A review of therapist characteristics and techniques positively impacting the therapeutic alliance

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A review of therapist characteristics and techniques positively impacting the therapeutic alliance

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Abstract

The present review is a comprehensive examination of the therapist's personal attributes and in-session activities that positively influence the therapeutic alliance from a broad range of psychotherapy perspectives. Therapist's personal attributes such as being flexible, honest, respectful, trustworthy, confident, warm, interested, and open were found to contribute positively to the alliance. Therapist techniques such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience were also found to contribute positively to the alliance. This review reveals how these therapist personal qualities and techniques have a positive influence on the identification or repair of ruptures in the alliance.
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1. Introduction

The therapeutic alliance has emerged as an important variable for psychotherapy process/ change in various schools of psychotherapy (Orlinsky, Grawe, & Parks, 1994). Originally, the therapeutic alliance was believed to be positive transference from the patient toward the therapist (Freud, 1913; Frieswyk et al., 1986). The perception of the therapeutic alliance later developed into a conscious and active collaboration between the patient and therapist. Currently, most conceptualizations of the therapeutic alliance are based in part on the work of Bordin (1979), who defined the alliance as including "three features: an agreement on goals,

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an assignment of task or a series of tasks, and the development of bonds" (p. 253). The emphasis that contemporary psychotherapy research has placed on the examination of the technical and relational aspects of the alliance has made it an important variable in the understanding of psychotherapy process.

In the last two decades, the technical and relational aspects of the alliance such as patient characteristics and therapist activity have been the focus of a great deal of empirical research studying the relationship between the alliance and therapy outcome (Barber et al., 1999; Blatt et al., 1996; Frieswyk et al., 1986; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Hillard, Henry, & Strupp, 2000; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). However, an area of research that has been less developed is the therapists' contributions to the development of the alliance. Although there has been some research focusing specifically on the therapist's in-session activity that impacts the therapeutic alliance (for a review of the literature examining therapist activity to treatment outcome, see Orlinsky et al., 1994), for the most part therapist contributions have been overlooked. More importantly, the findings from these studies have not been integrated across studies in a manner that clarifies the relationship between the therapist's specific in-session contributions (e.g., personal attributes and technical interventions) and the development of a positive alliance.

In a recent review of the literature on alliance and technique in short-term dynamic therapy, Crits-Christoph and Connolly (1999) identified only four studies that directly examined the relationship between technique and alliance. Although the Crits-Christoph and Connolly review had a narrow focus and only surveyed studies using short-term psychodynamic techniques, they concluded that there is not enough evidence to draw a link between technique and alliance. Similar conclusions were reported by Whisman (1993) in a review of the theoretical and empirical literature related to the therapeutic environment in cognitive therapy (CT) of depression. The therapeutic environment included the therapeutic alliance, therapist's adherence, and competence, as well as patient characteristics. Whisman stated that historically research examining the core components of CT have devoted "little discussion to the importance of the therapeutic relationship" (p. 253) and suggested that future research investigations need to focus on this interaction between the patient and therapist.

Therefore, psychotherapy research may benefit from a close examination of the relationship between therapist's variables (including personal attributes and technique) and alliance. As Saketopoulou (1999) states researchers should aim to better understand "the development of alliance in the course of therapy" (p. 338). In order to identify the distinctive elements of the therapist's variables that impact the development and maintenance of the alliance a review of existing empirical findings from a variety of therapeutic orientations (i.e., psychodynamic, cognitive, cognitive–behavioral, family therapy, etc.) is necessary. The present review is a comprehensive examination of the therapist's personal attributes and in-session activities that positively influence the therapeutic alliance from a broad range of psychotherapy perspectives. This broad focus on the therapist's variables positively impacting the alliance facilitates a closer examination of the psychotherapy process and is a step toward the integration of past research. This review is not intended to be a critique of methodological issues or measures of

the alliance (although a review of this sort would be a significant contribution to the literature). The present review is clinically focused with the aim of increasing the applied understanding of the therapists' unique contributions to the development of a positive treatment relationship. It is reasoned that focusing on the therapist's positive contributions to the alliance will not only refine and enhance our understanding and assessment of the construct, it may also guide future research toward the discovery of more efficacious and clinically superior therapeutic techniques. More importantly, this review may help therapists with a range of experience, in various forms of psychotherapy to obtain greater success developing stronger therapeutic connections with their patients.

The first step in the present review was a literature search using PsychLIT from 1988 to 2000 with the search terms: *therapist activity*, *therapeutic alliance*, and *psychotherapy process*. We also reviewed Horvath and Greenberg's (1994) book, *The Working Alliance: Theory, Research, and Practice*, chapters 8 and 11 in Bergin and Garfield's (1994) *Handbook of Psychotherapy and Behavior Change*, and *Psychoanalytic Abstracts* through 1999. Next, to identify additional studies we reviewed the references of the material meeting our inclusion criteria. As a final step, we manually reviewed the previous 12 months of the journals that provided therapist activity and alliance material in the previous steps (e.g., *Journal of Consulting and Clinical Psychology*, *Journal of Clinical Psychology*, *Journal of Counseling Psychology*, *Journal of Psychotherapy Practice and Research*, *Psychotherapy*, and *Psychotherapy Research*).

Our inclusion criteria were as follows: (a) The investigation had to report a quantifiable relationship between some index of therapist variables and the alliance. (b) The focus of the study had to be identified as specifically examining therapist's personal attributes and/or technical activity related to the development, management, and/or maintenance of the alliance. This does not include studies examining the relationship between alliance and outcome, unless the author(s) also examined and reported a quantifiable relationship between therapist variables and alliance. We chose to define therapist variables to include only those studies reporting therapist's personal attributes and/or use of therapeutic technique as positively impacting the alliance. Moreover, we chose to define the alliance based on Bordin's (1979) conceptualization of the alliance. These criteria revealed a total of 25 studies reporting therapist variables positively contributing to the alliance. The present review will be organized according to two categories (therapist attributes and therapist techniques) and include recommendations for future research examining the relationship between therapist activity and alliance.

2. Therapist variables that contribute positively to the alliance

2.1. Personal attributes

The ability of a therapist to instill confidence and trust within the therapeutic frame is essential to therapeutic success. Related to the development of these ideals is the therapist's capacity to connect with the patient and convey an adequate level of competence to

effectively help patients under distress. Moreover, the therapist's attributes similar to dependability, benevolence, and responsiveness are expected to be related to the development and maintenance of a positive alliance. It is also expected that therapist's confidence in their ability to help his/her patients will be related to a positive alliance. In an effort to organize and further understand the role of therapist's personal attributes in the development of the alliance, this section of the review examines studies linking the therapist's personal attributes with his/her ability to form an alliance with patients.

