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Chapter 19
How to Make Practical Use of Therapeutic Alliance Research in Your Clinical Work

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Keywords Patient Characteristics • Psychological Assessment • Rupture • Technique • Therapeutic alliance • Therapist Characteristics

One primary purpose for psychotherapy research is linking empirically based findings to applied treatment interventions. This use of research can potentially define optimal strategies and techniques that can help guide psychotherapy practice in the field. While caution is warranted considering the varied methodological attributes and findings across different studies, clinicians may be informed by the preponderance of extant data. Extensive prior research has consistently found a significant relationship between therapeutic alliance with therapy process and outcome [1–4]. Moreover, alliance has been found to be one of the most robust predictors of positive psychotherapy outcome regardless of the type of therapy utilized or whether assessed by therapist, client, or independent observer [1]. Thus, alliance research has the potential to significantly inform the treatment approach for a wide range of practicing therapists. With this in mind, the aim of this chapter is to review and summarize the contemporary research on the relationship between specific therapist attributes and interventions on the therapeutic alliance. The synthesized research is inclusive and incorporates varied models of psychotherapy, including humanistic, experiential, cognitive-behavioral, supportive–expressive, interpersonal, motivation-enhancing, relational, and other prevalent psychotherapy orientations. We will first summarize techniques that have been found to significantly enhance the alliance during specific, initial phases of psychotherapy and then move to therapist activities and characteristics that have been found to positively or negatively affect the alliance across treatment. Finally, we will discuss how these therapist activities and characteristics related to alliance may be related to both the initiation and resolution of treatment ruptures.

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Pre-Therapy Assessment

Emerging research suggests that psychological assessment procedures, when conducted with personalized, collaborative, and involved test feedback, have positive and clinically meaningful effects on both therapeutic alliance as well as treatment outcome [5–9]. One model that seeks to integrate aspects of patient–clinician interactions, more commonly found in the course of psychotherapy into the assessment phase of treatment, is a Therapeutic Model of Assessment (TMA [10–13]). This process incorporates a number of specific therapist activities and strategies that have demonstrated promise in fostering positive working alliances. Specifically, in a TMA, "the assessors are committed to:

(a) Developing and maintaining empathic connections with clients.
(b) Working collaboratively with clients to define individualized assessment goals (e.g., 'What's most important to you right now?', 'At the end of therapy what would you most like to be different or have changed?', 'How will you know at the end of our work together if treatment has been effective?').
(c) Sharing and exploring assessment results with clients" ([10, p. 378]; [11]).

By expanding the focus of assessment, both patient and clinician gain knowledge about treatment issues that, in turn, provide the opportunity for a more involved, empathic interaction and collaboration during the assessment phase of treatment (e.g., "We've covered a lot of ground today and I've asked a lot of questions, but is there something that we haven't touched on yet that you think is vitally important to knowing you as a person?").

Alliance developed during an assessment phase utilizing a TMA has been found to be superior to traditional information gathering (IG) models of assessment [13–15]. A number of specific interventions and techniques are highlighted in the TMA approach, such as the development of a Core Conflictual Relational Theme (CCRT [16–18]). The CCRT is a statement of the patient's wish (W), an expected, imagined, or actual response from another (RO), and a subsequent response from the self (RS). The RS includes both the actions/behaviors and the feelings/affect associated with this response. One practical example of a CCRT interpretation developed in the session process with a depressed patient was: "In that moment you described wanting a deeper connection and more support from your mother, but instead experienced her as rejecting and neglectful toward you. This led you to withdraw from her, feeling sad, hopeless that she will ever be concerned about your needs and also…even 'a little angry' (emphasis on the patient's words)." An initial CCRT interpretation is given during the assessment feedback session, and the exploration of these relational themes helps the clinician focus on collaboration and alliance building. A TMA also guides a clinician to discuss factors that contribute to the clinician–patient interaction throughout the assessment process (e.g., "You know we've talked a lot about the issue of ____ today, and I wonder how that might play out in here between the two of us?"). An additional TMA strategy is that "clients should first be given feedback that closely matches their own preconceptions and then be presented with information that is progressively more discrepant from their self-concepts" ([10, p. 380]; [11]).

Another specific TMA intervention that promotes a great deal of exploration and collaboration between patient and clinician is the utilization of a Socialization Interview (SI [17]) on what to expect in psychodynamic psychotherapy. The SI outlines the patient's and clinician's role during formal treatment while enhancing the patient's understanding of psychotherapy as well as the relational focus of the therapeutic process. Related to a more structured and collaborative feedback process, Yeomans et al. [19] examined factors related to premature treatment termination of borderline patients and found that both therapeutic alliance and the development of a treatment contract to be significantly related to length of treatment. The specific findings of Yeomans et al. ([19]; also see [8, 12]) are particularly relevant to the current review and consistent with an explicit, collaborative discussion of treatment goals, expectations, and structure in the TMA and SI.

While possessing the distinctive features of a traditional assessment process, a TMA also integrates therapeutic elements such as responding to acute stressors that may have developed since the last meeting (e.g., "Last time we spoke about several things that seemed rather intense and I wonder if any of those thoughts or feelings have come up for you since then?"), clarifying sources of distress and cyclical relational themes (e.g., "When is the first time you remember feeling that way?", "The last time?", "When has it been the hardest", "When has it been the most bearable?"), allowing the patient to initiate the discussion of salient issues (e.g., "What is most meaningful about that for you?"), facilitating client affect and experience (e.g., "Can you describe how you feel right now?", "Where do you experience that most in your body?"), exploring uncomfortable feelings (e.g., "What's it like,…how do you feel, to hear yourself say that?"), as well as in-session process and affect (e.g., "What's it like share this out loud, in here with me?").

