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

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A REVIEW OF THERAPIST CHARACTERISTICS AND TECHNIQUES NEGATIVELY IMPACTING THE THERAPEUTIC ALLIANCE

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The present review is a comprehensive examination of the therapist's personal attributes and in-session activities that negatively influence the therapeutic alliance from a broad range of psychotherapy perspectives. Therapist's personal attributes such as being rigid, uncertain, critical, distant, tense, and distracted were found to contribute negatively to the alliance. Moreover, therapist techniques such as over structuring the therapy, inappropriate self-disclosure, unyielding use of transference interpretation, and inappropriate use of silence were also found to contribute negatively to the alliance. In addition, this review reveals how therapist's personal qualities and use of technique have a similar influence on the identification or exacerbation of ruptures in the alliance.

Introduction

Originally, the therapeutic alliance was believed to be positive transference from the patient toward the therapist (Freud, 1913). Since that time, the therapeutic alliance has developed into one of the most important variables in the understanding of psychotherapy process and outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Orlinsky, Grawe, & Parks, 1994). However, an area of research that has been less addressed is the relationship between the alliance and the therapist's personality variables as well as therapist use (or misuse) of therapeutic techniques and interventions. Moreover, findings from the studies conducted have not been integrated in a manner that helps clarify the relationship between the alliance and specific personal attributes or technical interventions of the therapist.

Binder and Strupp (1997) reviewed the literature focused on "negative process" and outcome in individual psychotherapy of adults. The authors traced the history of negative process throughout the literature and concluded that negative process (i.e., alliance rupture) was unavoidable in the course of treatment regardless of the theoretical approach. The authors pointed out that positive treatment outcomes rely on the therapist's capacity to recognize and effectively control negative process in order to preserve a positive therapeutic relationship. In many cases severe ruptures in the alliance can impede the continued growth of the therapeutic relationship and, at times, lead to premature treatment termination.

In the development of the Vanderbilt Therapeutic Alliance Scale (VTAS), a measure designed to assess patient and therapist contributions to the alliance, Hartley and Strupp (1983) identified specific therapist intrusive behaviors that negatively impact the alliance. These intrusive behaviors include the therapist imposing his or her own values, fostering dependency, making irrelevant comments, and utilizing inappropriate interventions. The authors recommended that future research explore how these behaviors impact the

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relationship between the patient and therapist, as well as assess the process variables that influence fluctuations in the alliance.

Brossart, Willson, Patton, Kivlighan, and Multon (1998) explored alliance fluctuations in short-term psychoanalytic therapy dyads in an attempt to develop a general model of the alliance. The authors hypothesized that therapist's perception of the alliance would impact the patient's perception of the alliance. This hypothesis was supported, and they concluded that therapist's perceptions of the alliance in early sessions contributed significantly to patient's perceptions of the alliance in subsequent sessions. Specifically, they reported that "negative counselor perceptions of the working alliance, if accepted or left unnoticed may adversely affect the ability of the counselor and client to develop a healthy working alliance and ultimately damage the therapeutic endeavor" (p. 203).

These studies identify the therapist's global (i.e., perception of the alliance) and specific (i.e., making irrelevant comments) contributions that impede the development of a positive alliance. These studies not only underscore the need for investigating therapist activity that contributes negatively to the alliance, they recommend a direction for this research to follow. Specifically, they suggest that future psychotherapy research may benefit from a review of empirical findings from a variety of therapeutic orientations (i.e., psychodynamic, existential, cognitive-behavioral, family therapy, etc.) to identify the distinctive therapist variables that impede the development and maintenance of a positive alliance, as well as contribute to the emergence of alliance ruptures. The present review is a comprehensive examination of the therapist's personal attributes and in-session activities that negatively influence the therapeutic alliance from a broad range of psychotherapy perspectives. This broad focus on therapist variables in relation to the alliance facilitates a closer examination of the psychotherapy process and is a step toward the integration of past research. It is reasoned that focusing on the therapist's negative contribution to the alliance will not only refine and enhance our understanding of the construct, but 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 obtain a greater understanding of the factors that may impede the development of a strong connection with their patients on the therapeutic journey.

The first step in the present review was a literature search using PsycLit from 1988 to 1999 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 the alliance and some index of therapist variables; (b) the focus of the study had to be identified as specifically examining therapist's personal attributes or technical activity related to the deterioration or disruption of the alliance. This review did 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. These criteria revealed a total of 14 studies investigating the relationship between therapist variables and alliance. The present review will be organized according to therapist attributes and techniques and will include recommendations for future research examining the relationship between therapist activity and alliance.

