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THE POWER OF THE THERAPEUTIC RELATIONSHIP

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A review of the psychotherapy research literature of the last decade shows that considerable advances of clinical significance have been made toward defining and measuring components of the treatment relationship. The relevance of the therapeutic alliance for predicting outcome in diverse models of treatment is emphasized, and the implications of the findings for clinical training, practice, and research are discussed.

Historically psychotherapists have recognized that the client-therapist relationship provides the context for all treatment processes. While definitions of the nature and function of the therapeutic relationship have evolved and varied over time, the importance of the relationship in the treatment encounter has remained virtually unchallenged. What has varied is the centrality of specific factors of the relationship in defining the parameters of therapy. From a psychodynamic perspective, the therapist's role in developing and managing the treatment relationship is considered to provide both the context and the mutative agent through which change occurs; that is, the enhanced understanding of the treatment relationship is applied to understanding maladaptive aspects of the client's troubled relationships. In contrast, from a behavioral, problem-solving orientation, a friendly relationship develops in tandem with the strategies used to achieve the goals of treatment. In this case, the therapist-client relationship is viewed as a necessary context for the technical interventions. In practice the alliance evolves through an integration of the contextual and interventive aspects of the client-therapist interactions; consequently, the alliance is viewed as playing a central role in determining the outcome of treatment.

The need for empirical validation of practice has been articulated by both practitioners and clinical investigators *(Ivanoff, Blythe, & Briar, 1987; Luborsky, 1987)*. A series of meta-analytic studies have shown that a variety of treatment models are effective *(Lambert, Shapiro, & Bergin, 1986; Smith & Glass, 1977; Videka-Sherman, 1988)*. The studies reviewed employed group designs that explored psychodynamic, behavioral, cognitive-behavioral, and problem-centered treatment methods. The consistent conclusion drawn from the reviews is that all treatments are effective, regardless of their theoretical orientation or technique. One major gap in these studies is the paucity of attention paid to process variables *(Videka-Sherman, 1988)*. That is, which factors within a treatment model explain the obtained outcomes? Which fac-

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tors are common to several treatment approaches? Which factors are unique to any given treatment model?

This article examines process variables that tap important dimensions of the therapist-client relationship. Recent studies in the research literature on psychotherapy have found that considerable advances have been made toward defining and measuring components of the treatment relationship. A variety of measures of the therapeutic relationship have been developed and tested in treatment-outcome studies *(Barrett-Lennard, 1962; Gomes-Schwartz, 1978; Hartley & Strupp, 1983)*. Reviewed are studies that clearly show the power of the therapeutic relationship in predicting the outcome of psychological treatments. The implications of these findings for practice and clinical training are discussed.

THEORETICAL BACKGROUND

Most studies of the quality and effects of the treatment relationship are based on psychodynamic formulations about the nature of client-therapist interactions. Much of the measurement technology includes variables that were defined clinically by Zetzel *(1956)* and Greenson *(1965)*. Zetzel used the terms "working alliance" and "therapeutic alliance" to describe the treatment relationship. She believed that, early in the therapy, the client would project onto the therapist wishes that originated from the client's primary relationships. According to Zetzel, the alliance would be forged if the therapist used technically supportive responses that were sensitive to these developmentally linked projections. Greenson distinguished among "transference," the "real relationship," and the "working alliance." The client's realistic reactions to the therapist (real relationship) were to be differentiated from fantasy distortions of the relationship (transference). Greenson also proposed that the working alliance represented the collaborative efforts of the client and therapist to advance insight and change. This tripartite definition of the alliance has influenced most subsequent attempts to describe the qualities of the therapeutic relationship.

Bordin's *(1979)* writings about the treatment relationship provide the clearest descriptions of three key dimensions that best portray the therapist's and client's respective contributions to the evolution of the therapeutic alliance. A productive therapeutic relationship includes *1)* the client's and therapist's agreement on the goals of therapy, *2)* the client's and therapist's agreement on the tasks needed to achieve the agreed-on goals, and *3)* the development of an interpersonal bond. Bordin's formulation of the component parts of a working alliance has considerably influenced the development of systems for measuring the strength and direction of the alliance and their effects on the outcome of psychotherapy.