The TMA approach as a whole has been shown to foster positive alliances in a number of studies (as well as demonstrate superiority to traditional IG models in this regard). In addition, certain techniques and interventions inherent within it have also been supported in alternate contemporary psychotherapy studies on early psychotherapy process. Specifically, adopting a collaborative stance toward the patient [20, 21], such as by exploring the clients perspective of their disorder and developing individual treatment goals and tasks [13, 14, 21] in an interactive rather than one-sided manner [20] in order to foster more involved, depth-oriented interviews [13, 14, 20], has been shown to improve early alliances. Interventions such as clarifying sources of distress and maintaining an active focus on treatment related topics [22] have also demonstrated their utility in fostering positive early working relationships. In addition, providing the client with new understanding and insight [22], exploring in-vivo process and affect by adaptively exploring in-session experiences [21, 22], and offering psychoeducation on symptoms and the treatment process [6, 21] have also shown potential in significantly improving nascent therapeutic relationships.

The findings just summarized underscore that it is "never too early" for clinicians to attempt to adopt these attitudes and interventions [13, 14, 22]. A unique and important feature of an assessment phase is that it has the potential to allow clinician and client to review and explore the meaning of assessment results *together.* Not only does this deepen a clients understanding of him/herself, it is also found to promote a collaborative, empowering, and empathic connection. These findings combine to suggest that alliance-fostering techniques during assessment closely resemble the actual process of psychotherapy, and this more relational therapeutic stance does appear to be superior to traditional IG approaches to assessment, at least with regard to therapeutic alliance. The therapist's ability to form a relationship with the patient during this stage may enhance the patient's perception of being understood and aid in feeling more connected to the treatment process. A greater feeling of connection to the treatment process may also provide even more opportunity for patient improvement throughout psychotherapy. Accordingly, empirical findings also strongly suggest that the effects of patient and therapist-rated alliance developed during a pre-therapy assessment persist across the course of treatment [13, 22].

Initial Interviews and Alliance

Prior to the initiation of formal psychotherapy, a client may be involved in the treatment process via single session pre-treatment intakes, motivation enhancing meetings, screening interviews, or multi-session consultations. There is some empirical evidence that certain clinician attitudes and behaviors shown during a pre-therapy consultation or interview can be beneficial in promoting positive ensuing client–clinician therapeutic connections. Significant relationships have been found between pre-therapy alliance and therapist activities that convey warmth, respect, and potency [23]. Interventions such as adopting a collaborative stance toward the client [13–15, 24], actively exploring issues [23, 24],

using clear, concrete, experience-near language [24], providing the client with new understanding and insight [23], and collaboratively developing individual treatment goals and tasks [24] have been shown to also increase alliance levels between clinician and client during this initial phase of clinical contact. These clinician attributes and activities conducted during pre-treatment sessions as a precursor to Cognitive-Behavioral Therapy (CBT) have demonstrated positive treatment effects. Specifically, a Motivational Interviewing pre-treatment (MIPT), incorporating attitudes and behaviors that promote collaboration, empathy, respect, support of self-efficacy, providing new understanding (developing discrepancies between patient problems and values), reflectively supporting patient statements that favor change, and "rolling with resistance" has been shown to significantly improve subsequent treatment engagement, homework compliance, as well as more action-oriented therapies [25–29]. This increased engagement in subsequent CBT following a MIPT has been demonstrated in studies that investigate clinician [25–29] as well as patient perspectives [27]. In addition, a recent study by Crits-Cristoph et al. [30] provides additional evidence that motivation-enhancing pre-treatment interventions can have a significant impact on alliance levels for patients with substance abuse and dependence diagnoses. Specifically, this study compared the alliance fostering potential of three sessions of motivation enhancing therapy (MET) with counseling as usual (CAU) for patients subsequently entering formal group psychotherapy. The findings were that for both MET and CAU randomized groups, increased use of MET fundamental techniques (fostering collaboration, positive affirmations, use of open-ended questions, use of reflective statements, and general motivational interviewing style) and MET advanced techniques (problem discussion and feedback, exploring pros/cons/ambivalence, heightening discrepancies, enhancing motivation for change, and discussing a plan for change) during treatment sessions were associated with higher levels of alliance. These clinician activities and attitudes are quite similar to the findings presented earlier regarding psychological assessment and again highlight the benefit of a respectful, supportive, active, and collaborative pre-treatment process.

First Session and Alliance

Considering initial alliance development, it is thought that the first few psychotherapy sessions are quite important. Much of contemporary psychotherapy research has focused on the third session, but the initial psychotherapy session can also be considered critical in the development of positive alliances [1, 31, 32]. Considering the current focus of this chapter, what specific interventions can a clinician engage in during the first psychotherapy session to improve alliance levels?

Keeping in mind that approximately 40–50% of patients terminate therapy prematurely [33–35], psychotherapy process in initial sessions is an important area for clinicians to consider. The extant research indicates that a therapists' application of techniques that convey trust, appreciation [36], warmth [36, 37], and understanding [38] will likely increase opportunities to improve alliance levels in an initial session. In addition, specific interventions leading to higher alliances and patient continuation in psychotherapy include speaking with emotional as well as cognitive content [37], attending to the patient's unique experience [39, 40], fostering patient motivation for change [39], maintaining an active focus on treatment-related topics [37], exploring in-session process and affect in a nondefensive and nonjudgmental manner [36], presenting the treatment model [40], and identifying new clinical issues to foster deeper levels of understanding and insight [38].

Tryon in particular has conducted a number of studies specifically investigating client engagement in an initial psychotherapy session [38, 41, 42]. The major findings for this series of studies were that therapists who are more empathic and understanding have impactful (depth oriented, special, powerful) and longer first sessions that were significantly more likely to successfully engage their clients for a second session. She also found that fostering depth, new understanding, and insight

in patients were also conducive for positive client–clinician relationships. The beneficial effects of longer interviews may be partly due to the fact that longer sessions presumably have more verbal content and offer more opportunities to deepen the therapeutic relationship and the client's understanding of themselves. Therapist-rated depth of early sessions was again found to be positively correlated with therapeutic alliance [43, 44] as measured by the Working Alliance Inventory (WAI [45]. Mallinckrodt [43] also found both patient-rated depth and smoothness of first sessions to be positively correlated with the WAI during the early phase of treatment.