**Therapist Personal Attributes that Contribute Negatively to the Alliance**

The alliance is one component of the larger therapeutic process and encompasses the interaction between patient and therapist, including their expectations and attitudes about one another. The interaction between the patient and therapist is impacted by the values, beliefs, relational patterns, and expectations each participant brings into the treatment room. While there is common agreement about patient characteristics impacting
therapist characteristics. As Strupp (1980) pointed out, “major decrements to the foundation of a good working alliance are not only the patient’s characterological distortions and maladaptive defenses but—at least equally important—the therapist’s personal reactions” (p. 953). We believe the notion that therapists are well adjusted individuals with little negative contribution to the therapeutic process has been overestimated. Therapists (even those who are very well trained and experienced), like others, often find it difficult to deal constructively with interpersonal conflicts in which they are actively involved (Binder & Strupp, 1997). Therefore, it is important to identify the therapist’s personal characteristics that may lead to the emergence of negative process, disrupt the therapeutic process or obstruct the development of a positive and strong alliance.

Marmar, Weiss, and Gaston (1989) explored the construct validity of the California Therapeutic Alliance Rating System (CALTRAS) through the ratings of brief dynamic psychotherapy sessions for pathological grief. The authors found that therapists who were more rigid, self-focused, critical, and less involved in the psychotherapy process were perceived as less understanding. In addition, these therapists evoked more hostile resistance from their patients and had lower overall alliance ratings. However, a potential limitation of this study was the use of an alliance score averaged across sessions 2, 5, 8, and 11. Using an average alliance score makes it difficult to determine if one phase of the treatment (e.g., beginning, middle, termination) contributed more to the findings than another.

A number of additional studies reported similar patterns of undesirable attributes of the therapists that resulted in the inability to form or maintain a positive alliance. Eaton, Abeles, and Gutfried (1993) reported that across all phases of insight-oriented psychotherapy, therapists with poor alliance ratings were characterized as exploitive, critical, moralistic, and defensive, as well as lacking warmth, respect, and confidence. Examining unstructured psychotherapy from various orientations, Sexton, Hembre, and Kvarme (1996) found a significant relationship between negative alliance ratings and therapists who were rated as uncertain and tense. Likewise, using the Therapy Session Report (TSR) from an early session of unstructured, open-ended treatment, Saunders (1999) investigated the relationship between the patient’s emotional state and his or her perception of the therapist’s emotional state. Saunders found that a patient’s ratings of the overall session quality were lower when the therapist was perceived as distracted, tired, and bored. These findings are congruent with other findings 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 (Price & Jones, 1998).

The studies in this section of the review 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 (see Table 1). 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 (Marmar et al., 1989). There was common agreement among the studies that a poor alliance was 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 (Eaton et al., 1993; Price & Jones, 1998; Saunders, 1999; Sexton et al., 1996). 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. Patients will be less likely to engage in the treatment process with therapists who may remind them of other individuals in their lives with whom they find it difficult to relate. 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 vigorously work toward conveying a respectful, flexible, accepting, and responsive attitude toward their patients.

**Therapist Misapplication of Technique**

An important facet of psychotherapy research has been the identification of techniques used by
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<td>Brossart et al. (1998)</td>
<td>12 cases from a University-based outpatient clinic</td>
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<td>Eaton et al. (1993)</td>
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<td>Marmar et al. (1989)</td>
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<td>Price &amp; Jones (1998)</td>
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<td>Sexton et al. (1996)</td>
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<td>Time-limited unstructured therapy (10 sessions) from various orientations</td>
<td>Patient ratings of Working Alliance Inventory after each session (10 sessions total). Independent judges rated sessions therapy content (emotional &amp; verbal) and therapy from (activities &amp; topics)</td>
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Note: * Odds ratios < 1.0 indicate a decrease in the sessions.
therapists to facilitate the development of the alliance. If carried out appropriately, certain therapist’s techniques can impart a willingness from the patient to explore issues at a deep and potentially meaningful level. However, if carried out incorrectly, these same techniques can lead to negative treatment process and the experience of a weak alliance. This section of the review examines the therapist’s misapplication of techniques that impede the continued development of the alliance and cause the deterioration of an existing strong alliance. It is expected that failure to establish a treatment frame, unyielding use of interpretation, and self-disclosure will interrupt the development or maintenance of a positive alliance.

As described earlier, Marmar et al. (1989) investigated the therapeutic alliance in brief dynamic grief therapy. In addition to the findings presented earlier, the authors reported a significant positive relationship between the therapist’s increased focus on avoidance of important issues and the patient’s hostile resistance. Moreover, the therapist’s unyielding attempts to link a patient’s inappropriate reactions toward the therapist (e.g., “shows hostility toward therapist” and “engages in a power struggle with the therapist,” p. 48) to earlier conflicted relationships with parental figures (transference interpretations) were reported to be significantly and negatively related to patient’s commitment to the treatment process.