REVIEW OF STUDIES

The Alliance in Individual Psychotherapy

Considerable advances have been made in developing measures of the treatment relationship, especially in individual psychotherapy. The measurement technology has included observers', clients', and therapists' ratings of the treatment alliance.

One of the earliest measures of the therapeutic relationship, the Relationship Inventory (RI), was developed by Barrett-Lennard *(1962)*. Items for the RI were derived from Rogers' *(1957)* concepts of the necessary conditions of therapy. The RI consists of 16 items distributed across 4 dimensions: positive regard, empathic understanding, unconditionality of regard, and congruence. The RI has been used extensively in treatment-outcome studies, and the consistent finding is that clients' perceptions of the relationship, as measured on the RI, are related to change following a course of treatment *(Gurman, 1977)*. The scales have been used to assess *1)* clients' perceptions of relationships longitudinally, *2)* family relationships, and *3)* child and adult relationships *(Barrett-Lennard, 1986)*.

Developed by Orlinsky and Howard *(1975, 1986)*, the Therapy Session Report (TSR) was designed to capture clients' experiences of psychotherapy. It focuses on four aspects of the therapeutic experience: dialogue, exchange, feelings, and relationship. The TRS is completed following a treatment session. Orlinsky and Howard *(1986)* used responses to the questionnaire to characterize the interpersonal content of the treatment relationship. They concluded that the form of relatedness that occurs in effective treatment is one of mutual affirmation, mutual receptivity, and sensitive collaboration. In a later study *(Saunders, Howard, & Orlinsky, 1989)*, items from the TSR were selected to develop the Therapeutic Bond Scale, which includes three dimensions: the working alliance, empathic resonance, and mutual affirmation. Analyses of the psychometric properties of the new scale showed that the three subscales were associated with the overall quality of the session and with the outcome at termination.

The Vanderbilt psychotherapy research group developed and tested a series of measures to assess various domains of the psychotherapeutic process. The Vanderbilt Psychotherapy Process Scale (VPPS) was developed, tested, and modified by Strupp and colleagues *(Strupp, Hartley, & Blackwood, 1974; Gomes-Schwartz, 1978; O'Malley, Suh, & Strupp, 1983)*. Using audiotapes of selected therapy sessions, clinical raters judged the presence and intensity of the VPPS dimensions. A factor analysis of items in the scale yielded three subscales of process dimensions: Client Involvement, Exploratory Processes, and Therapist-Offered Relationship. Analyses of associations between these subscales and posttreatment effects showed that Client Involvement in therapy was positively associated with most measures of outcome *(Gomes-Schwartz, 1978)*. A later study *(O'Malley, Suh, & Strupp, 1983)* demonstrated that by the third session of therapy, the eventual outcome could be predicted on the basis of the VPPS ratings of the client's involvement. Since similar predictions could not be made from ratings of this dimension in either the first or second session, it was concluded that the therapists may have exerted a marked influence on the developing alliance between the first and third sessions for this change to occur. In a study of brief treatment, the Vanderbilt group *(Moras & Strupp, 1982)* showed that the client's capacity for interpersonal relating could be estimated at the time of assessment from the quality and duration of relationships established with family members and friends. Interpersonal relating capacity was shown to be significantly associated with the quality of the alliance developed with the therapist.

Investigators associated with the Penn Psychotherapy Project *(Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Luborsky et al., 1980)* further advanced the technology for measuring the qualities of the treatment relationship. They developed the Penn Helping Alliance Counting Signs Method *(Luborsky, 1976)* to quantify the concept of the helping alliance. The results of their work showed that two broad types of helping alliances could be identified. In Type I alliances, the client perceives the therapist as carrying the major responsibility for advancing the helpful components of the therapy; in Type II alliances, the client perceives the treatment as a collaborative process during which the client works with the therapist to achieve the goals of treatment. The results of analyses that compared a group of ten more-improved clients with a group of ten less-improved clients selected from the Penn Psychotherapy Project ($N = 73$) showed that the more-improved group had a higher frequency of Type II alliance "signs" than did the less-improved group *(Alexander & Luborsky, 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988)*. The Penn group developed a client and therapist self-report form of the Penn Alliance Scales that was tested in a treatment-comparison trial with drug-dependent clients *(Luborsky, McLellan,*

Woody, O'Brien, & Auerbach, 1985). The client-completed version of the questionnaire was the best predictor of outcome after seven months of treatment. Furthermore, strength of the alliance-outcome correlations matched or exceeded those obtained in other studies that used the helping alliance measures.