In the development and validation of a new alliance measure, Horvath and Greenberg (1989) compared therapist self-ratings on the Counselor Rating Form (CRF) and the Working Alliance Inventory (WAI) scales. The WAI is a 36-item measure that consists of three subscales (Goals, Bond, and Task) based on Bordin's (1975) tripartite conceptualization of the alliance. Using ratings from the third session of psychotherapy, they found that the WAI Bond scale was significantly related to CRF scales trustworthiness and expertness. A feeling of positive connectedness early in the therapeutic relationship was related to therapist training, consistency, nonverbal gestures (e.g., eye contact, leaning forward), verbal behaviors (e.g., interpretation, self-disclosure), and the maintenance of the therapeutic frame. This study also reported a strong correlation between the WAI Bond scale and the Empathy scale of the Relationship Inventory (RI; Barrett-Lennard, 1962) that measures a therapist's demonstration of empathy, congruence, and positive regard. These findings suggest that the therapist's ability to understand and relate to the patient's experience may be an important component in building a strong alliance.

Similar findings were reported in recent studies (Coady & Marziali, 1994; Hersoug, Hoglend, Monsen, & Havik, 2001; Price & Jones, 1998). Coady and Marziali (1994) examined the relationship between specific and global estimates of the alliance at Sessions 3, 5, and 15 of time-limited psychodynamic psychotherapy using the Therapeutic Alliance Rating System (TARS; Marmar, Horowits, Weiss, & Marziali, 1986) and the Structural Analysis of Social Behavior (SASB; Benjamin, 1984). The TARS is a 42-item scale that focuses on the therapist–patient relationship and the individual contributions each makes toward that relationship. The authors found that the percentage of SASB therapist's affiliative thought units were correlated with patient rating of therapist's contribution to the alliance at Session 3 and external judges ratings of therapist's contributions to the alliance at Session 15. A significant positive correlation was also found between therapist's helping and protecting behaviors and therapist's ratings of his/her own contribution to the alliance at Session 15.

To assess the relationship between alliance and therapist process, Price and Jones (1998) compared judges' ratings of psychodynamic psychotherapy Sessions 5 and 14 on the California Psychotherapy Alliance Scale (CALPAS) and Psychotherapy Process Q-Sort (PQS). The CALPAS is comprised of 24 items that break into four scales (Patient Working Capacity, Patient Commitment, Working Strategy Consensus, and Therapist Understanding and Involvement) intended to reflect different components of the alliance and taken together are believed to portray the overall alliance. The authors reported that the global alliance rating was significantly correlated with the Therapist Understanding and Involvement subscale. A significant positive correlation was found between the alliance and PQS items related to

therapist's affiliative behaviors ("Therapist adopts supportive stance" and "Therapist is sensitive to patient's feelings, attuned to patient, empathic"). A significant positive correlation was also found between the alliance and the patient–therapist interaction factor of the PQS that represents the therapist conveying an understanding of the patient as well as being supportive of the patient. In addition, the patient–therapist interaction factor was found to significantly predict the alliance. The authors suggested that the interaction represents the productive communication between the patient and therapist including both affective (i.e., empathic) and working-related (i.e., understanding) aspects of the alliance. It was proposed that the therapist capacity to express him/herself lucidly and be perceived as proficient in enacting therapeutic strategies might lead to higher overall alliance ratings.

In a study examining the quality of the working alliance, Hersoug et al. (2001) assessed therapist personal variables early and late in psychodynamic therapy. The WAI was used to assess the alliance at Sessions 3 and 12. The Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, & Baur, 1988), SASB, and Parental Bonding Instrument (PBI; Parker, Tuplin, & Brown, 1979) were used to assess therapist personal variables at the same sessions. Positive (warm) early memories of caregivers were related to higher therapist early and patient late ratings of the alliance. Greater amounts of training (i.e., experience) were related to higher therapist late alliance ratings. Moreover, a dominant interpersonal style was predictive of higher patient late alliance rating that supports the belief that patients' may feel comfortable with a confident and involved therapist. Taken together, the findings from these studies suggest that the patient–therapist interaction plays a key role in the defining and maintaining the alliance.

Mallinckrodt and Nelson (1991) used the WAI to examine the relationship between training level and the formation of a working alliance at Session 3. They surveyed patient–therapist dyads from three separate training sites that included novice (in first practicum), advanced (in second practicum through predoctoral internship), and experienced (postdoctoral staff) therapists. The authors reported that both patients and therapists rated therapists with greater levels of training higher on the Tasks and the Goals subscales of the WAI. However, there were no significant differences found across the level of training on the Bond subscale of the WAI for either patient or therapist ratings. These findings suggest that less experienced therapists are capable of forming a bond with the patient but may be less effective at establishing treatment goals and performing the tasks necessary to achieve these goals early in the treatment process.

Utilizing patient and therapist dyads from an university outpatient clinic, Al-Darmaki and Kivlinghan (1993) compared patient and therapist alliance ratings on the WAI with external judges ratings on the Revised Psychotherapy Expectancy Inventory (PEI-R; Berzins, 1971) from Session 3 of formal psychotherapy. The therapists were in various levels of training from beginning student therapists to senior supervising psychologists. They reported that if the therapist expected the relationship to be positive (i.e., positive, egalitarian), it facilitated the development of a better working alliance (higher ratings on the WAI Bond, Agreement on Tasks, and Agreement on Goals subscales). These findings support Mallinckrodt and Nelson's (1991) notion that training level does not necessarily impact the development of a therapeutic bond early in treatment.

Using the WAI with a sample of undergraduate students who were given courses credit to act as patients, Kivlighan, Clements, Blake, Arnzen, and Brady (1993) examined counselor sex role orientation, flexibility, and the formation of a working alliance across four sessions. The recruited patients were expected to present personal concerns from their current lives and rate the alliance after each sessions. The authors reported no significant relationship between counselor sex role orientation and patient ratings of the working alliance averaged across all sessions. However, they found a significant relationship between increased counselor flexibility and higher patient ratings of the working alliance on the WAI average across all sessions.

Mohl, Martinez, Tichnor, Huang, and Cordell (1991) asked patients to rate their therapist using the Helping Alliance Questionnaire (HAq; Luborsky, Mintz, Auerbach, et al., 1980) and the Osgood Semantic Differential (OSD; Osgood, Suci, & Tannenbarum, 1975) after an initial screening interview. They reported that those patients who experienced a stronger helping alliance felt they gained new understanding, liked the therapist, and felt more liked and respected by the therapist. In general, therapists who were recognized as being warm, friendly, and facilitating a greater sense of understanding had higher helping alliance ratings early in the treatment process.

Najavits and Strupp (1994) also used the HAq as well as the Vanderbilt Psychotherapy Process Scale (VPPS; Suh, Strupp, & O'Malley, 1986), the Vanderbilt Negative Indicators Scale (VNIS; Suh et al., 1986), and the Vanderbilt Therapeutic Strategies Scale (VTSS; Butller, Lane, & Strupp, 1988) to examine the relationship between alliance and therapist's in-session behavior. Using the ratings of the patient, therapist, supervisor, and an external observer at various points in treatment, the authors found that most of the significant results were connected to a relational aspect of the treatment process. Najavits and Strupp reported that therapists with higher alliance scores were rated by both themselves and patients as more affirming and understanding than therapist with lower alliance ratings. These findings suggest that being accepting of patients may help them feel even more connected to the therapist, and in turn increase their confidence in the treatment process.