A study by Eaton et al. (1993) that was also described earlier, identified a significant positive relationship between a weak alliance and the therapist’s failure to structure the session, failure to address resistance, inflexibility, inappropriate use of silence, and use of superficial and destructive interventions. It is important to note the contradiction between the finding in this study that the failure to address resistance was related to a weak alliance and the finding presented by Marmar et al. suggesting that addressing resistance was related to the patient’s negative experience of the alliance. These diverging results may be due to the amount of time and emphasis placed on addressing resistance as well as the way in which the resistance was addressed. It is also possible that these contradictory findings are the result of methodological differences. Specifically, Eaton et al. (1993) rated sessions from outpatients seeking psychotherapy for general problems, while Marmar and his colleagues rated sessions from outpatients seeking psychotherapy to deal with issues related to loss of a spouse or parent. On the one hand patients seeking therapy to deal with the death of a significant person in their lives may experience a therapist who focuses on resistance as uncaring and inattentive to their problems. On the other hand, patients seeking therapy for general issues may experience a therapist who does not focus on resistance as uncaring and inattentive to their problems. Taken together, these findings suggest that it is important to consider the patient’s presenting problem when attempting to find a balance between disregarding patient resistance and placing too much emphasis on challenging resistance.

Studying the alliance at different points in time-limited psychodynamic psychotherapy, Coady and Marziali (1994) 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. In addition, they found a negative relationship between therapist disclosure (i.e., sharing personal emotional conflicts) and expressing behaviors (i.e., expressing negative sentiments regarding the patient in a way that belittles or blames the patient), and ratings of the alliance early in therapy. Similar results were reported by Price and Jones (1998), who found that therapists who disclosed their own emotional conflicts into the therapeutic setting had significantly lower alliance ratings. Taken together, these results suggest that when the therapist focuses too much on this type of self-disclosure (e.g., sharing personal conflicts) during the treatment process, they may be breaching therapeutic boundaries with the end result being a weaker alliance.

A series of studies by Piper and colleagues (Piper, Azim, Joyce, & McCallum, 1991; Piper, McCallum, Azim, & Joyce, 1993; Piper et al., 1999) focused on understanding and examining the relationship between the use of transference interpretation and the therapeutic alliance. The authors independently aggregated patient and therapist ratings of the alliance taken after each session of short-term, time-limited psychodynamic psychotherapy to form a patient impression score, a therapist immediate-impression score, and a therapist reflective-impression score. Piper et al. (1991, 1993) examined the impact of the therapist’s use of transference interpretations by comparing the patient’s and therapist’s alliance scores with external judges’ ratings on the Therapist Intervention Rating System (TIRS; Piper et
Transference interpretations were defined as focusing on the conflicted dynamics in the current relationship between the patient and therapist, and linking this dynamic to repeated problems that the patient may have had with parental figures in the past. Both studies reported that high concentrations of transference interpretations were inversely related to the therapist's immediate and reflexive rating of the alliance. Piper and colleagues suggested that the excessive, unyielding use of transference interpretations (one out of every five interpretations) may have contributed to a weak alliance. The therapist's perception of a weak alliance may be the result of patients withdrawing in response to the overwhelming amount of attention paid to the transference relationship. The therapist may have reacted to the presence of a weak alliance by increasing the amount of transference interpretation in an attempt to move past a therapeutic impasse. It could also be that the weak alliance may be a byproduct of the interaction between the patient feeling overwhelmed and the therapist feeling pressured.

Similar results were reported by Piper et al. (1999), who compared therapists with low and high patient alliance ratings on external judge's ratings on the Vanderbilt Psychotherapy Process Scale (VPPS; Suh, Strupp, & O'Malley, 1986). The authors reported that the low-alliance-rated therapist group was rated higher on the use of transference interpretations. The authors also described a pattern of interaction between the patient and therapist in the last therapy session attended by patients who were treated by the therapists in the low-alliance group. The interaction started with the patient expressing a wish to leave therapy that may be related to frustration around not having expectations met or increased discomfort around addressing painful issues. The therapist responded by drawing attention to the potential transference issues as well as by making links to other relationships. The patient responded with resistance such as silence or verbal disagreement. The therapist continued to focus on transference issues, and a power struggle developed between the patient and therapist. As the session continued, the patient became increasingly resistant, and the therapist maintained a focused line of inquiry into the transference. By the end of the session, the therapist recommended continued treatment, and the patient reluctantly agreed to return for future sessions. However, the patient did not come for any additional sessions. We can conclude from this interaction that the therapist's unyielding use of transference interpretations, inflexibility, and lack of responsiveness to explore the patient's feelings or the "real" relationship (nontransference) in the room (Greenson, 1967) may have influenced the weakening of the alliance as well as the patient's decision to discontinue treatment. It is important to state here that the therapist's continued focus on the transference relationship is not necessarily the same as focusing on the treatment relationship. Piper and colleagues defined the transference relationship as specific to linking feelings, thoughts, and behaviors in the present moment (patient-therapist) with specific persons from past experiences. However, a focus on the treatment relationship would be specific to the interior of the therapy room and what is happening in the therapeutic moment. To clarify, the authors reported that therapist's emphasis on the transference interpretation, not the treatment relationship per se, was significantly related to the experience of a weaker alliance. This is an important distinction that will be discussed further in the next section of the review.