Summary of Clinician Activities and Characteristics Related to Alliance During Early Phases of Psychotherapy

The therapeutic alliance has been found to form relatively early in psychological treatment and is predictive of later positive psychotherapy outcomes [1, 2, 4, 31, 46, 47]. This underscores the importance of psychotherapists' active attempts to foster positive working relationships as early as possible in treatment. The studies included thus far suggest that certain therapist's attitudes and therapeutic techniques, not tied to any particular psychotherapy orientation, have been found to positively influence the development and maintenance of an initial, positive working alliance. Table 19.1 summarizes these findings in a convenient format.

Specific therapist interventions that have been found to improve initial alliances can be summarized within three major categories. These categories are Treatment Frame, Session Focus, and Feedback. In addition, we would offer the interventions in Table 19.1 as a practical outline for clinicians to organize a psychological assessment or intake interview. Within the treatment frame, it is important to conduct longer, more involved, depth-oriented interviews; to adopt a collaborative stance toward the patient, speak with emotional and cognitive content, utilize open-ended and reflective queries; and to use clear, concrete, experience-near language in order to offer clinicians an initial therapeutic structure with significant alliance-fostering potential. An example of a collaborative,

Table 19.1 Summary of clinician activities found to be significantly related to positive therapeutic alliance during the initial interview and psychological assessment

Frame
Conduct longer, more involved, depth-oriented interviews
Adopt a collaborative stance toward client
Speak with emotional and cognitive content
Use clear, concrete, experience-near language
Utilize open-ended and reflective queries
Focus
Allow client to initiate discussion of salient issues
Actively explore these issues
Clarify sources of distress or discrepancy
Identify cyclical relational themes
Facilitate client affect and experience
Explore uncomfortable feelings
Explore in-session process and affect
Maintain active focus on these related topics
Feedback
Review and explore meaning of assessment results
Provide client new understanding and insight
Offer psychoeducation on symptoms and treatment process
Collaboratively develop individual treatment goals and tasks
Foster motivation for change

involved, and emotionally forthcoming early clinical interaction utilizing experience-near language is as follows:

Therapist: Take your time…I'd really like to get a feel for what your biggest struggles are. You know, it's normal for people to be a little nervous the first time they speak to someone new about such personal issues.
Patient: Nervous?…I'm not nervous…why would you say that? Maybe you're nervous?
Therapist: Well, you're right, that is part of what I'm feeling. When I meet people for the first time I usually do feel some nervousness about how things will go, and also an interested excitement about getting to know them better and the kind of work we might do together. So you might have picked up on that, what do you think? Do you feel some overall nervous energy in here?
Patient: Yeah, that's what I said. Maybe I'm a tiny bit nervous, but as you said, that makes sense right?
Therapist: Sure, sure it does (moving to attempts at fostering depth). And I'm curious, from what you've told me, it seems that you might feel more nervous when you get the impression people are boxing you in or judging you?

The treatment focus interventions are the most numerous and include directions for psychotherapy attention and discourse that have been found to increase alliance levels. Focus interventions include allowing the client to initiate the discussion of salient issues, focusing on discrepancies in clients value systems, clarifying sources of distress and discrepancy, highlighting cyclical relational themes, exploring uncomfortable feelings, facilitating client affect and experience, exploring in-session process and affect, identifying new clinical concerns, and maintaining an active focus on these issues. An overarching intent of these focus interventions is the active fostering of in-session emotional experiencing. While these affects generally stem from past or present sources of distress, clinicians should vigorously encourage the patient to bring them "into the room" by empathically encouraging affective experiencing in early sessions. The following interaction provides an example of a therapist intervention that aids in fostering a patient's emotional experience that may be uncomfortable or threatening:

Therapist: What's it like for us to talk about this in here?
Patient: (loudly) No problem at all.
Therapist: Well, I noticed that your voice changed a bit when we were talking about it, and I wonder what you are feeling right now?
Patient: Whatever, I'm feeling nothing. I'm just trying to explain to you what's going on with me and my daughter. I'm just trying to get this all out, it's complicated.
Therapist: Yes, it is and you're making a great effort to help me understand what exactly took place. At the same time, I often find that when someone's voice gets louder like that, then maybe they're describing something that can be uncomfortable. In "trying to get this all out" you could be feeling lots of different things or a few complicated things intensely? In order to make these complicated feelings more clear it might help to try and focus in on exactly what you're experiencing right now, in this moment.

An example of utilizing a cyclical relational theme in an interpretive manner to foster an affective response is as follows:

Patient: You won't believe what my boss did the other day! I handed him my assignment and he snatched it out of my hand, huffed, and turned away. I just couldn't believe it considering how much work I had put into it.
Therapist: I imagine that your boss's statement may have been particularly hurtful, especially given your history of being criticized by important people in your life. Perhaps some of that

anger can also protect you from the disappointment of being constantly criticized by others whom you turn to for support.

Patient: When I'm not mad at him I do feel sad and worthless. When I am angry at him, I share that with coworkers and get some support, but it's embarrassing to talk about how he makes me feel pathetic. It's a little easier in here though.

Third, feedback interventions are those in which the therapist offers specific information to the patient. Reviewing and exploring the meaning of assessment results, providing the client new understanding and insight, offering psychoeducation on symptoms and the treatment process, fostering heightened motivation for change, and collaboratively developing individual treatment goals and tasks have all been found to improve the working alliance between client and clinician during psychological assessment and initial sessions. Therefore, it is also important to recognize that even within a single-session intake interview or consultation, the clinician should make an effort to provide client feedback at the end of this session. An example of this exploration, insight, and collaboration in feedback on assessment results is as follows:

Therapist: You know as we talk more and more about the meaning of your depression, I'm really struck by the aspects of hopelessness and confusion that seem very prominent in your description of sadness. It reminds me of your response on the inkblot test (Card VI), the one where you saw a car driving through a dark scary forest at night. And later said you had no idea who was driving it, where it was going to, or coming from.

