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■ REVIEW ARTICLE

Examining Therapists' Traits That Do/Do Not Affect Therapeutic Alliance.

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ABSTRACT: The therapeutic alliance is the collaborative relationship between a client and their therapist and is vital for successful therapy outcomes. Freud first explored its concept, but the term was coined and theorized by other researchers. Research has established that clients and therapists have different perspectives on the alliance and various techniques to measure and assess it. Further understanding the components or elements that influence the therapeutic alliance would prove beneficial in increasing positive therapy outcomes. One way would be to study therapists' and clients' traits and their effects on the alliance. Much literature has focused on clients' traits, while less has investigated therapists' traits. Yet, empirical findings show that the therapist's contributions are more influential on the alliance. Hence, this review seeks to summarize how a therapist's traits may or may not affect the therapeutic alliance. Key factors explored and discussed in various studies include therapists' personal and professional attributes, attachment styles, demographic matching, and similarities between therapy participants. Further research will be required to better understand the role of demographic matching, particularly in age and race.

KEYWORDS: Behavioral and Social Sciences; Clinical and Developmental Psychology; Therapy; Therapeutic Alliance; Therapist Traits.

■ Introduction

The therapeutic alliance is defined as the collaborative relationship that exists between a client and their therapist. The concept of the therapeutic alliance was first brought to the surface by Freud.[1] His early writings spoke of a 'positive transference' between a client and therapist, which was a connection between the two, that bound the client to the therapy process—despite any of the client's anxiety, sense of fear, and urge to flee the therapeutic process. He implied that even though a client's prior experiences and projections should be central to the therapeutic process, the conscious self of the client develops a relationship with the "real" therapist, making the task of healing possible.[2]

Zetzel coined the term alliance.[3] She made distinctions between Freud's positive transference and the alliance, establishing that the alliance is a non-neurotic element of the client-therapist connection that helps the client incorporate the therapist's interpretations and draw differences between them their past relationships and the real association between them and their therapist.[2]

However, an extensive definition suggests that the alliance needs to consider the influences of the past (including transference) while simultaneously delineating it as a distinct feature of the existing and ongoing client-therapist relationship.[4] Moreover, according to Bordin, the therapeutic alliance varies according to the agreement on treatment goals, a defined set of therapeutic tasks to achieve said goals, and the formation of a positive emotional bond.[5,6]

However, it is pertinent to note that the therapist need not actively create the alliance, and the treatment process may be carried out so that a natural alliance is forged with the client. This may be distinguished by the fact that the focus of the process of therapy shifts into being a collaborative enterprise, and the therapeutic alliance becomes a measure of how well the client and therapist work together. Establishing a good alliance is vital for successful therapeutic outcomes as it prevents clients from abandoning the therapy process as well as creates room to set up a "working space".[7]

Although there is some debate on the specificity of the therapeutic alliance, with some arguing that it is a precondition necessary for successful therapy outcomes,[8-10] some arguing that it is nonspecific and important across all kinds of therapy and some saying that it is specific and may be of greater significance in particular psychotherapies,[11] (for example, the alliance is reliably associated with and predictive of positive treatment outcomes in group therapy), it has been demonstrated many times over that the alliance is consistently linked to positive treatment outcomes irrespective of psychotherapy modality.[12]

After the Institute of Medicine called for research to find elements that contribute to therapeutic change, Baier conducted a systematic review evaluating research examining the therapeutic alliance as a potential mediator of symptom change.[12] The review results suggested that alliance was a mediator and affected therapy outcomes in 26 of the 37 reviewed studies (70.3%).[12] According to Laurenceau, Hayes & Feldman, mediators are components that show how and why change occurs and explain potential mechanisms of therapeutic change.[13] Hence, the idea that the alliance is likely to play a vital role pantheoritically in effective psychotherapy is reinforced. It is established that the alliance must be developed as early as possible clinically for optimal treatment outcomes.[12]

Similarly, Horvath and Symonds employed meta-analytic techniques to synthesize quantitative research linking the therapeutic alliance and therapy outcomes in adult and child

DOI: 10.36838/v5i2.5

populations. Their study confirmed that a strong positive correlation existed between good alliance and positive outcomes, underlining the importance of the concept of the therapeutic alliance.[14]

Therefore, a strong alliance seems to reflect an independent influence that results in symptom reduction across many processes that drive therapeutic change, including the type of therapy, characteristics of the patient, treatment settings, etc.[12]

This review seeks to first examine how the therapeutic alliance has been measured and assessed in the literature, then how clients and therapists interpret and perceive the therapeutic alliance, and finally, factors that influence the therapeutic alliance with a particular focus on therapist traits.