Ogrodniczuk, Piper, Joyce, and McCallum (1999) also assessed the impact of transference interpretations in manualized short-term dynamic psychotherapy on the alliance. The authors reported mixed findings regarding the frequency and concentration of transference interpretations. Specifically, they reported a significant negative association between the frequency of transference interpretations and patient-rated alliance in patients with low quality of object relations, but not in patients with high quality of object relations. Conversely, a significant positive association was reported between the frequency of transference interpretation and therapist-rated alliance with high quality of object-relations patients, but not in patients with low quality of object relations. However, no significant findings were reported between the frequency or concentration of transference interpretations and patient- or therapist-rated alliance when both the high and low quality of object-relations patients were grouped together. Similar to Piper et al. (1991, 1993), this study reported that the patient's quality of object relations (high or low) was a moderating variable in the use of transference interpretation. These findings highlight the importance of the therapist's need to accurately assess the patient's qual-
ity of object relations in order to be able to modu-
late the amount and intensity of transference inter-
pretation that she or he provides to patients. It is
clear that with some patients, too much trans-
ference interpretation detracts from the therapist’s
effectiveness and weakens the alliance.

A limitation of the previous three studies was
the use of a composite rating of the therapist’s
interventions, which did not allow the authors to
control for the possibility that the phase of treat-
ment impacted the results. It is unclear if one
phase of the treatment (e.g., early or late) may
have contributed more to the findings than an-
other. It may be that the use of transference inter-
pretations early in treatment may be less appropri-
ate and aversive compared to the later phases of
treatment. Another potential limitation of these
studies was the fact that the accuracy of the inter-
pretations was not assessed. Evidence exists to
support the conclusion that accurate interpreta-
tions are related to a positive alliance (Crits-
Christoph, Barber, & Kurcias, 1993) and positive
treatment outcomes (Crits-Christoph, Cooper, &
Luborsky, 1988). Therefore, the negative rela-
tionship reported between alliance and the amount
of transference interpretations may also be associ-
ated with the inaccuracy of the interpretations
provided.

As expected, the studies reviewed in this sec-
tion identified that the therapist’s misuse of cer-
tain therapeutic strategies adversely affects the
alliance (see Table 2). These strategies include
therapist inflexibility in treatment planning, inap-
propriate use of silence (Eaton et al., 1993), plac-
ing too much emphasis on patient resistance
(Marmar et al., 1989), self-disclosure of thera-
pist’s focus on the patient’s interpersonal func-
tioning. Castonguay and his colleagues examined
Newman, & Hayes, 1989) to measure the thera-
pestim of Therapist Feedback (CSTF; Goldfried,
Price & Jones, 1998), and unyielding
use of transference interpretation (Ogrodniczuk

While the misapplication of technique by ther-
apists is generally related to technical strategies,
it is important not to underestimate the relational
impact these misapplications may have on the
alliance. It is likely that patients who interact with
a therapist who makes these technical errors will
feel less connected, less understood, and less will-
ing to commit to the therapeutic relationship. The
development and support of a strong alliance may
serve as a springboard for patient change as well
as provide the therapist the opportunity to use a
range of different therapeutic interventions. How-
ever, the therapist’s inappropriate use of thera-
peutic strategies can decrease the likelihood of a
positive therapeutic relationship and reduce the
opportunity for patient change.

**Therapist Behaviors Producing Ruptures in the
Alliance**

This section of the review discusses research
focusing on ruptures or breaches in the therapeutic
alliance. Much of the research presented here sup-
ports the idea that ruptures are an expected part
of the treatment process and, subsequently, ar-
gues for the use of ruptures in the alliance as
fertile ground for patient change as well as oppor-
tunities for deepening the therapeutic alliance (for
a detailed description of this topic see: Safran
& Muran, 2000; Watson & Greenberg, 2000). How-
ever, it is important to recognize that for a
rupture in the alliance to be a growth experience
and to be resolved, it must first be recognized as
occurring within the interior of the therapy
relationship. The primary goal of this section is
to present findings related to therapists’ behaviors
proposed to create ruptures in the alliance. More-
over, this section identifies potential markers that
may facilitate the recognition of rupture in the
alliance. All of the studies presented focus on
specific therapist behaviors or responses that lead
to the development or continuation of ruptures in
the alliance.

Using external judges’ ratings on the Working
Alliance Inventory, Castonguay, Goldfried, Wiser,
Raue, and Hayes (1996) examined the impact of
therapist’s use of cognitive therapy strategies with
a sample of depressed patients on the develop-
ment of ruptures in the alliance. The authors also
used external judges’ ratings on the Coding Sys-
tem of Therapist Feedback (CSTF; Goldfried,
Newman, & Hayes, 1989) to measure the ther-
pist’s focus on the patient’s interpersonal func-
tioning. Castonguay and his colleagues examined
randomly selected therapy sessions from the first
half of treatment (between sessions four and
seven) that focused on issues related to interper-
sonal functioning. The sessions with low alliance
ratings contained a number of signs that pointed
to a strain or breach of the alliance including
“the expression of negative sentiment regarding
therapy, avoidance of therapeutic task, and unre-
sponsiveness to the therapist’s interventions” (p.
301). 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 ex-
explore the painful emotion connected to the negative experience. In addition, strains in the alliance were not resolved when therapists focused on how faulty cognitions influence the construction of negative emotions and highlighted the importance of replacing these faulty cognitions. These findings suggest 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 interpersonal problems while encouraging patients to behave in ways that can help them manage their interpersonal problems.

