, Krull, & Lockwood, 2000; MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002).

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