Bachelor (1995) used a qualitative analysis to assess the patient's perceptions of the alliance. Patients described the main characteristics of a "good client–therapist relationship" (p. 524) at three separate points in therapy (pretherapy, initial session, and a later session). Approximately one-half of the patients in the sample reported that therapist competence and respect for the patient was characteristic of a good working relationship. These results were consistent at all three measurement points. These findings highlight the idea that the quality of the alliance may be influenced by the patient's perception of the therapist at various stages of the treatment process.

In a study focusing on the assessment of the session affective environment and overall quality, Saunders (1999) hypothesized that the patient's in-session emotional state may be related to his/her perception of the therapist's emotional state at Session 3. To assess the affective environment in the session, Saunders utilized the Therapist Confident Involvement (TCI; therapist interested, alert, relaxed, and confident), Therapist Distracted (TD; therapist distracted, bored, and tired), and Reciprocal Intimacy (RIn; conceptually represented the

alliance and included items related to the patient feeling close and affectionate, as well as the therapist being perceived as close, affectionate, and attractive) subscales of Therapy Session Report (TSR; Orlinsky & Howard, 1986). Session quality was estimated from the average of patient ratings on two individual items from the TSR. The first item asked patients to rate the session just completed on a seven-point Likert-type scale with higher ratings equal to increased quality. The second item asked patients to rate how effective the session was in dealing with their problems on a five-point Likert-type scale again with higher ratings equal to increased quality. Saunders reported that TCI and RIn (alliance) ratings were significantly related to each other. Furthermore, it was found that higher patient ratings of the session quality were significantly related to higher scores on the TCI and RIn, as well as lower scores on the TD subscales. Patient's perceptions of the therapist as confident and interested were found to be related to feeling intimate with the therapist as well as a feeling of being helped. These findings suggest that when patients perceived the session as worthwhile, they perceived the therapist as involved and felt more connected with the therapist.

The research reviewed in this section revealed that specific therapist's personal attributes were significantly related to the development and maintenance of a positive alliance (see Table 1). It appears that the therapist's attributes may influence the development of an alliance early and late in treatment. A potential methodological concern regarding the studies in this section is that many only report data from one or two points in treatment (typically Session 3 and a point at which 75% of the treatment is completed). While this is common practice within psychotherapy research, it may limit the generalizability of the findings to other points in treatment (i.e., the middle phase) where a decline in the experience of a positive alliance may occur in some forms of therapy. Significant relationships were found between early alliance and therapist's attributes such as conveying a sense of being trustworthy (Horvath & Greenberg, 1989), affirming (Najavits & Strupp, 1994), flexible (Kivlinghan, Clements, Blake, Arnez, & Brady, 1993), interested, alert, relaxed, confident (Hersoug et al., 2001; Saunders, 1999), warm (Mohl et al., 1991), and more experienced (Hersoug et al., 2001; Mallinckrodt & Nelson, 1991). In addition, patient's perception of a therapist as competent and respectful (Bachelor, 1995) early in the treatment process were found to be characteristic of a positive alliances. Therapist's affiliative type behavior such as helping and protecting were 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 an affirmative 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.

Table 1
Summary of therapist personal attributes that contribute positively to the alliance

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
Al-Darmaki and Kivlighan (1993)	25 outpatients at a university clinic	25 therapists (2 senior psychologists, 2 predoctoral interns, 11 beginning student therapists, and 10 advanced student therapists)	not reported	WAI:	Therapist expectation of comfortable and egalitarian relationship is predictive of therapist-rated WAI Bond (R^2=.44, adjusted R^2=.42, F=18.19); Agreement on Tasks (R^2=.36, adjusted R^2=.33, F=12.81); Agreement on Goals (R^2=.49, adjusted R^2=.47, F=21.89).
				Therapist version: Cronbach's alpha=.91–.93 Patient version: Cronbach's alpha=.88–.93 PEI-R Patient and Therapist ratings on the WAI from Session 3 External judges ratings on the PEI-R from Session 3	
Bachelor (1995)	34 self-referred outpatients	23 master's level psychology trainees being trained in a broad range of therapies	Treatment was dependent on supervisors' orientation (36.4% cognitive–behavioral, 36.4% humanistic–existential, 15.1% analytic, and 12.1% gestalt)	Open-ended self-report inquiry of patient's perception of the alliance (pretherapy, initial session, and at a later phase)	Therapist *competence* and *respect* for the patient were characteristics of good working relationship.

Coady and Marziali (1994)	9 outpatients seeking psychotherapy	psychodynamically oriented therapists with a minimum of 4 years postgraduate clinical experience	time-limited (20 sessions) individual psychodynamic therapy	TARS: Cronbach's alpha=.81–.91.	Patient ratings on the TARS are related to SASB Therapist Affiliative Thought Unit at Session 3 (r=.76, P<.01); external judges ratings on the TARS are related to SASB Therapist Affiliative Thought Unit at Session 15 (r=.65, P<.05); therapist ratings on the TARS are related to SASB Therapist Helping/Protecting behavior at Session 15 (r=.76, P<.01).
				SASB Patient, therapist, and external judges ratings on the TARS and SASB from Sessions 3, 5, and 15	
Hersoug et al. (2001)	270 outpatients from seven sites	39 clinical psychologists, 13 psychiatrists, 4 social workers, and 3 nurses	open-ended psychodynamic psychotherapy	WAI	Patient ratings on the WAI are related to PBI warm father care (r=.20, P<.01) and warm mother care (r=.15, P<.05) at Session 12. Therapist ratings of the WAI are related to warm mother care (r=.24, P<.01), skill (r=.24, P<.01), and progress as a psychotherapist (r=.26, P<.01) at Session 3. Therapist ratings of the WAI are related to skill (r=.24, P<.01) at Session 12. Patient WAI ratings at Session 12 predicted by therapist's dominant style (t=1.98, P<.05).

Table 1 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
Horvath and Greenberg (1989)	25 outpatients seeking services on a fee for services basis	25 experienced professionals from various orientations (client-centered, analytic, Jungian, behavioral, or cognitive)	short-term counseling (less than 15 sessions)	IIP SASB PBI WAI: Cronbach's alpha=.87	WAI Bond scale is related to CRF Trustworthiness (r=.72) and Expertness (r=.66) scales. WAI Bond scale is related to RI Empathy scale (r=.76).
Kivlighan et al. (1993)	42 undergraduate psychology students recruited to present real personal concerns	42 master's level counseling students enrolled in a counseling skills course	counseling interview	CRF RI Empathy Scale Patient and therapist ratings at Session 3 WAI: Cronbach's alpha=.92	Counselor flexibility is related to WAI average score across sessions (r=−.26; lower flexibility scores represent greater flexibility).
Mallinckrodt and Nelson (1991)	58 outpatients	18 novice graduate students, 24 advanced graduate students, and 8 experienced counselors	eclectic time-limited brief therapy model	Intentions list Counselor flexibility Ratings are taken after each session (total of four sessions) WAI:	Significant main effects found for training level [$F(6,90)$=4.18, P<.001]. Patients rated therapists with more training higher on WAI Tasks [$F(2,47)$=3.27, P<.05] and Goals [$F(2,47)$=5.84, P<.01] subscales. Therapists rated therapists with more training