Patient: Yeah, I've thought about that one too. I feel like I'm in the backseat, lying on the floor, it's pitch black and I can't see anything, I don't know whose driving the damn car or where we're going! I think that's exactly what needs to change in order for me to not feel as depressed.

Therapist: Then I imagine it's going to be important for us to come back to this image and your experiences associated with it as we continue our work together.

Patient: You're right (tearing up), I want to get out of the backseat, and I know I need to understand how I got there in the first place in order to do that.

In fact, this assessment-derived treatment metaphor was frequently explored and used throughout the course of the psychotherapy by both parties and on several occasions spontaneously by the patient, including one day when she arrived in a session and announced "I did some things this weekend that leave me feeling like I'm finally driving the car. I'm still not 100% sure where this road is taking me, but now I can at least start to enjoy the ride."

Finally, specific therapist attitudes that convey empathy, support, exploration, activity, confident collaboration, appreciation, trust, warmth, attunement, potency, competence, respect, attentive, engaged listening, and appearing to understand the patient in a nonjudgmental and welcoming fashion have also been found to significantly improve alliances with patients in pre-therapy and initial sessions of psychotherapy.

In regard to specific therapist activities and characteristics found in this review, it appears that the same beneficial elements recommended for increasing alliance during the assessment and intake are quite similar to those observed across psychotherapy (see [48, 49]). In fact, when examining the alliance enhancing techniques observed during psychological assessment listed in the "Focus" section of Table 19.1, we are hard pressed to imagine any effective psychotherapy session that would not also include these elements. That is, we believe these interventions found to be central regarding positive alliance during the assessment process may also provide an excellent template for the focus of psychotherapy sessions as well. These positive interventions are relatively consistent, and it appears that the earlier these interactions take place, the better. Overarching themes inherent in therapist interventions found to contribute positively to the alliance can generally be seen as supportive, experiential-affective, active, engaged, explorative, and collaborative in nature. The empirical evidence has demonstrated that these initial patient–therapist interactions (whether conducted

during pre-therapy intakes, assessments, or first sessions) have the potential to significantly influence the ensuing treatment process, even capable of impacting later outcome. Certain initial clinician attitudes, techniques, and activities have indeed been shown to be more successful in promoting these positive alliances than others (Table 19.1).

Therapist Variables That Contribute Positively to the Alliance over the Course of Therapy

Personal Attributes

Certain clinician personal attributes, characteristics, or attitudes have been found to significantly and positively impact the working alliance throughout the course of treatment (Table 19.2; also see [49]). Significant relationships have been found between alliance and therapist's attributes such as conveying a sense of being trustworthy [45, 50], affirming [51, 52], flexible [53], egalitarian [52], interested, alert, relaxed, confident [54, 55], warm [23, 52], empathic [50], and more experienced [43, 50, 54]. In addition, patient's perception of a therapist as competent and respectful [22] was found to be characteristic of positive alliances. Therapist's affiliative type behavior such as helping and protecting

Table 19.2 Summary of therapist's techniques and attributes found to contribute positively to the alliance

Techniques positively related to alliance	Attributes positively related to alliance
Supportive	
Support the patient's struggle	Helpful
Affirm the patient's experience	Affirming
Convey a sense of understanding and connection	Understanding
Note past therapy success	Accepting
Foster a collaborative treatment process	Collaborative
Enhance motivation for change	Enthusiasm
Exploratory	
Utilize open-ended questions	Open
Clarify areas of distress or discrepancy	Empathic
Communicate clearly	Warm
Foster depth	Friendly
Provide appropriate, nonhostile, confrontation	Egalitarian
Provide accurate interpretation	
Experiential and affect focused	
Attend to patient experience	Honest
Reflect patient statements and experience	Trustworthy
Facilitate the expression of affect	Respectful
Explore different patient emotional states	
Engaged and active relationship	Interested
Active-engaged involvement	Alert
Focus on the here and now of therapy relationship	
Discuss therapist's own contribution to process	Flexible
Provide ongoing feedback to patient	Relaxed
	Confident
	Experienced
	Competent

was found to be significantly related to alliance ratings taken later in the treatment process. A possible explanation for these findings is that the therapist's personal qualities such as dependability, benevolence, responsiveness and experience help patients have the confidence and trust that their therapist has the ability to both understand and help them cope with the issues that brought them to therapy. Moreover, it is important to keep in mind that it may be necessary for a patient to have a positive opinion of the therapist before s/he has enough influence to facilitate therapeutic change. A benevolent connection between the patient and therapist helps create a warm, accepting, and supportive therapeutic climate that may increase the opportunity for greater patient change. If a patient believes the treatment relationship is a collaborative effort between her/himself and the therapist, s/he may be more likely to invest more in the treatment process and in turn experience greater therapeutic gains.

It is interesting to note that a recent medical study conducted at the Mayo Clinic provides evidence that the value of these personal attributes is not solely limited to psychotherapy relationships. Bendapudi et al. [56] investigated patient perspectives regarding their medical doctors and isolated a set of clinician attributes that clients considered significantly beneficial in developing strong patient–physician working relationships. These clinician attributes are strikingly similar to those identified in our review of the psychotherapy research [12, 48]. Specifically, medical patients valued clinicians who were confident, empathic, humane, personal, forthright, respectful, and thorough. Likewise, there is emerging research in psychiatry and general medicine that suggests the construct of alliance is quite important with regard to patient outcome in the pharmacologic treatment of depression [57], the clinical management of bipolar disorder [58], and the quality of life for lupus patients [59]. This intersection of medical and psychological research findings speaks to the salience and ubiquity of these basic relational attributes in forming effective healing relationships.