Horvath and Greenberg *(1986, 1989)* developed a measure of the alliance, the Working Alliance Inventory (WAI) that represents Bordin's *(1979)* three dimensions of the alliance (goals, tasks, and bond). Client and therapist versions with parallel items were tested and showed positive alliance-outcome associations. Tracey and Kokotovic *(1989)* carried out a factor-analytic study of the WAI and found that only 12 of the 36 items were most indicative of the three subscale factors and that these items combined to represent one overriding alliance factor. Although more scale analysis is needed, a 12-item questionnaire would be easier to use and could replace alliance measures that are considerably longer or are expensive to use because ratings are obtained from a trained panel of judges.

With few exceptions, investigators have used alliance measures that provide only one perspective of the alliance: the perspective of clinical judge, therapist, or client. In an attempt to assess the associations among the three perspectives of the therapeutic alliance, Marziali, Marmar, and Krupnick *(1980)* and Marziali *(1984)* developed an alliance measure that could be completed by the client, the therapist, and impartial clinical judges. The dimensions of the measure parallel those used by the Vanderbilt and Penn groups. The scales were tested in a study of time-limited psychotherapy. The results showed that there was considerable correspondence among the three perspectives of the treatment relationship, but the strongest agreement was between the clients' and therapists' perceptions of the alliance. The study corroborated the findings of other investigators; that is, from all three rating perspectives (client, therapist, and clinical judge), significant associations between the quality of the alliance and outcome were evident at the third treatment session.

Investigators at the Langley Porter Institute extended the analysis of the Marziali alliance measure and developed the California Therapeutic Alliance Rating System (CALPAS) *(Marmar, Horowitz, Weiss, & Marziali, 1986; Marmar, Weiss, & Gaston, 1989)*, which has been shown to have similar properties to other alliance-measurement systems. For example, the results of several studies showed positive associations between alliance ratings and outcome. Also, positive contributions to the alliance were associated with clients' pretreatment interpersonal functioning *(Gaston, Marmar, Thompson, Gallagher, 1988; Marmar, Weiss, & Gaston, 1989)*. The first version of the CALPAS was judge-rated and consisted of five factor-derived scales: Therapist Understanding, Therapist Negative Contribution, Patient Hostile Resistance, Patient Commitment, and Patient Working Capacity. In a later study, Gaston *(1990)* developed and tested a patient-rated version of CALPAS—CALPAS-P which contains four scales: Patient Commitment, Patient Working Capacity, Therapist Understanding and Involvement, and Working Strategy Consensus. New items were developed to reflect an expanded theoretical perspective of the alliance, and some original CALPAS items were excluded. The final 24-item scale was completed by patients seen in private practice. Several of the CALPAS-P subscales were related to symptomatology and problems with intimacy. All scales were associated with satisfaction with therapy.

Some investigators have explored how therapist variables enhance or impede the development of a positive treatment alliance. Forman and Marmar *(1985)* explored therapists' behavior that was associated with improvements in initially poor alliances. They analyzed the therapies of six clients

who had initially poor alliances and found that three of them went on to have improved alliances and good outcomes, but that the alliances of the other three clients did not improve and these clients had poor outcomes. Therapists' actions that occurred more frequently in the improved cases included *1)* addressing the client's defenses, *2)* addressing the client's problematic feelings toward the therapist, and *3)* linking the client's defensive behavior with the conflicts in the client's feelings toward the therapist.

In another study *(Henry, Schact, & Strupp, 1986)*, detailed ratings of all utterances by therapists and clients were generated from a circumplex model of interpersonal behavior. These researchers used Benjamin's Structural Analysis of Social Behavior *(Benjamin, 1974)* to rate 36 types of interpersonal behavior on two interrelated circumplex surfaces. They compared the good- and poor-outcome cases of four therapists. The following interpersonal process variables differentiated the good versus the poor outcomes: high-change cases were associated with the therapist's higher levels of "helping and protecting" and "affirming and understanding" and lower levels of "blaming and belittling." Client's "disclosing and expressing" was associated with high-change cases. In contrast, low-change cases had higher levels of clients' "walling off and avoiding."