					higher on WAI Tasks [$F(2,47)$= 3.48, $P<.05$] and Goals [$F(2,47)$=8.39, $P<.01$] subscales.
				Therapist version: Cronbach's alpha= .88–.93 Patient version: Cronbach's alpha= .88–.91 Patient and therapist ratings on the WAI after Session 3	
Mohl et al. (1991)	80 outpatients seeking psychotherapy	four senior faculty psychiatrists	initial screening interview	HAq and OSD after the initial screening interview	Higher alliance ratings are related to therapist being warm and friendly (t=−2.41, P .02).
Najavits and Strupp (1994)	80 outpatients recruited through newspaper announcements	16 experienced psychodynamic therapists with at least 2 years postdegree experience (8 psychiatrists and 8 psychologists)	time-limited dynamic psychotherapy (25 sessions)	Helping Alliance Scale (HA)	Higher alliance ratings are related to increased warmth/friendliness (F=4.34, P=.01); affirming/ understanding (F=4.91, P=.05), and decreased belittling/blaming (F=5.03, P=.05) and attacking/ rejecting (F=6.00, P −.03).
				VPPS VNIS VTSS SASB Independent observer ratings on the HA and VNIS at Session 3 and VPPS, VTSS, and SASB at Sessions 3 and 16	

Table 1 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
Price and Jones (1998)	30 outpatients	15 psychodynamic therapists (8 psychiatrists, 6 psychologists, and 1 psychiatric social worker with an average of 6 years, range=1–19 years, of private practice experience)	brief psychodynamic psychotherapy treatment	CALPAS: Cronbach's alpha=.96	CALPAS total alliance score is related to CALPAS Therapist Understanding scale (r=.76, P<.001), CALPAS is related to PQS items "therapist communicates with patient in a clear, coherent style" (r=.24, P<.05), "therapist adopts a supportive stance" (r=.22, P<.05), and "therapist is sensitive to patient's feelings, attuned to patient; empathic" (r=.21, P<.05).
				PQS External ratings on the CALPAS and PQS from Sessions 5 and 14	
Saunders (1999)	268 outpatient cases	not reported	unstructured and open-ended individual psychotherapy (median length of treatment=26 sessions)	TSR: coefficient alpha=.62–.82	RIn is related to TCI (r=.28, P<.001) and Patient Remoralized (r=.38, P<.001). Session Quality is related to TCI (r=.43, P<.008), RIn (r=.28, P<.008), and TD (r=−.29, P<.008).
				patient ratings on the TSR from Session 3	

2.2. 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 review is to explore the application of therapeutic techniques that increase the therapist's ability to identify with the patient and the patient's ability to identify with the therapist. This includes, but is not limited to the therapist ability to develop an affiliative atmosphere within the nucleus of the therapeutic setting. Creating an environment in which the patient and therapist are working together with one another requires contributions from both participants. Therapists who work toward cultivating a comfortable (and productive) therapeutic environment are expected to be rated by patients, external observers, and themselves as having strong alliances. The studies in this section of the review specifically explore the therapist application of techniques that contribute positively to the alliance. It is predicted that therapist interventions that contribute positively to the alliance will demonstrate to the patient an investment in the treatment process, help the patient attach to the treatment, and deepen therapeutic understanding (Freud, 1913).

The findings of several studies suggest that more responsive and collaborative therapist activities often lead to the growth of a positive alliance. Working on the development of measures of the helping alliance in psychotherapy, Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen (1983) compared the ratings of external judges for counting signs of therapist behaviors that facilitate or inhibit alliance growth with external ratings of the helping alliance both early and late in treatment. The authors reported that therapist's helping and "we" behaviors that were found to facilitate the development of an alliance included communicating a sense of hope for patients to achieve their goals, noting patient progress toward goals, understanding, accepting, and respecting patients, being open-minded and enthusiastic, referring to common experiences between the patient and therapist, conveying a feeling of working together in a shared effort against the patient's anguish, communicating a trust in the patient's growing ability to use what has been learned in treatment, as well as facilitating the use of healthy defenses and supportive activities. Similar findings were reported by Allen et al. (1996) using supportive–expressive (SE) psychotherapy. The authors examined sessions from various points in treatment and reported that higher proportions of interpretation and clarification were associated with higher ratings on the HAq patient collaboration subscale.

Saunders, Howard, and Orlinsky (1989) set out to develop a scale to measure the patient's perspective of the therapeutic relationship early in treatment (Session 3 or 4). The authors conceptualized the therapeutic relationship as consisting of three dimensions—investment, understanding, and acceptance. Saunders et al. assessed the therapeutic relationship using four scales that consisted of items taken from the TSR (Orlinsky & Howard, 1986), the Working Alliance scale (WA), Empathic Resonance scale (ER), Mutual Affirmation scale (MA), and Global Bond (GB) scale. Saunders et al. reported that the GB scale was significantly related to all three scales (WA, ER, and MA). In addition, the WA scale was positively correlated with the MA scale and the MA scale was positively correlated with the

ER scales. In general, it was found that in sessions rated highly by patients they felt understood by their therapist, that their therapist expressed her/himself well, and that s/he was genuinely invested in the process. The authors concluded that a therapeutic relationship consists of both investment of personal energy (i.e., WA) and relational variables (i.e., ER). A methodological advantage of the scales utilized in this study was that items were grouped conceptually and then subjected to psychometric modification to obtain high reliability and validity. However, a potential methodological limitation of this study was that the ratings were from only one point early in treatment.

As described earlier, Mohl et al. (1991) reported that higher alliance ratings were related to therapist warmth and friendliness. The authors also found that intake interviewers with higher helping alliance averages were seen as more active, explorative, and potent compared to intake interviewers with lower helping alliance averages. One of the aspects of activity and potency described by the authors included the therapist leading a discussion with the patient about the psychotherapy process that emphasized the patient could be helped but that it would require hard work from both the patient and therapist. This particular activity may help to ensure that the patient understands the therapy process and assess whether s/he is comfortable with the demands of therapy.

Bachelor (1991) used the Penn Helping Alliance Rating Method (PENN; Morgan, Luborsku, Crits-Christoph, Curtis, & Solomon, 1982), Therapeutic Alliance Rating System (TARS; Marziali, 1984), and the VPPS (Gomez-Schwartz, 1978) to compare patient's and therapist's perceptions of what constitutes the alliance in various types of treatment at Sessions 3 and 10. Both patient's and therapist's ratings at Sessions 3 and 10 revealed a significant positive relationship between the therapeutic relationship being a joint or team effort (alliance) and therapist explorative behaviors. This finding was consistent across the PENN Type I (patient experience of receiving help or a helpful attitude from the therapist) and PENN Type II (patients experience of being in a joint or team effort with the therapist) alliances both earlier and late in therapy. These results highlight that the patient and therapist have similar views about the positive impact therapist exploration can have on the development of the alliance early and late in treatment.

Using the Inventory of Therapeutic Strategies (ITS) to measure therapist technique, Gaston and Ring (1992) also reported that increased exploration was related to higher alliance ratings across 15 sessions of psychotherapy (cognitive–behavioral and brief dynamic). Taken together, the findings from these studies (Bachelor, 1991; Gaston & Ring, 1992) suggest that the use of exploratory strategies may communicate an interest in the patient's experience as well as increase feelings of connectedness between the patient and therapist. If a patient experiences the therapist as more engaged, they are more likely to have trust in the therapist and more importantly the therapeutic process. Moreover, patients may perceive the therapist's continued attempts to explore problems as a manifestation of an empathic connection demonstrating warmth and concern.