Therapist Application of Technique

The strategic interventions used by the therapist in treatment may be at least one discernable component of the overall alliance that develops between the patient and therapist. The focus of this section of the chapter is to explore the application of therapeutic techniques that increase the therapist's potential to identify with the patient and the patient's potential to identify with the therapist. This includes, but is not limited to, the therapist ability to develop an affiliative atmosphere within the therapeutic setting. Therapists who work toward cultivating a comfortable as well as productive therapeutic environment are expected to be rated by patients, external observers, and themselves as having strong alliances. The studies in this section specifically explore the therapist application of techniques that contribute positively to the alliance (also see [49]). As can be seen in Table 19.2, the therapist techniques found to contribute positively to the alliance can be organized into four major types of interventions: Supportive, Exploratory, Experiential-Affect Focused, and Engaged-Active Relationship.

Therapist's application of techniques that increase the patient's understanding of the problems that brought them to treatment, as well as enhance the level of connection between the patient and therapist has been found to aid in the development and maintenance of the alliance. Techniques anchored within a motivation-enhancing therapeutic model, such as fostering collaboration, positive affirmations, use of open-ended questions, use of reflective statements, problem discussion and feedback, exploring client ambivalence, heightening discrepancies, enhancing motivation for change, and discussing a plan for change [52, 60], have all been positively related to alliance over the course of varied treatments. A recent study by Colli and Lingaardi [61] incorporated a transcript-based method for the assessment of therapeutic alliance ruptures and identified nine specific therapist interventions that were positively related to a collaborative treatment process. These interventions were verbalizations where the therapist focused on the here and now of the relationship, explored

different patient states, provided feedback to the patient, explore a patient's emotion, provided an empathic statement to the patient, made a clarification, made a confrontation, admitted to his/her participation in a rupture process, and self-disclosed countertransference feelings. Additional contemporary studies underscore the importance of exhibiting a sense of understanding [23, 62–65] and active therapist involvement to foster greater session depth [14, 66, 67] in the development of a positive alliance in ongoing treatment. Although most of the extant evidence supports that therapist engagement with the patient enhances subsequent alliance levels [55, 65, 68–70], one study [70] failed to support this goal. Specifically, the use of either prescriptive or exploratory techniques failed to aid in developing the alliance at the third session of dynamic psychotherapy. A possible explanation for these contrary findings is that in the Kolden [70] study the ratings were only taken early in treatment and the techniques investigated (e.g., suggesting behavior changes and focusing on past events) may be more related to alliance later in treatment. In general, when therapist's activities convey a sense of understanding, connectedness, and collaboration in the therapeutic process, a greater sense of partnership and trust may transpire in the therapeutic relationship [55, 64, 66, 71, 72]. Moreover, a recent study by Bachelor et al. [73] which investigated client perceptions of their interactions with their therapists highlighted the importance of an active therapeutic stance in the development of a collaborative treatment process. Specifically, the majority of patients in this study valued the therapist's active involvement and emphasized the helpfulness of their collaborative experiences. The therapist's ability to form a relationship may enhance the patient's perception of being understood and help him/her feel even more connected to the treatment process. A greater feeling of connection to the treatment process may also provide even more opportunity for patient change and therapeutic growth throughout.

The studies included in this section suggest that the therapist's personal attributes and the use of therapeutic technique applicable in varied psychotherapy orientations have been found to positively influence the development and maintenance of the therapeutic alliance. Table 19.2 summarizes therapist personal attributes and techniques that were reported to be important in the development and maintenance of a strong alliance (also see [49]). They include: trustworthiness [45, 50], experience [43, 50], confidence [74], clear communication [69], motivation-enhancing techniques [52, 60], and accurate interpretation [75, 76]. The therapist's investment in the treatment relationship was found to be manifested through enthusiasm [77], interest [74], exploration [23, 62, 63, 65, 72], involvement [69], and activity [23, 68, 73]. The key elements of empathy include affirming [51], helping [71], warmth/friendliness [55, 63], and understanding [22, 51, 55, 64, 65].

We found very little variation between the different theoretical orientations regarding the therapist's positive impact on the alliance. The evidence found in this section supports the belief that the alliance is a pan-theoretical construct impacting psychotherapy process on multiple levels. While some theoretical orientations may prove to be more efficacious with specific patient populations, the findings from the present review suggest that many therapeutic pursuits can benefit from a focus on the factors contributing to a positive alliance.

Therapist Variables That Contribute Negatively to the Alliance over the Course of Therapy

Personal Attributes

It may come as no surprise that certain therapist characteristics or attributes have been shown to have a significantly negative impact on the working alliance at various stages of psychotherapy. Marmar et al. [78] found that therapists who were more rigid, self-focused, critical, and less involved

Table 19.3 Summary of therapist's techniques and attributes found to contribute negatively to the alliance

Techniques negatively related to alliance	Attributes negatively related to alliance
Managing the treatment in inflexible manner	Rigid
Over structuring the therapy	Tense
Failure to structure the therapy	Defensive
Inappropriate self-disclosure	Self-focused
Inappropriate use of silence	Exploitive
Unyielding transference interpretations	Distant/detached
Belittling or hostile communication	Cold
Superficial interventions	
	Distracted
	Uncertain
	Critical
	Aloof
	Indifferent

in the psychotherapy process were perceived as less understanding, evoked more hostile resistance from their patients and had lower overall alliance ratings. Eaton et al. [79] reported that across all phases of psychotherapy, therapists who were characterized as exploitive, critical, defensive, as well as lacking warmth, respect, and confidence had lower alliance ratings. Examining unstructured psychotherapy from varied orientations, Sexton et al. [69] found a significant relationship between negative alliance ratings and therapists who were rated as uncertain and tense. Saunders [74] found that a patient's ratings of the overall session quality were lower when the therapist was perceived as distracted, tired, and bored. A recent study by Hersoug et al. [80] also found that therapists' self-reported scores on the "cold/detached" dimension of Inventory of Interpersonal Problems (IIP [81]) assessing therapists' interpersonal style, such as being distanced, disconnected or indifferent, had a negative impact on the working alliance as rated both by patients as well as therapists. These findings are consistent with additional studies reporting that therapists who were perceived as belittling, blaming, watching, managing, aloof, and distant had a difficult time engaging in the treatment process and, consequently, had lower alliance ratings [66].