In a study of similar factors, Kiesler & Watkins *(1989)* examined the relationship between the therapeutic alliance and interpersonal complementarity during the early phase of therapy. Following the third treatment session, 36 pairs of patients and therapists completed the WAI *(Horvath & Greenberg, 1986)* and Kiesler's *(1984)* Checklists of Interpersonal Transactions. The results showed positive associations between the patients' and therapists' interpersonal complementarity and their respective perceptions of the alliance. Of significance were the correlations between a less positive working alliance and more abnormal interpersonal behavior by the patients.

The Alliance and Other Forms of Treatment

While much of the research on the effects of the therapeutic alliance on outcome has evolved from a psychodynamic perspective of individual treatment, behavior therapists have, in the past decade, shown increasing interest in examining the interaction between relationship variables and behavioral techniques. In a review of the role played by the quality of the therapeutic relationship in behavior therapy, Sweet *(1984)* traced the development of interest in relationship issues by behaviorists. He cited several studies *(Alexander, Barton, Schaino, & Parsons, 1976; Ford, 1978)* showing that, contrary to expectations, relationship variables, rather than the behavioral techniques used, contributed significantly to the variance in outcome. Sweet concluded that the power of the therapeutic relationship in predicting the outcome of treatment lies in the mutual liking, trust, and respect of client and therapist. A similar review focused on the importance of the client-therapist relationship in cognitive psychotherapy *(Thompson, 1989)*.

There is also a growing interest in the role of the therapeutic relationship in family, couples, and group treatment. Although family therapists typically do not refer to a therapeutic alliance, they have explored this factor in such terms as "joining with the family" *(Minuchin, 1974)*, "connecting" *(Davatz, 1982)*, initiating a "coalitionary process" with the family *(Sluzki, 1975)*, and "engaging families" *(Solomon, 1977)*. Similarly, marital therapists are focusing more specifically on understanding the role of the treatment bond in marital therapy *(Gurman, 1982; Rutan & Smith, 1985)*. Johnson and Greenberg *(1989)* explored the relevance of the therapeutic alliance in their model of emotionally focused marital therapy.

Until recently, there were no tools for

assessing the quality of a family's or couple's relationships with a therapist. In the mid-1980s, Pinsof and Catherall *(1986)* developed preliminary versions of alliance measures that are applicable to couples and families. The scales' psychometric properties have been explored, and studies of the effects of the alliance on outcome of family treatment are in progress.

In group models of treatment, the development of group "cohesion" is an essential factor for ensuring the continuance of the group and for sustaining its work. Except for studies of the function of cohesion in group treatment *(Yalom, 1975),* little effort has been devoted to examining the effects of the treatment alliance in these models of treatment. Budman et al. *(1989)* studied both cohesion and alliance in time-limited group psychotherapy. As expected, cohesion and alliance were strongly related and both predicted improved self-esteem and reduced symptomatology. Of particular interest was the finding that cohesion measured early in a group session (in the first 30 minutes) was more related to outcome than was cohesion measured later in a group session.

DISCUSSION

As this review of empirical studies of the therapeutic alliance demonstrates, this key client-therapist factor plays an important role in determining the outcome of treatment. The therapeutic alliance is a potent curative factor in all forms of treatment. This point was emphasized by Wolfe and Goldfried *(1988)* when they stated that the alliance:

> . . . is probably the quintessential integrative variable because its importance does not lie within specifications of one school of thought. It is now commonly accepted by most orientations that the therapeutic relationship is of essential importance to the conduct of psychotherapy. *(p. 449)*

Inferences about early development of the alliance were explored in several of the reviewed studies. For example, some studies showed that the degree of the client's involvement in treatment increased considerably between the first and the third treatment sessions. The implication is that by the third session, the therapist's success in engaging the client in the treatment process can be judged on the basis of the quality of the alliance. Although good alliances are consistently associated with good outcomes, the specific independent and combined contributions to the alliance by both the client and the therapist are unknown. There is some evidence that client factors, such as high levels of pathology and the poor quality of interpersonal relationships, affect the quality of the therapeutic alliance. In addition, negative attitudes and behavior by therapists are associated with poor alliances and outcomes. Similarly, when therapists fail to explore clients' communications about negative elements in the therapeutic interaction, the alliance suffers.