One study was found that do not support the use of exploration to aid in the development of the alliance (Kolden, 1996). Kolden, assessed the relationship between ratings on the TSR and the Therapeutic Procedures Inventory—Revised (TPI-R; Orlinsky, Lundy, Howard, Davidson, & O'Mahoney, 1987) at the third session of dynamic therapy. It was

reported that therapeutic bond (alliance) ratings from Session 3 were not significantly related to therapist prescriptive interventions (such as suggesting behavior changes, giving explicit advice), as well as exploratory interventions (e.g., focusing on past events, interpreting defenses, and encouraging patient exploration of the meaning behind his/her thoughts, behaviors, or feelings). A possible explanation for these findings is that the ratings are from Session 3 only and the interventions described may be premature for the early sessions of dynamic therapy. Since the author did not present the correlations of bond and therapist interventions from a later phase in treatment it is unclear whether the same interventions used later in treatment would enhance or at least maintain a bond between the patient and therapist.

Crits-Christoph, Barber, and Kurcias (1993) examined the relationship between the accuracy of interpretation and the development of the alliance early and late in the treatment process. The authors used the ratings of two early and two late sessions from independent judges on the Helping Alliance Counting Signs Method (HAcs; Luborsky et al., 1983). These ratings were compared with independent judges' ratings of the accuracy of interpretations of the patients Core Conflictual Relationship Theme (CCRT; Luborsky, 1984). The CCRT contains three key components: a statement of the patient's wish (W), an expected (imagined) or actual response from another (RO), and a subsequent response from self (RS). The W is understood in the context of a real or imagined relationship and the RO is rooted in the context of this wish. The RS includes both the actions/behaviors and the feelings/affect associated with this response (Book, 1998; Luborsky, 1984; Luborsky & Crits-Christoph, 1997). An interpretation was rated as accurate when it addressed the patient's CCRT wishes, responses from others, and responses of self. Since interpretations of the wish and response from other components of the CCRT were found to be highly correlated in this study, the authors combined them into a single composite interpersonal interpretation rating. Alliance early in treatment was not found to be significantly correlated with the alliance later in treatment. In addition, the accuracy of interpretations of the RS component of the CCRT was not found to be significantly related to either early or late alliance. However, the authors did report a significant positive relationship between both early and late alliance with the accuracy of interpretations related to the interpersonal components of the CCRT (W and RO). The authors conducted exploratory analyzes to determine if the significant relationships found were more a function of the W or RO dimension. They found a significant positive relationship between both the W and RO dimensions and the alliance later in therapy. These findings suggest that interpersonal dimensions of a patient's CCRT were more related to the development of a strong alliance than intrapersonal dimensions of a patient's CCRT. Based on these findings, Crits-Christoph et al. concluded that a weak alliance early in treatment may be improved through accurate interpretation of a patient's CCRT later in treatment and that high alliance early in treatment may be maintained through accurate interpretation of the CCRT later in treatment.

As described earlier, Bachelor (1995) completed a qualitative analysis that examined the patient's perspective of the therapeutic alliance. The results also revealed three types of alliance that may help to identify some distinct qualities of the overall therapeutic alliance.

The nurturant type was characterized by therapist facilitative behaviors such as being nonjudgmental, listening attentively, and conveying a feeling of understanding the patient. The collaborative type included therapist contributions such as helping the patient recognize alternate ways to interpret situations as well as a willingness to accept criticism or confrontation within the therapeutic relationship. The therapist's willingness to address these issues and ability to respond nondefensively to them enhanced the patient's trust and feeling of being heard and understood. Therapist contributions to the insight-oriented type included the identification and clarification of patient problems, the facilitation of patient expression of affect, and keeping the patient focused on therapy relevant topics. These findings underscore the influence of therapist's strategic interventions on the development of a positive therapeutic environment.

Dolinsky, Vaughan, Luber, Mellman, and Roose (1998) conducted a study of the therapeutic relationship focusing on the agreement about the quality of the ''goodness of fit'' between the patient and therapist (alliance) and whether this match correlated with other variables such as the therapist verbal activity. Both patients and therapists reported a significant relationship between positive match (alliance) and the therapist being more active in verbal exchanges. These results may be interpreted bidirectionally, meaning that an active therapist facilitates the experience of a positive match and the experience of a positive match may lead to the therapist being more verbally active.

Sexton, Hembre, and Kvarme (1996) examined the interaction of the alliance and therapy microprocesses (i.e., questioning, interpretation, verbal content, emotional content, listening, etc.) using sequential analyses at early, middle, and late phases of cognitively oriented psychotherapy. The results indicated that alliance was formed early in treatment and was maintained in the middle and late phases of treatment by therapist techniques such as the use of reflection, listening, interpreting, questioning, and advising.

Joyce and Piper (1998) used patient and therapist ratings taken before therapy began on a modified version of the Session Evaluation Questionnaire (SEQ; Stiles, 1980) that asked the patient and therapist to respond to the stem ''the typical therapy session will be....'' In addition, the authors used patient and therapist ratings after each session on the SEQ to evaluate the patient's and therapist's experience of sessions. Based on the SEQ ratings the authors calculated an expected and evaluation Depth–Value score (perceived usefulness of the session; valuable, deep, full, powerful, and special) and an expected and evaluation Smoothness–Ease score (perceived comfort of the session; easy, relaxed, pleasant, smooth, and comfortable). In addition, the authors subtracted the SEQ expectancy score from the SEQ evaluation score to obtain a discrepancy score. A positive discrepancy score indicated the session exceeded the initial expectancy, and a negative discrepancy score indicated the session failed to meet the initial expectations. To rate the alliance, the authors had patients and therapists independently rate 6 seven-point items. Four items were rated immediately after each session and addressed whether the patient felt understood by the therapist, was able to understand the therapist's intervention, and how the patient experienced the usefulness of the session. The remaining two items were rated reflectively after Sessions 7, 14, and 20. These two items addressed the collaboration and helpfulness of the session. The ratings on the alliance questions were aggregated together to form

patient impression score, a therapist immediate impression score, and a therapist reflective impression score.

The authors reported a significant positive relationship between the patient-rated impression of the alliance and the patient expectancy Depth–Value (usefulness) rating; a significant positive relationship between the therapist-rated immediate impression of the alliance and the therapist expectancy Depth–Value rating. In other words, both the patient and therapist expectancy of usefulness were found to be significantly related to the alliance. These findings suggest that starting therapy with the expectation that it will be useful may positively influence the actual experience of therapy as useful and increase the development of an alliance. A significant positive relationship was also reported between the therapist-rated reflective impression of the alliance and therapist expectancy Smoothness–Ease (comfort) rating. In other words, if the therapist feels s/he will be comfortable in the session, the overall perceptions of the treatment relationship will likewise be positive.