In a series of studies spanning the last decade, Safran and his colleagues (Safran, 1993; Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996, 2000) have extensively examined ruptures in the alliance. Within this body of research, the authors have operationally defined alliance ruptures as well as proposed a therapeutic model to facilitate the recognition and repair of ruptures in the alliance. Ruptures in the alliance are defined as either fluctuations in the quality of the therapeutic relationship or an ongoing problem in establishing an alliance. In general, ruptures are believed to occur when therapists either engage in or refrain from engaging in patient’s maladaptive interpersonal cycles that resemble the patient’s relationships outside of therapy. Alliance ruptures are an expected part of the treatment process and may occur in a number of therapeutic interactions. Markers of tears in the alliance were also 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 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.

Another alliance rupture identification model was proposed by Watson and Greenberg (2000) for experiential therapy. The authors described three types of ruptures that can emerge when the alliance is developing early in treatment. First, patients may experience a difficulty “turning inward to discover and represent their experience in new ways” (p. 178). Second, patients “may question the purpose and value of engaging in therapy, and view it as ineffective in helping them to achieve their goals” (p. 178). Third, patients may have “expectations that diverge from those of their therapist” (p. 178) Watson and Greenberg also described alliance ruptures that arise later in treatment. These included the patient’s refusal to engage in treatment activities or more relational issues related to the therapeutic bond.

An additional rupture identification model was presented in a study conducted by Rhodes, Hill, Thompson, and Elliot (1994), which examined the patient’s memory of resolved and unresolved therapeutic misunderstandings. The participants in this study were therapists-in-training or practicing therapists who contributed data about experiences from their personal treatment. The authors used narrative accounts of past therapeutic misunderstandings, which were categorized as either resolved or unresolved. Resolution was defined as the patient perceiving a satisfactory outcome and feeling able to continue working with the therapist. A misunderstanding was considered unresolved when the patient perceived an unsatisfactory outcome and felt the communication with his or her therapist was diminished.

Rhodes and her colleagues reported that the precipitants of all the misunderstandings reported could be classified as either the therapist doing something the patient did not like or want (e.g., therapist was critical of patient decision, therapist was not attentive to patient, or therapist gave unwanted advice), or the therapist not doing something that the patient expected or wanted (e.g., therapist did not remember important facts, and therapist missed important facts, and therapist missed importance of an issue). Regardless of the outcome, in all of the misunderstandings reported, the patients experienced negative feelings in response to their therapist’s behavior. In the unresolved cases, patients typically suppressed their negative feelings and placed the blame for the therapist’s behavior on themselves. Moreover, in the resolved cases the patients reported that their therapist accommodated (e.g., apologized, accepted responsibility for the problem, or simply changed their behavior). In the cases with unresolved misunderstandings, the patients reported that their therapists were nonresponsive, closed off, nonaccepting, or that they dogmatically maintained their original point of view without taking the patient’s point of view into consideration.

The work of Rhodes and her colleagues differs from the work of Safran and his colleagues as
TABLE 2. Summary of Therapist Misapplication of Techniques that Contribute Negatively to the Alliance