These findings support the notion that the negative characteristics of the therapist can impede the development of a positive alliance and diminish the quality of an already established alliance (Table 19.3; also see [48]). Therapists who exhibited disregard for their patients, were less involved in the treatment process, and were more self-focused were less likely to form a positive connection with their patients [78]. There was common agreement among the studies that poor alliances were related to therapists who were not confident in their ability to help their patients and were tense, tired, bored, defensive, blaming, or unable to provide a supportive therapeutic environment [66, 69, 74, 79]. These findings suggest that how therapists react to patients influences whether or not they are able to form a positive treatment relationship. If the therapist reacts negatively toward the patient and appears disinterested in the patient's concerns, it will likely be difficult to develop a positive treatment relationship. Consequently, these negative interactions may weaken the alliance and reduce the opportunity for patient change. Taken together, these findings underscore the potentially adverse impact therapist's personal attributes can have on the therapeutic relationship and process. Whether or not therapists can be taught to be empathic and warm, it is of critical importance that they vigilantly work toward conveying a respectful, flexible, accepting, and responsive attitude toward their patients.

Therapist Misapplication of Technique

Therapists may also make errors in their application of technique that may negatively influence alliance levels. Marmar et al. [78] reported a significant positive relationship between the therapist's avoidance of important issues and the patient's hostile resistance. Moreover, the therapist's repeated attempts to link a patient's inappropriate reactions toward the therapist (such as frustration) to earlier conflicted relationships with parental figures (transference interpretations) were significantly and negatively related to patient's commitment to the treatment process. Eaton et al. [79] found that therapist inflexibility, inappropriate use of silence, use of superficial interventions, or a failure to structure a session or address resistance were all significantly and positively correlated to a weak alliance. Coady and Marziali [71] found that the therapist's increased use of belittling, blaming, watching, and managing behaviors both early and late in therapy led to a decrease in the alliance. Price and Jones [66] found that therapists who disclosed their own emotional conflicts into the therapeutic setting had significantly lower alliance ratings. Piper et al. [82–84] reported that the number of transference interpretations offered by the therapist was inversely related to a positive alliance. They concluded that a therapist's unyielding use of transference interpretations, inflexibility, and lack of responsiveness to explore the patient's feelings or the "real" relationship may have influenced the weakening of the alliance.

This section highlights certain therapeutic misapplications of technique that have been found to adversely affect the alliance (Table 19.3 [48]). These errors include therapist inflexibility in treatment planning, inappropriate use of silence [79], placing too much emphasis on patient resistance [78], self-disclosure of therapist's own emotional conflicts [66, 71], and unyielding use of transference interpretation [78, 82–84].

Therapist Behaviors Producing Ruptures in the Alliance

The focus of this section is to present findings related to therapists' behaviors that may contribute to ruptures in the alliance as well as patient behaviors that can alert clinicians to the presence of a strained alliance. Ruptures in the alliance have been defined as either fluctuations in the quality of the therapeutic relationship or an ongoing problem in establishing an alliance [85–87], and research continues to demonstrate that higher levels of rupture resolution significantly contribute to better alliance and outcome [88, 89]. Castonguay et al. [90] examined cognitive-behavioral psychotherapy sessions with low alliance ratings and identified potential markers that pointed to potential ruptures. They identified a patient's expression of negative feelings toward the therapy process, avoidance of the therapeutic task, and unresponsiveness to therapist interventions as predictive of rupture. In addition, the authors found that the strain was not resolved when therapists continued to try to fit the patient's negative experience into the cognitive model despite his or her expressed desire to explore the painful emotion related to the experience. This suggests that a strain in the alliance may be exacerbated by the therapist's inflexible adherence to cognitive treatment strategies and the inability to focus on the emotional impact of their experience (also see [91–94]). Safran et al. [85–87, 95–97] have extensively examined ruptures in the alliance. Within this body of research, ruptures are seen as an expected part of the treatment process and that the use of ruptures can be a fertile ground for patient change and an opportunity for deepening the alliance. These authors have operationally defined alliance ruptures as well as proposed a therapeutic model to facilitate the recognition and repair of ruptures in the alliance (Tables 19.4–19.6). Markers of a weakening alliance were identified in this research and separated into two general categories, confrontation and avoidance of confrontation markers. Confrontation markers exist when patients directly express their negative sentiments

Table 19.4 Summary of precipitants and markers of ruptures in the alliance

Precipitants to ruptures (data from [98])
Breach of patient's wants and/or needs:
(A) Therapist does something the patient does not want or need
Therapist confronts unsupportively1
Therapist focus is off
Therapist gives unwanted advice
Therapist interpretation is off
Therapist focused on something other than client
(B) Therapist fails to do something the patient wants or needs:
Therapist misses importance of issues
Markers of ruptures (Data from [97])
Confrontational
Overt expression of negative sentiments
Disagreement about the goals or tasks of therapy
Self-esteem enhancing operations
Nonconfrontational
Compliance
Indirect communication of negative sentiments or hostility
Avoidance maneuvers
Nonresponsiveness to intervention

Table 19.5 Therapist actions that aggravate alliance ruptures

1. Therapist not paying attention to the patient's experience
2. Therapist's refusal to accept any responsibility for the rupture experience
3. Dogmatic and rigid use of therapeutic interventions (i.e., transference interpretation, focus on patient resistance)
4. Belittling and rejecting the patient's expression of negative feelings