Similar results were reported in a recent study examining the relationship between therapist technique and alliance during the assessment phase of treatment (Ackerman, Hilsenroth, Baity, & Blagys, 2000). The authors reported that patients rated the assessment as more positive on the SEQ when therapists worked toward developing and maintaining an empathic connection, interacted collaboratively with patients to develop individualized goals, and explored assessment results with patients. Moreover, it was reported that patient's experience of the assessment as deep and positive was related to the patient's experience of a positive working alliance.

Svenson and Hanson (1999) reported comparable results assessing the therapeutic alliance in the initial phase of cognitive treatment. Specifically, they reported patient's rating of the therapeutic alliance was significantly correlated with the SEQ Depth index. Taken together, these findings help to further expand the understanding of the interaction between the therapeutic alliance and process in various types of treatment. They suggest that increased exploration of salient interpersonal themes in a powerful, valuable, deep, full, and special way, regardless of treatment modality, may increase the patient's experience of a positive alliance with the therapist.

Crits-Christoph et al. (1998) compared the effects of training in Cognitive (CT), SE, and Individual Drug Counseling (IDC) therapies on the treatment and development of alliance with cocaine-dependent patients. The authors measured the alliance using ratings from clinical supervisors and independent judges at Sessions 2, 5, and 24 on the Helping Alliance Questionnaire—Revised (HAq-R; Luborsky et al., 1996) and the CALPAS (Gaston, 1991). They reported no significant linear changes in the SE or IDC types of treatment on either alliance measure. However, they did find a significant training effect over sessions for CT on the HAq-R, CALPAS total score, CALPAS Working Strategy subscale, and the CALPAS Therapist Understanding subscale. The specific therapist behaviors used in the CT therapy included guided discovery, focusing on essential cognitions, planning for change, and homework. These findings suggest that over the course of CT treatment the alliance may be further developed through the therapist's understanding of how different interventions might impact cocaine-dependent patients.

In a recent study describing the use and validity of a new measure of psychotherapy process (Interpretive and Supportive Technique Scale, ISTS), Ogrodniczuk and Piper (1999) examined the relationship between therapist adherence to treatment guidelines and the strength of the alliance. The authors measured the degree of therapist adherence to therapeutic strategy using the ISTS as well as two other measures of therapist technique, the Therapist Intervention Rating System (TIRS; Piper, Debbane, deCarufel, et al., 1987) and the Perception of Technique Scale (PTS; Piper, Joyce, McCallum, et al., 1993). They tested the hypothesis that greater adherence to treatment guidelines in a form of short-term psychodynamic psychotherapy would lead to a stronger alliance. In addition, they investigated whether the amount of technique used in treatment would have a curvilinear relationship with alliance. The authors utilized both therapist's and patient's ratings of the alliance taken after each session on 6 seven-point Likert-type questions focusing on the patient feeling understood, whether or not the therapist was helpful, and whether the patient and therapist worked well together. Ogrodniczuk and Piper reported that the adherence and amount of interpretive technique was significantly related (positively) to therapist-rated alliance. They also found that across all cases, adherence to supportive technique was positively related to the strength of the alliance. However, no significant curvilinear relationships were found between the amount of technique and either patient- or therapist-rated alliance.

Therapist's application of techniques that convey support, 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 have been found to aid in the development and maintenance of the alliance (see Table 2). The studies reviewed in this section underscore the importance of exhibiting a sense of understanding (Allen et al., 1996; Bachelor, 1991; Crits-Christoph et al., 1998; Gaston & Ring, 1992; Mohl et al., 1991) and fostering greater session depth (Ackerman et al., 2000; Price & Jones, 1998; Svenson & Hansson, 1999) in the development of a positive alliance earlier in treatment. Although most of the evidence presented in this section supports the goal of the therapist being engaged with the patient to aid in developing the alliance (Dolinsky et al., 1998; Gaston & Ring, 1992; Saunders et al., 1989; Sexton et al., 1996), one study (Kolden, 1996) 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 (1996) study the ratings were taken only 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 and connectedness in the therapeutic process a greater sense of partnership and trust may transpire in the therapeutic relationship (Coady & Marziali, 1994; Crits-Christoph et al., 1998; Joyce & Piper, 1998; Price & Jones, 1998; Saunders et al., 1998). The therapist's ability to form a relationship with the patient 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 treatment process.

Table 2
Summary of therapist application of technique that contribute positively to the alliance

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
Ackerman et al. (2000)	38 outpatients seeking services at a university based psychological clinic	10 advanced doctoral students enrolled in an APA approved clinical PhD program	psychodynamic psychotherapy	Combined Alliance Short Form (CASF): Cronbach's alpha=.84−.91	Patient SEQ Bad/Good ratings are related to CASF total score (r=.71, P<.0001), the HAq-R (r=.70, P<.0001). CASF total score is related to SEQ Depth ratings (r=.66, P<.0001) and Positivity ratings (r=.64, P<.0001). HAq-R total score is related to SEQ Depth ratings (r=.59, P<.0001) and Positivity ratings (r=.62, P<.0001).
				Penn HAq-R: Cronbach's alpha Session 3−.91 Session 9−.88 SEQ Patient and therapist ratings on the CASF and SEQ after assessment feedback session; patient and therapist ratings on the CASF and HAq-R after Sessions 3 and 9	
Allen et al. (1996)	39 patients diagnosed with borderline personality disorder	experienced therapists from three different psychotherapy research centers	open-ended SE psychotherapy	Menninger Global Collaboration scale: intraclass reliability coefficient=.72	Menninger Global Collaboration scale is significantly related to Interpretation (r=.43, P<.01) and Clarification (r=.45, P<.01).

Table 2 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
				HAq: intraclass reliability coefficient=.83 and .71	HAq Type 1 alliance is significantly related to Interpretation (r=.35, P<.05) and Type II alliance is significantly related to Interpretation (r=.38, P<.05).
Bachelor (1991)	47 self-referred clients seeking outpatient services at a university counseling center	23 master's level students in a first-year practicum	Treatment is dependent on supervisors' therapeutic orientation (39% humanistic–existential, 22% humanistic, 17.5% analytic, 17.5% bioenergetic, and 4% cognitive–behavioral)	PENN: Cronbach's alpha=.91	Therapist PENN Type I alliance ratings are related to VPPS therapist exploration (r=.57, P>.0007), warmth/friendliness (r=.82, P>.0007), patient PENN Type I alliance ratings are related to VPPS therapist exploration (r=.61, P<.0007), warmth/friendliness (r=.66, P<.0007). Patient PENN Type II alliance ratings are related to VPPS therapist exploration (r=.61, P<.0007), warmth/friendliness (r=.56, P<.0007). Therapist rating on TARS therapist positive scale is related to VPPS therapist exploration (r=.69, P<.007), patient rating on TARS therapist positive scale is related to VPPS therapist exploration (r=.77, P<.007), warmth/friendliness (r=.68, P<.007), patient rating on TARZ therapist positive scale is related to VPPS

					therapist warmth/friendliness (r=.82, P<.007).
				TARS: Cronbach's alpha=.18–.93 VPPS: Cronbach's alpha=.65–.95 Patient and therapist ratings on the PENN, TARS, and VPPS from Sessions 3 and 10	
Bachelor (1995)	34 self-referred outpatients	23 master's level psychology trainees being trained in a broad range of therapies	Treatment was dependent on supervisors' orientation (36.4% cognitive–behavioral, 36.4% humanistic–existential, 15.1% analytic, and 12.1% gestalt)	Open-ended self-report inquiry of patient's perception of the alliance (pretherapy, initial session, and at a later phase)	Three types of alliance are found: nurturant (nonjudgmental, listening attentively, understanding), collaborative (helping patient recognize alternative ways to interpret situations and willing to accept criticism), and insight-oriented (identification and clarification of patient problems, facilitate expression of affect, keeping patient focused on therapy topics).
Crits-Christoph, Barber, and Kurcias (1993)	33 outpatients	25 psychiatrists (33% psychoanalytic and 66% eclectic) utilizing	brief psychodynamic psychotherapy	HAcs	Early alliance is not related to late alliance (r=.16, n.s.); late alliance is related to accuracy of wish and response of other (r=.52, P<.005) but not to response of self (r=.06, n.s.).
				two independent judges ratings of two early and two late sessions	