Discussion

Measurement and Assessment of the Therapeutic Alliance:

The characteristics of a therapeutic alliance were first recognized in the humanistic psychotherapy work of Rogers, wherein the patient's experience of therapist empathy was highlighted.[15] after that, Howard *et al*. built on this and other preexisting theories and empirical data to propose three dimensions of the alliance: the working alliance, empathic resonance, and mutual affirmation.[16] Bordin[5] reworked these dimensions into 'goal, task, and bond' and applied them to different psychotherapeutic modalities.[17]

Hougaard published a persuasive review wherein empirical data was used to distinguish the 'personal alliance' and the 'task-related alliance'.[18]

Today, there are more than 11 alliance assessment and measurement methods.

Horvath and Symonds have identified five measures that are related and used most frequently, namely:

1. *the California Psychotherapy Alliance Scales* (CALPAS).[19,20]
2. *the Penn Helping Alliance Scales (*Penn/HAQ/HAcs/HAr).[21,22]
3. *the Therapeutic Alliance Scale* (TAS).[23]
4. *the Vanderbilt Therapeutic Alliance Scale* (VPPS/VTAS).[24]
5. *the Working Alliance Inventory* (WAI).[25]

Although several versions exist of each, most have been adapted to be used either as an observer's rating scale or as a self-report measure to which participants respond on a Likert-type scale. They report that the therapist-based measures are the most stable, while the observers' ratings are the least reliable.[14] However, there is no one current measure that meets all the predefined criteria in adult or child populations.[26]

The two core components of the alliance are personal attachments and willingness to invest in the therapy process, which is common to all five measures. Besides these elements, two or more of the measures consider therapists' and clients' positive or negative contributions, shared or agreed-on goals for the therapy, capacity to form a relationship, acceptance or endorsement of therapy tasks and active participation in therapy.[26]

A closer conceptual review was undertaken by Hatcher & Barends for three of the measures (WAI, CALPAS, and HAq), wherein it was found that six factors were typical for each, namely confident collaboration, goals and tasks, bond, idealized relationship, dedicated patient and help received.[27]

According to Elvins, the most successful measures of the therapeutic alliance are the WAI, VTAS, and CALPAS, as they have received a more thorough inspection and consequent support in the adult literature than other scales while also having been used in robust outcome trials.[26] Martin *et al*. recommended that the Penn scale be used for future research in the adult population unless persuasive reasons exist to develop or use a different measure later.[28]

Therapy Participants' Views on the Therapeutic Alliance:

Research suggests that the participants in the therapy process (namely client and therapist) have different perceptions of the therapeutic alliance than the widely used measures used to assess it. This is to say that elements that are used to assess the alliance show little correspondence to empirical groupings stemming from the same participants' ratings of the therapeutic alliance, e.g., Gaston, Sabourin, Hatcher, & Hansell; Hatcher; Hatcher & Barends; Tracey and Kokotovic.[29]

It is consistently found that there is a low association between both participants' perceptions, meaning that the therapist and client have different views of the therapeutic alliance and its dimensions.[23] Furthermore, clients rate the alliance according to their past interpersonal experiences, which they represent or transfer to the therapeutic alliance, while therapists objectively rate the alliance according to professional, clinical experience, and theoretical knowledge.[30,31] It is still essential to remember that disagreement between therapist and client assessment may occur. It does not necessarily mean something negative but indicates that a discussion surrounding the relationship may be helpful.[32]

Hatcher and Barends investigated the clients' views on three measures—Working Alliance Inventory (WAI),[26] California Psychotherapy Alliance Scales (CALPAS),[19,20] and Penn Helping Alliance Questionnaire (HAQ),[21,22] using exploratory factor analysis and identified six factors that make up the therapeutic alliance:

1. *Confident Collaboration*, reflecting clients' sense of confidence in and commitment to therapy;
2. *Goal and Task*, grouping mostly WAI Goal and Task-related items;
3. *Bond*, consisting primarily of cross-measure bond-related items;
4. *Idealized Relationship* involving a sense of helpful collaboration as well as non-disagreement about the work of therapy;
5. *Dedicated Patient*, reflecting aspects of clients' participation in therapy; and
6. *Help Received*, containing HAQ helpfulness-toned items;

Of these six items, Confident Collaboration, Idealized Relationship, and Help Received correlated significantly with the clients' concurrent ratings of improvement.[33]

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Similarly, using exploratory factor analysis, Hatcher investigated the therapists' views of the alliance based on the WAI and the CALPAS. Four components from the WAI—*Shared Goals*, *Bond*, *Goal* & *Task Disagreement*, and *Therapist Confidence in Treatment*—and three components from the CALPAS—*Patient Working Engagement*, *Patient Confidence and Commitment*, and *Therapist Understanding and Involvement*—were identified and said to make up the therapeutic alliance.[34]

Even though both participants may have different perceptions of the alliance, it is argued that the more the therapist and the client agree on the bond, tasks, and goals of therapy, the higher the likelihood of positive therapy outcomes.[35,36] Furthermore, the growing literature in this area focuses on the congruence and convergence between the perceptions of both patients and therapists.

Factors influencing the alliance:

According to Ackerman, since the alliance has been established as essential for therapeutic outcomes, knowing the key components of a healthy alliance may lead to increased patient change and positive outcomes.[37] Research has brought to light that the characteristics of both participants (client and therapist) influence the development of the alliance.[38]

To begin with clients' characteristics, Horvath divided factors into three categories: interpersonal capacity/skills (measurement of the clients' social and family relationships), intrapersonal dynamics (clients' motivation, psychological status, and attitudes), and diagnostic features (clients' severity of symptoms at the beginning of treatment).[15] On the other hand, according to Nissen-Lie, few studies focus on the role of therapist characteristics in building and influencing the therapeutic alliance. Consequently, there is a lesser understanding of the same compared to the role of clients' characteristics.[39] Empirical findings show that the professionals' contribution to the alliance is more significant for the positive outcome than the clients' contribution.[40] However, other studies find contradicting results, indicating that more research is needed to unpack this claim further. Hence, this review condensed holistically from various studies on the factors that do and do not affect the therapeutic relationship as a trait.

Therapists' Personal Attributes:

Past research has shown that therapists' personal attributes are essential to building a strong therapeutic alliance. Ackerman and Hilensroth summarized that a warm, trustworthy, empathetic, confident, open, honest, and interested therapist achieved higher patient-rated alliance scores than those who came off as critical, tense, rigid, rigid, rigid, distanced, and distracted.[37,41] Horvath and Greenberg

compared the WAI with the self-rating measure Counsellor Rating Form (CRF) to find that positive connectedness was fostered early in the therapeutic process regarding therapists' training, nonverbal gestures, abilities to maintain the therapeutic frame, and consistent and verbal behaviors. They also found and suggested that therapists' empathy, understanding, and ability to relate to the client's experiences may be important factors in forming strong alliances with their clients.[42] Both these findings are confirmed and backed by some recent studies.[43-45]

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Price & Jones also proposed that a therapist's capacity to express themself lucidly and proficiently when enacting therapeutic strategies might strengthen the alliance.[45] Similarly, Mohl, Martinez, Tichnor, Huang, and Cordell concluded that generally, therapists that were warm, friendly, and facilitated a greater sense of understanding were more likely to establish a positive therapeutic alliance early in the therapeutic process.[46]

Moreover, a warm dimension—calling back of a caring mother—leads to a positive impact on the alliance, whereas a cold dimension has the opposite effect.[44] Nissen-lie *et al*. highlighted that a therapist's negative emotional traits are more noticeable to patients and lead to lower patient-rated alliance ratings.[39]

Therapists' Professional Attributes:

According to Mallinckrodt and Nelson, it is possible for therapists with lesser training to still form a strong bond with their clients, even though they might be less effective when it comes to establishing and achieving therapeutic goals early in the therapeutic process.[47] Al-Darmaki and Kivlinghan also supported this notion, by showcasing that if the therapist expected a positive relationship with their client, they were more likely to foster a strong therapeutic alliance irrespective of the level of training they had undergone.[37] Hersough *et al*. researched to explore therapist characteristics as predictors of the therapeutic alliance. It concluded that if longer experience, higher training, better professional skills, and/or more progress as a therapist had an impact on the alliance, it was likely that that impact was negative.[44]

Therapists' Attachment:

Ainsworth, Blehar, Waters, and Wall established three attachment patterns: secure, insecure-avoidant, and insecure anxious-ambivalent, which leads to patterns of regulating distress and various internal working models.[48] Attachment patterns may be relevant to the alliance as it may be expected that therapists' attachment plays a role in the way they can facilitate a secure working relationship with their clients. However, further research and more methodologically rigorous studies are required to strengthen the existing literature.[49] However, Bucci *et al*. summarized that the severity of clients' symptoms might influence therapists' attachment and its effect on the therapeutic alliance and that therapist attachment style was related to the alliance with more symptomatic clients.[50]

Demographics—Age, Race, and Gender:

Kivlighan, Clements, Blake, Arnzen, and Brady reported no significant relationship between therapist sex role orientation and patient ratings of the alliance, meaning it may not be relevant to forming a strong therapeutic alliance.[51] Furthermore, Zlotnick and colleagues examined the role of gender (therapist gender, therapist-patient gender matching vs. mismatching, and patients' belief about whether a male/female therapist would be more helpful). They contended that gender does not influence the process and outcome of therapy.[52] Matching clients and therapists based on gender has been the most widely recommended and examined method of demographic matching and is a significant theme in counseling research.[52] Bhati found that across all therapy stages, female clients with female therapists had higher therapeutic alliance ratings when compared to those with a male therapist. Similarly, female therapists with male clients reported alliance higher than male gender-matched dyads.[53] In contrast, if one focuses only on the adolescent demographic, Wintersteen, Mensinger & Diamond

DOI: 10.36838/v5i2.5

found that patients matched with same-gender therapists rated the alliance higher.[54] Moreover, Karver, De Nadia, Monahan, and Shirk found that, especially for the adolescent demographic, multiple alliances should be created as that alliance between the parent/carer and therapist were as closely related as that between the patient and therapist.[55]

However, most research over time on attribute matching in psychotherapy has found that racial or ethnic match effects have no significant impact on the treatment outcome or the therapeutic alliance.[56-59] Behn *et al*. observed that where the therapist is younger than the client, additional growth in the alliance is promoted, known as the 'youth effect,' which is also the case for same-aged participants.[60]

Similarities between Therapist and Client:

Hersoug *et al*. found that similarities between the personal characteristics of therapists and clients did not affect the alliance. However, similarity in values (even if not explicit) between both may still be positively relevant to the alliance regarding patients' ratings.[44]

Conclusion

A good understanding of the therapeutic alliance currently exists, and the literature shows that ample attention has been paid to assessing and measuring it. Research has shown extensively how therapists' professional and personal attributes are predictive of the therapeutic alliance, but the same cannot be said for therapists' specific demographic characteristics. Although a small body of the literature has focused on the influence of gender and gender matching on the alliance, not as much research has investigated age and race. Hence, it is recommended that future research focus on disentangling further the role, if any, of these and more demographic characteristics on patient-therapist matching and the consecutive impact on the alliance. Moreover, not enough literature exists on the alliance in the child and adolescent population, which may prove helpful to better understand the alliance as a whole in the future.[60] Given the prevalence of psychopathology, this review concludes that psychology would benefit from further research exploring more therapist traits that affect the therapeutic alliance and a deeper understanding of how such information may be employed to improve therapy outcomes in the future.

Acknowledgments

I am grateful and extremely thankful to my mentor, who has helped me explore my research topic, helped me learn how to conduct a literature review, and given me numerous helpful suggestions to develop my paper better. I would also like to express my deep appreciation to my parents, who willingly supported me through the research and writing process.

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DOI: 10.36838/v5i2.5

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