Table 19.6 Strategies for the repair of alliance ruptures

Therapist intervention	Technique
1. Focus on immediate experience	(a) Inquiry
	(b) Empathic reflection
	(c) Subjective feedback
2. Facilitate patient self-assertion	(a) Inquiry
	(b) Empathic reflection
	(c) Subjective feedback
	(d) Awareness experiment with direct expression
	(e) Acceptance of own responsibility for rupture
	(f) Focus on the therapeutic relationship
3. Explore patient's negative feelings	(a) Explore the meaning underlying the feelings
	(b) Facilitate patient awareness of feelings
4. Validate patient assertion	(a) Support and empathize with patient's assertion

Data from [96]

about the therapist or treatment process. The avoidance of confrontation markers include times when patient's negative sentiments are behaviorally acted out through withdrawal, distancing, or avoiding. Once a rupture has been recognized it can be systematically examined, interpreted, and hopefully resolved within the treatment process. Safran and Muran [85–87, 96] proposed a model that described four specific therapist interventions to facilitate the repair of alliance ruptures (Table 19.6). In the first intervention, the therapist addresses the immediate experience of the patient using metacommunication. Keisler [99] defined metacommunication as "any instance in which the therapist provides to the patient verbal feedback that targets the central, recurrent, and thematic relationship issues occurring between them in the therapy session" (p. 284). As we have previously cited, the key components include the therapist's personal attributes (i.e., affirming, communicate clearly, confident, accurate, understanding) and use of technique (i.e., active, exploratory, involved). It is also important to note that these attributes and techniques are *necessary* for the therapist to be optimally prepared to recognize and identify the markers of a rupture in the alliance.

The second intervention of this model consists of two parts, the therapist acknowledging his/her contribution to the rupture experience and the use of an awareness experiment to foster direct communication. In this model, self-disclosure is less a sharing of one's past experiences and more an expression/exploration of in-session affect related to the therapeutic relationship. In this model, in-session self-disclosure serves as a vehicle of connection and support that validates the patient's experience in the moment of the session. For instance, a therapist might say "*You're right. What I said does sound critical*" to a patient who expresses that s/he was feeling that his/her therapist was being critical. In the second part of this intervention, the use of an awareness experiment not only demonstrates a therapist's active involvement and exploration: it may also help to build trust, increase understanding, and convey an interest in the patient's affective experience. Through the practice of adaptive expression, the patient may work on modifying their relationship patterns to include more benevolent responses from self and others. In addition, through the practice of adaptive expression with the therapist, the patient may learn to more effectively express his/her feelings in present and future relationships.

The third intervention of the resolution model is an exploration of the patient's experience in order to gain a greater sense of understanding. To successfully manage this intervention, Safran and Muran [85–87, 96] recommend that the therapist convey an affirming, understanding, and nurturing stance. These recommendations support previous findings that therapist behaviors such as exploration, depth, interest, affirming, and understanding [22, 51, 63, 72, 74] contribute to the development of a stronger alliance. The final intervention in the rupture resolution model is the validation of the patient's experience. The success of this intervention relies on the therapist's ability to effectively use therapeutic strategies and empathically connect with the patient.

An analogous pattern emerged between the therapist activities identified to cause deteriorations in the alliance and the essential features related to the aggravation of breaches in the alliance ([48]; Table 19.5). In unresolved breaches in the alliance, the therapist was portrayed as nonresponsive, closed-off, nonaccepting, and dogmatically maintaining his/her original point of view without taking the patient's perspective into account. These therapist characteristics and technical errors are similar to the personal attributes (e.g., rigid, aloof, distant, disrespectful, and self-focused) and misapplications of technique (e.g., unyielding use of transference interpretation) found to contribute negatively to the alliance (Table 19.3).

An additional rupture identification model was outlined in a study conducted by Rhodes et al. ([98]; Table 19.4), which examined the patient's perspective of resolved and unresolved therapeutic misunderstandings. Rhodes et al. [98] reported that misunderstandings were precipitated by either the therapist doing something the patient did not like or want (e.g., therapist was critical, inattentive, or gave unwanted advice), or the therapist not doing something that the patient expected or wanted (e.g., therapist did not remember important facts or missed the importance of an issue). In the resolved cases, the patients reported that their therapist accommodated (e.g., took responsibility for the prob-

lem, apologized, or modified their behavior). In the cases with unresolved misunderstandings, the patients reported that their therapists were nonresponsive, defensive, cold, nonaccepting, or that they stubbornly maintained their original point of view without taking the patient's point of view into consideration.

Therapist's behaviors found to be effective in addressing and resolving strains in the alliance include addressing negative sentiments the patient may have about the therapist; [85–87, 96, 97, 100, 101], exploring the avoidance of negative emotions and expected responses from others [100], using accurate interpretations that focus on the patient's interpersonal problems and not necessarily on transference issues [75, 90, 92, 101], conveying a sense of affirmation, understanding, protection, and nurturance [85–87, 96], and accepting part of the responsibility for the emergence of a rupture [85–87, 96, 98]. Those therapist's behaviors that were found to be ineffective in the resolution of alliance strains included rigid adherence to a treatment model [58, 90–93], inflexibility [90–93, 98], being unresponsive, closed-off, and conveying a sense of nonacceptance [98]. The findings from these studies suggest that the resolution of ruptures in the alliance are not only possible, they may be an integral component of therapeutic change and more importantly the development of a healthy therapeutic relationship. A summary of empirically supported precipitants, strategies that aggravate, and strategies that repair alliance ruptures are presented in Tables 19.4, 19.5, and 19.6.