Table 2 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
				accuracy of Core Conflictual Relational Theme interpretation (wish, response of other, response of self) three independent judges ratings of two early and two late sessions	
Crits-Christoph et al. (1998)	202 cocaine-dependent outpatients	65 therapists: 20 CT, 25 SE, and 20 IDC	CT (based on Beck's cognitive model), SE therapy (a psychodynamic treatment derived from Luborsky), and IDC (based on the 12-step addiction model)	HAq-R	Reported no significant training effect for SE or IDC on alliance, with significant training effect over session of CT on HAq-R total score (*P*<.0001), CALPAS total score (*P*<.01), CALPAS Working Strategy subscale (*P*<.05), and CALPAS Therapist Understanding subscale (*P*<.0005).
				CALPAS CT Scale Penn Adherence and Competence Scale for SE therapy Adherence and Competence Scale for Addiction Counseling Independent judges ratings at Sessions 2, 5, and 24	

Dolinsky et al. (1998)	50 undergraduate and graduate students referred by student health services for long-term psychodynamic psychotherapy	31 psychiatric residents being supervised in psychoanalytic treatment	twice weekly, open-ended psychodynamic psychotherapy	Questionnaire was designed to assess (a) attitude toward the therapy and therapist (or patient) and (b) perceptions of similarities and differences between therapist and patient in terms of characterological traits such as humor or cognitive style	Found a positive match between therapist activity and patient responses (χ^2=10.9, P=.001, r=.48) as well as therapist responses (χ^2=4.0, P=.05, r=.28).
Gaston and Ring (1992)	16 outpatients diagnosed with current major depressive disorder	four therapists (two cognitive–behavioral and two dynamic)	cognitive–behavioral guided by Beck or manualized brief dynamic therapy	CALPAS: ICC (2,3)−.72	CALPAS total score is related to ITS exploration scale (r=.65, P<.01).
				Therapist Understanding and Involvement Scale: ICC (2,3)−.61 ITS cognitive–behavioral: ICC (2,2)=.61–.98 Brief Dynamic: ICC (2,2)=.21–.91 clinical judge's ratings from Sessions 5, 10, and 15	
Joyce and Piper (1998)	64 outpatients	three psychiatrists, one psychologist, and four social workers with an average of 11.5 years individual practice	time-limited dynamically oriented therapy	To measure alliance, patients and therapists rated therapeutic relationship after each session on six questions related to helpfulness, understanding, and the quality of the treatment relationship	Patient expectancy of usefulness is related to patient-rated alliance (r=.46, P<.001). Therapist expectancy of usefulness is related to therapist immediate impression of alliance (r=.46, P<.001);

Table 2 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
					therapist expectancy of comfort is related to therapist reflective rating of alliance (r=.42, P<.001).
				Patient and therapists completed a modified version of the SEQ (the typical therapy session will be...) prior to the start of therapy and the SEQ after each session (total of 20 sessions)	
Kolden (1996)	self-referred outpatients seeking individual psychotherapy	86 psychodynamic therapists at a center for clinical training in psychiatry (psychology practicum students, psychology interns, and psychiatric residents)	dynamic therapy guided by a generic model (traditional drive theory, ego analytic, or object relations)	TSR: Cronbach's alpha=.62–.80	Therapeutic Bond was found to not be prescriptive (r=−.038, n.s.), exploratory with a past focus (r=.002, n.s.), or exploratory experiential (r=.255, n.s.).
				TPI-R Independent judge's ratings of Session 3	
Luborsky et al. (1983)	20 outpatients (10 most improved and 10 least improved)	18 experienced psychiatrists	SE psychoanalytic psychotherapy	HAcs	Early HArm ratings are related to early TFB ratings (r=.85, P<.001), early HArm ratings are related to late TFB ratings (r=.76, P<.001), and late HAcs ratings are related to late TFB ratings (r=.80, P<.001).
				Helping Alliance rating method (HArm)	

				Therapist Facilitating Behaviors (TFB) Independent judges of Sessions 3, 5, and the session at which 90% of the treatment was completed	
Mohl et al. (1991)	80 outpatients seeking psychotherapy	four senior faculty psychiatrists	initial screening interview	HAq and OSD after the initial screening interview	Higher alliance ratings are related to therapist being active ($t=2.32$, $P<.03$) and potent ($t=-2.93$, $P<.005$).
Ogrodniczuk and Piper (1999)	144 outpatient sessions	eight therapists	short-term, time-limited psychotherapy emphasizing interpretive, or supportive interventions	to measure alliance patients and therapists rated therapeutic relationship on six questions related to helpfulness, understanding, and the quality of the treatment relationship

ISTS
TIRS
PTS
Independent judge's ratings on ISTS, TIRS, and PTS | Adherence to interpretive technique is related to alliance in interpretive cases ($r=.23$, $P<.05$), amount of interpretive technique is related to alliance in interpretive cases ($r=.36$, $P<.01$), and amount of supportive technique is related to alliance across all cases ($r=.18$, $P<.05$). |
| Saunders et al. (1989) | 113 psychotherapy outpatients | 80 therapists in some stage of training (psychology practicum students, psychology interns, psychiatric residents) with previous clinical experience | individual psychodynamic psychotherapy (median sessions attended=26) | TSR | GB subscale is related to WA subscale ($r=.70$, $P<.001$), ER subscale ($r=.65$, $P<.001$), and MA subscale ($r=.88$, $P<.001$). WA subscale is related to MA subscale ($r=.51$, $P<.001$). |

Table 2 (*continued*)

Study	Participants	Therapist	Treatment	Instruments and raters	Findings
				WA: Cronbach's alpha=.72 ER: Cronbach's alpha=.77 MA: Cronbach's alpha=.87 Patient ratings from Sessions 3 or 4	
Sexton et al. (1996)	32 outpatients referred by their primary physician for psychotherapy	10 therapists (5 psychiatrists, 2 clinical psychologists, 2 psychiatric social workers, and 1 master's-level psychiatric nurse); all therapist had psychodynamic training, 8 identified themselves as eclectic, and 2 were primarily cognitively oriented	time-limited unstructured therapy (10 sessions) from various orientations	WAI rated by patient after each session (total of 10 sessions): Cronbach's alpha=.96	Therapist listening in the beginning phase of treatment indicates an increase in alliance (odds ratio*=1.34). Therapist interpretation and reflection during middle phase of treatment indicates an increase in alliance (odds ratio*=1.83 and 2.36, respectively). Therapist informing–advising during the end phase of treatment indicates an increase in alliance (odds ratio*=2.40).

				sessions therapy content (emotional and verbal) and therapy form (activities and topics) rated by independent judges	
Svensson and Hanson (1999)	26 inpatients who had been discharged to supervised apartments	experienced psychiatric nurses with a degree in CT	CT in the context of milieu and group therapy	Therapist ratings of the alliance on the Psychotherapy Status Report	Therapist alliance ratings are correlated with SEQ Depth (r=.57, P<.01) and Smoothness (r=.46, P<.01). Patient alliance ratings are correlated with SEQ Depth (r=.69, P<.001) and Smoothness (r=.59, P<.01).
				patient ratings of the alliance on questions focused on the collaboration with the therapist	
				patient ratings of the session process using the SEQ	

Odds ratios >1.0 indicate an increase in the sessions.