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Therapists</th>
<th>Treatment</th>
<th>Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coady &amp; Marzials (1994)</td>
<td>9 outpatients seeking psychotherapy</td>
<td>Psychodynamically oriented therapists with a minimum of 4 years postgraduate clinical experience</td>
<td>Time-limited (20 sessions) individual psychodynamic therapy</td>
<td>Patient, therapist, and external judges' ratings on the Therapeutic Alliance Rating System (TARS), and the Structural Analysis of Social Behavior (SASB) of sessions 3, 5, and 15</td>
<td>External judge ratings on the TARS negatively related to SASB Therapist Belittling/Blaming Behavior at session 3 ($r = -73$, $p &lt; .01$), session 5 ($r = -88$, $p &lt; .001$), and across all sessions ($r = -71$, $p &lt; .05$). Patient ratings on the TARS negatively related to SASB Therapist Watching/Managing Behavior at session 3 ($r = -85$, $p &lt; .01$). Therapist ratings on the TARS negatively related to SASB Therapist Watching/Managing Behavior at session 3 ($r = -72$, $p &lt; .01$)</td>
</tr>
<tr>
<td>Eaton et al. (1993)</td>
<td>40 cases from a University-based outpatient clinic (12 patients seen for over 40 sessions, 15 patients seen for 20–40 sessions, and 13 patients seen for less than 20 sessions)</td>
<td>Therapists included practicum students, psychology Ph.D. candidates, and Ph.D. clinical psychologists</td>
<td>Individual psychotherapy from a predominantly insight-oriented theoretical orientation as well as client-centered and cognitive-behavioral</td>
<td>External ratings on the Therapeutic Alliance Rating System (TARS) and Vanderbilt Negative Indicator Scale (VNISS) of three 15-minute segments sampled from the 40 cases</td>
<td>TARS Therapist Negative Alliance scale related to VNISS Therapist Errors in Technique scale ($r = .41$, $p &lt; .01$); TARS Therapist Positive Alliance scale negatively related to VNISS Therapist Errors in Technique scale ($r = -71$, $p &lt; .001$); TARS Therapist Negative Alliance scale negatively related to VNISS total score ($r = -37$, $p &lt; .01$) across all cases</td>
</tr>
<tr>
<td>Marmor et al. (1989)</td>
<td>52 outpatients seeking therapy after the death of either a parent or a husband</td>
<td>9 therapists with an average of 9 years post-training clinical experience</td>
<td>12 weekly sessions of brief dynamic psychotherapy with the goal of relieving distress through the transformation from a pathological to a normal grieving process</td>
<td>External judges ratings on the California Therapeutic Alliance Rating System (CALTRAS) for sessions 2, 5, 8, and 11 for each case</td>
<td>CALTRAS Patient Hostile Resistance subscale related to CALTRAS Therapist Negative Contribution ($r = .43$, $p &lt; .01$) across sessions. CALTRAS Patient Hostile Resistance subscale related to discussing avoidance in session ($r = .31$, $p &lt; .05$) and addressing view of therapist ($r = .33$, $p &lt; .05$). CALTRAS Patient Commitment and Patient Working Capacity negatively related to therapist linking patient reaction toward therapist to parents ($r = -50$, $p &lt; .001$)</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Therapists</td>
<td>Settings</td>
<td>Measures</td>
<td>Results</td>
</tr>
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<tr>
<td>Ogrodniczuk et al. (1999)</td>
<td>40 outpatients seeking therapy at a walk-in clinic</td>
<td>8 therapists (3 psychologists, 2 social workers, 2 occupational therapists, and 1 psychiatrist) with an average of 11.8 years post-training experience</td>
<td>Manualized, interpretive, short-term, individual, dynamically oriented psychotherapy (20 weekly sessions)</td>
<td>To measure alliance, patients and therapists rated therapeutic relationship after each session on 6 questions related to helpfulness, understanding, and the quality of the treatment relationship. External judges rating on the Therapist Intervention Rating Scale (TIRS) from sessions 3, 7, 9, 11, 15, and 19 for each of the 40 cases</td>
<td>Patient-rated alliance negatively related to the Frequency of Interpretation for low quality of object-relations patients ($r = -0.41, p &lt; .03$)</td>
</tr>
<tr>
<td>Piper et al. (1991)</td>
<td>64 outpatients seeking therapy at a walk-in clinic</td>
<td>8 therapists (3 psychiatrists, 1 psychologist, and 4 social workers) with an average of 11.5 years of experience</td>
<td>Manualized, short-term, individual, dynamically oriented psychotherapy (20 weekly sessions)</td>
<td>To measure alliance, patients and therapists rated therapeutic relationship after each session on 6 questions related to helpfulness, understanding, and the quality of the treatment relationship. External judges rated the Therapist Intervention Rating Scale (TIRS) from sessions 4, 7, 9, 11, 14, 16, 18, and 20 for each of the 64 cases</td>
<td>Therapist-rated immediate impression of the alliance was negatively related to the proportion of transference interpretation for high quality of object-relations patients ($n = 32; r = -0.36, p &lt; .05$) and the total sample ($n = 64; r = -0.33, p &lt; .01$). Therapist-rated reflective impression of the alliance was negatively related to the proportion of transference interpretation for high quality of object-relations patients ($n = 32; r = -0.51, p &lt; .01$) and the total sample ($n = 64; r = -0.32, p &lt; .01$)</td>
</tr>
<tr>
<td>Piper et al. (1999)</td>
<td>44 outpatients referred from a psychiatric outpatient clinic of a university hospital</td>
<td>8 therapists (3 psychologists, 2 social workers, 2 occupational therapists, and 1 psychiatrist) with an average of 11.8 years post-training experience</td>
<td>Manualized, interpretive, short-term, individual, dynamically oriented psychotherapy (20 weekly sessions)</td>
<td>To measure alliance, patients and therapists rated therapeutic relationship after each session on 6 questions related to helpfulness, understanding, and the quality of the treatment relationship. External judges rating on the Vanderbilt Psychotherapy Process Scale (VPPS)</td>
<td>Low therapist-rated alliance group ($n = 22$) were higher on therapist focus on transference ($M = 1.99, p = .05$) than high-therapist rated alliance group ($n = 22$)</td>
</tr>
<tr>
<td>Price &amp; Jones (1998)</td>
<td>30 outpatients</td>
<td>15 psychodynamic therapists (8 psychiatrists, 6 psychologists, 1 psychiatric social worker with an average of 6 years of private practice experience (range 1–19 years)</td>
<td>Brief psychodynamic psychotherapy treatment</td>
<td>External ratings of the Psychotherapy Process Q-Set (PQS) and California Psychotherapy Alliance Scale (CALPAS) from sessions 5 and 14</td>
<td>CALPAS total alliance score negatively related to PQS item “therapist own emotional conflicts intrude into the relationship” ($r = -0.26, p &lt; .05$)</td>
</tr>
</tbody>
</table>
well as from Watson and Greenberg (2000) in how the alliance rupture was recognized and brought into awareness. In the Rhodes et al. model the patient was left to initiate the expression of his or her negative feelings and identify the rupture in the alliance. The therapist’s role was to follow up on the patient’s feelings and facilitate additional expression. In the other models the therapist’s recognition of the patient’s negative feelings was also highlighted. The therapist has the responsibility to draw attention to the patient’s negative reaction and acknowledge the existence of a breach in the therapeutic alliance. A possible explanation for this difference is the fact that the patients in the Rhodes et al. study were therapists-in-training or actual therapists involved in their own personal psychotherapy. Because a therapist involved in personal psychotherapy is potentially more informed about therapeutic strategy, she or he may be more likely to express negative sentiments toward his or her therapist if the therapeutic needs are not being met. An individual without psychotherapy training may rely on the therapist to point out potential negative feelings related to therapist behaviors.