Conclusions

The studies covered in these reviews suggest that therapists' use of techniques from a range of psychotherapy orientations (e.g., cognitive-behavioral, experiential, interpersonal, person-centered, psychodynamic) may influence the therapeutic alliance in both positive and negative ways. Tables 19.1 and 19.2 summarize therapist techniques identified in these reviews that were reported to be important in the development and maintenance of a strong alliance. Conversely, Table 19.3 presents technical and personal therapist factors that have been found to be related to lower levels of, or even to, deterioration in the alliance.

Therapist techniques found to contribute positively to the alliance could generally be categorized as: Supportive, Exploratory, Experiential-Affect Focused, and Engaged-Active Relationship. Research indicated therapist techniques that specifically convey support, understanding, affirmation, and noting adaptive changes across treatment were significantly related to higher alliance. Higher alliance was also related to therapist techniques that increased a patient's understanding of the problems that brought him/her to treatment through greater exploration and in-depth (i.e., full, special, powerful) discussion of these topics, as well as accurate, high quality, case-specific interpretations (not simply quantity). Techniques that maintained focus on the patient's in-session subjective experience (i.e., reflection) and affect, or that facilitated the expression of these emotions, were also related to higher alliance. Finally, a more active, engaged, motivating, yet open-ended stance by the therapist was important in a positive therapeutic relationship.

Conversely, therapist interventions found to have negative effects on the alliance were at extreme ends of particular technical continua. For instance, over-structuring and managing therapy in an inflexible manner, as well as failure to structure the treatment in an organized or coherent manner, were both negatively related to alliance. Also, the therapist spending too much time regarding superficial information not related to key treatment issues, or self-disclosure of the therapist's own emotional conflicts had a negative impact on alliance levels. Conversely, therapists dedicating too little attention to the patient through the misuse of extended silence or withdrawal from the in-session process were also detrimental to alliance. The use of transference interpretations (patient–therapist–past other) in a sustained, high volume and unremitting manner was detrimental to the alliance. However, it is important to note that continued focus on the transference relationship (i.e., linking patient,

therapist, and past others) is not the same as exploring the "here-and-now" in-session process, including thoughts and feelings about the treatment relationship (i.e., exploring patient–therapist here-and-now interactions from a dyadic, interactive, relational theoretical perspective without directly linking to a past other; [85, 86, 89]). This is an important distinction that often muddies the water in research on transference interpretations. Finally, and not surprisingly, communication of hostility or disrespect by the therapist toward the patient was found to be related to lower alliance.

According to the studies reviewed, disruptions or ruptures in the alliance are generated from a patient's negative reaction to the therapist and/or treatment process. Addressing the patient's adverse reaction to the therapist and/or treatment process within the interior of the therapeutic frame was found to be the key element in the repair of ruptures in the alliance. One study reported that it was important for the patient to initiate the expression of his/her negative sentiments [98] while other studies emphasized the importance of the therapist drawing attention to the patient's negative sentiments [85–89, 96]. However, it appears that how the patient's negative sentiments are brought into the room is less important than ensuring that the negative sentiments are acknowledged and openly explored ([75, 85–88, 96–98, 100–102]; Table 19.6). When a therapist is not paying attention to a patient's experience, s/he is likely to overlook a breach in the alliance and/or mistakenly assume that they have not contributed to the breach. Errors such as these can be conceptualized as a lack of empathy and may lead to the eventual breakdown of the alliance [101]. The eventual breakdown of the alliance may also occur when a therapist dogmatically relies on strategic interventions in an attempt to resolve breaches in the alliance ([90]; Table 19.5). It is important to note that the essential features related to the repair of ruptures in the alliance are similar to the significant therapist contributions to the development and maintenance of a positive alliance mentioned previously in this chapter. To successfully manage the resolution of ruptures in the alliance, Safran and Muran [85–87, 96] recommend that the therapist convey an affirming, understanding, and nurturing stance as well as validate the patient through exploration of the patient's experience in order to gain a greater sense of understanding. These recommendations support previous findings that therapist behaviors such as exploration, depth, interest, affirmation, and understanding [14, 22, 51, 63, 67, 72, 74] may contribute to the development of a stronger alliance.

The studies included in this chapter suggest that the therapist's activity from a range of psychotherapy orientations have been found to positively influence the development, maintenance, and repair of ruptures in the therapeutic alliance. These interventions are relatively uniform and consistent throughout this review, also mirroring the conclusions of alternate contemporary sources [3, 103]. A possible explanation for the consistency is that a potential common factor imbedded within these elements is a connection between the patient and therapist that provides the opportunity for relief from suffering, although caution is warranted when interpreting process–suboutcome correlations without considering the responsive properties of helping interactions [104]. That is, more of advantageous process components may only be "better" when patients are not already getting enough of these interactions in a given therapy [105].

While some theoretical orientations may prove to be more efficacious with specific patient populations, the findings from the present review suggest a better understanding of the alliance can benefit all therapeutic pursuits. Therefore, it seems possible that the most effective therapists will be able to synthesize and integrate differing aspects of insight-oriented, experiential, humanistic, and cognitive-behavioral therapies into a cohesive therapeutic stance. In addition, perhaps a measure of the success attributed to these interventions, as Rumpold et al. [21] noted, can be seen as accessing avenues to increase a patient's motivation for change and prepare them for the psychotherapy process, both relationally and through psychoeducation. Nevertheless, one of the most important overall themes inherent in the literature is that careful awareness of the therapeutic relationship as early as possible in treatment (i.e., psychological assessment, initial interview, first session) may well offer patients the best opportunity for development of a positive therapeutic relationship across the treatment process. Finally, we believe the summary findings of this review (Tables 19.1–19.3)

provide an excellent resource for future scale and treatment developments designed to better understand, evaluate, and maximize the benefit of alliance throughout the treatment process.

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Query	Details Required	Author's Response
AU1	In Refs. [85, 102] the journal title "In Session: Psychotherapy in Practice" has been changed to "J Clin Psychol". Please check and correct if necessary.	