3. Conclusions

The studies included in this review suggest that the therapist's personal attributes and the use of therapeutic technique from a range of psychotherapy orientations have been found to positively influence the development and maintenance of the therapeutic alliance. Table 3 summarizes the therapist's personal attributes and techniques that were reported to be important in the development and maintenance of a strong alliance. They include trustworthiness (Horvath & Greenberg, 1989), experience (Mallinckrodt & Nelson, 1991), confidence (Saunders, 1999), lucid communication (Price & Jones, 1998), and accurate interpretation (Crits-Christoph et al., 1993; Ogrodniczuk & Piper, 1999). The therapist's investment in the treatment relationship was found to be manifested through enthusiasm (Luborsky et al., 1983), interest (Saunders, 1999), exploration (Allen et al., 1996; Bachelor, 1991; Gaston & Ring, 1992; Joyce & Piper, 1998; Mohl et al., 1991), involvement (Sexton et al., 1996), and activity (Dolinsky et al., 1998; Mohl et al., 1991). The key elements of empathy found in this comprehensive review include affirming (Najavits & Strupp, 1994), helping (Coady & Marziali, 1994), warmth/friendliness (Bachelor, 1991; Saunders et al., 1989), and understanding (Bachelor, 1995; Crits-Christoph et al., 1998; Diamond et al., 1999; Najavits & Strupp, 1994; Price & Jones, 1998; Saunders et al., 1989).

We found very little variation between the different theoretical orientations regarding the therapist's positive impact on the alliance. A possible explanation for the consistency is that many of the therapist's techniques identified emphasize focusing on the therapeutic interactions occurring between the patient and therapist within the context of the treatment session. Another possible explanation comes from the work of Frank (1974) who proposed that if a variety of treatments generate similar findings, there must be therapeutic elements that are common to all treatment approaches. A potential core of these elements is a connection (therapeutic alliance) between two people that provides the opportunity for relief from suffering. The evidence found in this review 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 certain patient populations, the

Table 3
Summary of therapist's attributes and techniques found to contribute positively to the alliance

Personal attributes	Technique
Flexible	Exploration
Experienced	Depth
Honest	Reflection
Respectful	Supportive
Trustworthy	Notes past therapy success
Confident	Accurate interpretation
Interested	Facilitates expression of affect
Alert	Active
Friendly	Affirming
Warm	Understanding
Open	Attends to patient's experience

findings from the present review suggest that many therapeutic pursuits can benefit from a focus on the factors contributing to a positive alliance.

It is interesting to note that the research identifying the therapist's significant contributions to the development and maintenance of the alliance are similar to the features identified as useful in the identification and repair of ruptures in the alliance. The research focused on ruptures in the alliance support the notion that ruptures are an expected part of the treatment process and argue for the use of ruptures as fertile ground for patient change and an opportunity for deepening the alliance (Safran & Muran, 2000). The resolution of ruptures in the alliance begins with the therapist acknowledging and disclosing his/her contribution to the rupture experience. To successfully manage the resolution of ruptures in the alliance, Safran and Muran (1996, 2000) 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, affirming, and understanding (Ackerman et al., 2000; Bachelor, 1991, 1995; Joyce & Piper, 1998; Najavits & Strupp, 1994; Saunders, 1999; Svenson & Hansson, 1999) may contribute to the development of a stronger alliance.

Although the present review focuses on the therapist's contributions to alliance, it is critical that we not lose sight of the equally important role patients play in the development of the therapeutic relationship. Moreover, it is likely that the most promising strategy for future research may be to examine the interpersonal exchanges between the patient and therapist that impact alliance development. Investigating these in-session interactions may deepen our understanding of the nature of alliance development and the specific variables impacting it. Future researchers should work toward integrating quantitative and qualitative analyses of the interactions between patients and therapists to present a clinically meaningful picture of the data.

A potential limitation of the present review is the limited critical evaluation of methodological issues of the studies reviewed. Many of the studies reviewed utilize correlational analyses that can be influenced by confounds, rater biases, and at times difficult to interpret accurately. More specifically, direction of causality errors are important in that feeling positive about the alliance may influence therapist's judgments about patients as well as patient's judgments about the therapist. Those studies that utilize independent judges to rate the alliance may avoid this potential issue. However, the limitation inherent in using independent judges to rate the alliance is that they may be less attuned to the nuances that often occur between the patient and therapist within the interior of the treatment room. Therefore, it is possible that they may not be as accurate in their appraisal of the patient–therapist interaction or each of these individuals beliefs concerning the relationship (positive or negative).

Halo effects are also potential confounds when measures of therapist characteristics and alliance are assessed by the same person. In addition, many of the studies in this review assessed the relationship between alliance and therapist activity at a single point in the treatment (typically early or late). This may limit the external validity of these findings and our understanding of this complex relationship. Moreover, as others have pointed out a single assessments of the perception of the treatment relationships may not be representative of

perception throughout the course of treatment (Bachelor & Salame, 2000). It would be important for future studies to more categorically assess these and other methodological issues that are beyond the clinically applied scope of the present review.

In summary, the present review has identified that therapist's personal qualities and use of technique are positively related to development and maintenance of the alliance during the general course of therapy. In addition, this review links therapist's personal attributes and techniques with the identification and resolution of ruptures in the alliance. Since the alliance has already been established as one of the essential variables in a positive treatment outcome (Horvath & Symonds, 1991; Martin et al., 2000), knowing the key components that help to build a healthy alliance may lead to even more positive outcomes and increased opportunities for patient change.

A greater understanding of the therapist's contributions to alliance that include personal qualities and therapeutic techniques may better equip clinicians to design and implement specific methods to cultivate better alliances with their patients. While the findings of this review do not provide the clinician with a prescriptive manual to develop a strong alliance, they do provide a synthesized understanding of the relationship between the therapist and the alliance. Having a greater understanding of this relationship may lead to better-trained therapists and possibly greater therapeutic successes. Future research may take this under-standing even further and explore how to integrate these findings into existing training principles. In conclusion, we feel that the present review provides researchers and clinicians alike with information that brings them closer to answering the question "What impact does the therapist have on the alliance?"

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