The studies reviewed in this section support the notion that ruptures in the alliance are an expected part of the therapeutic process. There is common agreement that a rupture is likely to occur when a patient experiences negative feelings regarding the therapist or the therapeutic process. Those therapist’s contributions found to be related to the development and exacerbation of alliance strains were similar to those reported to contribute negatively to the alliance (see Table 3). These therapist behaviors included rigid adherence to a treatment model (Castonguay et al., 1996), inflexibility (Castonguay et al., 1996; Rhodes et al., 1994), being unresponsive, being closed off, and conveying a sense of nonacceptance (Rhodes et al., 1994). In general, these findings suggest that ruptures (controntational or nonconfrontational) can clearly be identified within the treatment process (see Table 4). In addition, a common theme among these studies is that ruptures occur when the therapist is not being attentive to the ongoing treatment relationship. Specifically, ruptures most often transpire from the therapist not actively doing something the patient wants or actively doing something that the patient does not want (see Table 4). The findings of these studies suggest that while ruptures are a common treatment experience they can have either a positive or negative impact on the treatment process. On the one hand, the resolution of ruptures can lead to deeper exploration of relational patterns and help patients develop the skills necessary to understand and resolve similar patterns in other relationships. On the other hand, the nonresolution of ruptures can lead to treatment failures and, more importantly, the continuation of maladaptive relational patterns in the patient’s life.

**Conclusions**

The studies included in this review suggest that the therapist’s personal attributes and use or misuse of therapeutic technique from a range of psychotherapy orientations influence the maintenance and deterioration of the therapeutic alliance as well as the establishment and progression of breaches in the alliance. The alliance appears to capture the interactive process between the patient and therapist, which may be an important variable in negotiating change in all forms of psychotherapy. We found very little variation between the different theoretical orientations regarding the therapist’s negative impact on the alliance. While the majority of studies in the present review utilized a form of psychodynamic treatment, evidence was also presented to support the therapist characteristics and techniques as a variables impacting the alliance in unstructured (Hartley & Strupp, 1983; Saunders, 1999; Sexton et al., 1996), cognitive-behavioral (Castonguay et al., 1996; Eaton et al., 1993), and client-centered therapy (Eaton et al., 1993). However, we encourage other treatment orientations to explore further the therapist’s negative impact on the alliance as intently as psychodynamic psychotherapy researchers.

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**TABLE 3. Summary of Therapist’s Attributes and Techniques Found to Contribute Negatively to the Alliance**

<table>
<thead>
<tr>
<th>Personal Attributes</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rigid</td>
<td>Overstructuring the therapy</td>
</tr>
<tr>
<td>Uncertain</td>
<td>Failure to structure therapy</td>
</tr>
<tr>
<td>Exploitive</td>
<td>Inappropriate self-disclosure</td>
</tr>
<tr>
<td>Critical</td>
<td>Managing</td>
</tr>
<tr>
<td>Distant</td>
<td>Unyielding transference interpretation</td>
</tr>
<tr>
<td>Tense</td>
<td>Inappropriate use of silence</td>
</tr>
<tr>
<td>Aloof</td>
<td>Belittling</td>
</tr>
<tr>
<td>Distracted</td>
<td>Superficial interventions</td>
</tr>
</tbody>
</table>
TABLE 4. Summary of Precipitants and Markers of Ruptures in the Alliance