For each measurement system reviewed, ratings of the client's alliance behavior were better predictors of outcome than were ratings of therapist's alliance behavior. In other words, it was the quality of the client's participation in the alliance that had the greater impact on outcome. It may be that, in their current form, alliance measurement systems are not as effective in capturing the therapist's contribution to the alliance. The exception was the method used by Henry, Schact, and Strupp *(1986)*—the Structural Analysis of Social Behavior—which determined therapists' as well as clients' behavior that distinguished cases with good outcomes from cases with poor outcomes. Therapists who showed high levels of helping, protecting, affirming, and understanding behavior and low levels of blaming and belittling behavior were in the good-outcome group.

IMPLICATIONS

Analyses of the nature and function of the treatment relationship have important implications for clinical practice and research. If the "baseline" meanings of the treatment relationship are established as early as the third to fifth treatment session, then it would be prudent for the therapist to

monitor carefully the client's cues about confusions and anxieties in their interactions during these early sessions. When these cues are detected and explored, the therapist demonstrates to the client a willingness to understand the client's unique relationship qualities. In tandem, the therapist will need to monitor her or his subjective reactions to the client's style of communicating. These self-observations help the therapist to distinguish between subjective reactions that need to be contained and subjective reactions that inform him or her about the client's style of relating. Alliance-mending strategies are derived from understanding both the therapist's and client's contributions to the alliance. The results of Forman and Marmar's *(1985)* study suggest that some therapists are unaware of or choose to ignore problems early in the treatment relationship. In contrast, they showed that the good-outcome therapists recognized cues in the interaction that alerted them to conflicts in the relationship and that they explored with their clients the meaning of these problems. Similarly, for group treatment, the therapist's activity in the first third of each group session may considerably enhance cohesive-bonding interactions among group members *(Budman et al., 1989)*.

Many studies have shown that clients drop out of therapy within the first three to five sessions *(Garfield, 1986)*. Therapists may conclude that these clients were either not suitable candidates for psychotherapy or were not ready to commit themselves to this arduous process. Studies of the therapeutic alliance challenge these assumptions because of their consistent findings of the strong associations between the quality of the alliance early in therapy and outcome. Thus, the problems with early attrition may be fruitfully addressed by examining the quality of the therapeutic alliance and the relative contributions to the alliance by both the client and the therapist.

Therapists learn about the quality and functions of the treatment relationship in supervision, both during their training and subsequently. Perhaps more emphasis should be placed on helping the trainees detect relationship cues that require attention. In a recent review of the use of manuals for training psychotherapists, several authors stressed the need to focus on factors in the therapists' and clients' personalities because of their effects on alliance-building and -mending behavior *(Dobson & Shaw, 1988; Guest & Beutler, 1988; Strupp, Butler, & Rosser, 1988)*. The present review underlines the fact that supervision and training can no longer ignore the strong evidence showing the alliance as a significant predictor of outcome, regardless of the orientation of therapy.

Many trainees may lose initial training cases because they have failed to grasp the client's often subtle expressions of anxiety and confusion about the treatment relationship. Alliance measures, such as the short form of the WAI *(Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989)*, could be used as tools for monitoring the alliance during the supervision of training cases. In supervision, alliance ratings of a treatment session could be reviewed in tandem with an audio recording of the session. The aim would be to examine client-therapist interactions that explain or support the subscale scores on the inventory. Confusions, differences in observations, misunderstandings, and distortions could be discussed. The supervisor could help the therapist translate observations of interpersonal factors into interventions which would communicate to the client that despite the intensity of the shared emotions, troubled transactions such as those occurring in the treatment relationship can be explored and understood.

The helping professions have made significant contributions to the development of new treatment models with a wide range of client populations. Yet there is a paucity of studies of the elements of new treatment processes that explain outcome. Measurement technology for detecting the qualities of the treatment relationship has advanced

considerably, and most of the measures are well suited to most clinical settings. Similarly, measures of various outcome factors are readily available. Thus, it is now possible to design within-group process-outcome studies of treatment models that have been well articulated clinically, but that have not been tested empirically. Such studies could be used to explore interactions between alliance factors and strategies for intervention that are specific to the model, especially during the early phase of treatment. If it is true that the success of therapy is supported largely by the quality of the treatment relationship, it is imperative that this factor be monitored and measured in all forms of treatment.

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