**Precipitants to Ruptures (Rhodes et al., 1994)**

- Breach of patient’s wants and/or needs:
  - (A) Therapist does something the patient does not want or need
    - Therapist confronts unsupportively
    - Therapist focus is off
    - Therapist gives unwanted advice
    - Therapist interpretation is off
    - Therapist focused on something other than the patient
  
- (B) Therapist fails to do something the patient wants or needs:
  - Therapist misses importance of issues

**Markers of Ruptures (Safran et al., 1990)**

- 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

A possible explanation for the consistency is that many of the identified therapist techniques emphasize the therapeutic interactions that occur 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. The core of these elements may be the relationship (therapeutic alliance) between two people that provides the opportunity for relief from suffering. This evidence supports the belief that the alliance is a pan-theoretical construct impacting psychotherapy process on multiple levels. In addition, the present review extends the findings of Krupnick et al. (1996) who reported no difference in the strength and importance of the alliance between interpersonal psychotherapy, cognitive-behavioral therapy, imipramine with clinical management, or a placebo with clinical management. While some theoretical orientations may prove to be more efficacious with certain patient populations, the findings from the present review suggest that all therapeutic pursuits can benefit from a focus on the factors contributing to negative alliance.

Tables 1 and 2 summarize the therapist’s personal attributes and the misapplication of therapeutic technique that were found to be significantly related to the experience of a weak alliance and the deterioration of an already existing alliance. The personal attributes of the therapist that were found to negatively influence the alliance include being rigid (Marmar et al., 1989), aloof (Eaton et al., 1993; Price & Jones, 1998), tense (Sexton et al., 1996), uncertain (Sexton et al., 1996), self-focused (Marmar et al., 1989), and critical (Eaton et al., 1993; Marmar et al., 1989). The therapist’s failure to develop a therapeutic frame (Eaton et al., 1993), inappropriate use of self-disclosure (Coady & Marziali, 1994; Price & Jones, 1998), and unyielding use of transference interpretations (Piper et al., 1991, 1993, 1999; Ogrodniczuk & Piper, 1999) were found to exemplify the category of misapplication of therapeutic technique.

According to the studies reviewed, disruptions or ruptures in the alliance are generated from a patient’s negative reaction to the therapist or the treatment process (see Table 4). This negative reaction may be generated in all treatment interactions through the therapist participating in a patient’s relational pattern or the therapist choosing not to engage in a relational pattern. One study reported that it was important for the patient to initiate the expression of his or her negative sentiments (Rhodes et al., 1994) while other studies emphasized the importance of the therapist drawing attention to the patient’s negative sentiments (Safran & Muran, 1996, 2000; Watson & Greenberg, 2000). However, it appears that how or by whom the patient’s negative sentiments are brought into the room is less important than ensuring that the negative sentiments are acknowledged and openly explored (Crits-Christoph et al., 1993; Foreman & Marmar, 1985; Horowitz, Rosenbaum, & Wilner, 1988; Rhodes et al., 1994; Safran et al., 1990; Safran, 1993; Safran & Muran, 1996, 2000; Watson & Greenberg, 2000). When a therapist is inattentive to a patient’s experience, she or he is likely to overlook a breach in the alliance or mistakenly assume that he or she has 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 (Horowitz et al., 1988). The eventual breakdown of the alliance may also occur when a therapist dogmatically relies on strategic interventions.

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Therapist Impact on Alliance
in an attempt to address breaches in the alliance (Castonguay et al., 1996).

A 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. In unresolved breaches in the alliance the therapist was portrayed as nonresponsive, closed off, nonaccepting, and dogmatic in maintaining his or 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 interpretation) found to contribute negatively to the alliance.

Although the present review focused on the therapist’s contributions to alliance, it is critical that we not lose sight of the equally important role patients play in 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 the alliance. Investigating these in-session interactions may deepen our understanding of the nature of the alliance 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.

In summary, the present review has identified that a therapist’s personal qualities and use of technique can be significantly related to the deterioration of the alliance during the general course of therapy. In addition, this review reveals how therapist’s personal qualities and use of technique have a similar influence on the identification or exacerbation of ruptures in the alliance. A greater understanding of the therapist’s contributions to alliance, which include personal qualities and therapeutic technique, may better equip clinicians to design and implement specific methods to identify weak alliances with their patients. While the findings of this review do not provide the clinician with a prescriptive manual to avoid the deterioration of the alliance, they do provide a synthesized understanding of the variables negatively impacting the relationship between the patient and therapist. Having a greater understanding of this relationship may lead to better-trained therapists and possibly more therapeutic successes. Future research may take this understanding even further and explore how to integrate these findings into existing training principles. For instance, since therapist attributes are relatively static it may be important to encourage therapists-in-training to engage in their own personal psychotherapy to better understand potential countertransference issues. In turn, supervision can then focus on developing interventions and techniques to further the therapeutic process. 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?

References


