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The Impact of Clients' and Therapists' Characteristics on Therapeutic Alliance and Outcome

Tschuschke V*[1], Koemeda M[2] and Crameri A[3]

[1]Department of Medical Psychology, University Hospital of Cologne, Germany
[2]Swiss Charta for Psychotherapy, Zurich University of Applied Sciences, Switzerland
[3]Department of Applied Psychology, Zurich University of Applied Sciences, Switzerland

***Corresponding author:** Volker Tschuschke, Professor, Chair Medical Psychology University of Cologne (emeritus), Kerpener Strasse 68, 50937, Germany, Tel: +175 55 00 604; Email: volker.tschuschke@icloud.com

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Abstract

This article investigates distances in the therapeutic alliance experiences of therapists' and their clients' across the durations of the psychotherapeutic treatments in a naturalistic study. We looked at the working alliances from different vantage points: rupture, repair of ruptures, distances in the alliance impressions of both clients and therapists, and their correlation with treatment outcome. The only predictive variable of alliance ruptures and the subsequently premature ending of the treatments that we found was the inability of therapists to bond sufficiently with their clients regarding a sustainable working atmosphere. Although therapists' degree of effectiveness, clients' psychological burden at treatment entry and the quality of the therapeutic alliance were important with regard to treatment outcome in previous studies of our sample, the only predictive variable of the combination alliance rupture/premature termination of the treatments was the inability of therapists to attune to their clients' level of alliance experience. The paper discusses the possible role of the quality of therapists' attachment styles as a crucial variable regarding successful therapeutic treatments.

Keywords: Therapeutic alliance; Alliance rupture; Alliance repair; Therapist-client agreement

Introduction

In the last decades, psychotherapy research has consistently addressed the importance of the working alliance between therapists and their clients [1-5]. In general, studies tend to show that the quality of the therapeutic relationship is a strong predictor of therapeutic outcome [6]. Most studies have investigated the effects of the quality of the alliance at the beginning of treatments and mainly on the side of the clients.

As the importance of the alliance for treatment outcome is no longer questioned, research has started to study the role of agreement between clients' and therapists' alliance perspectives [6-9]. Another topic of growing interest is features on both sides of the therapist-client dyad that impact the alliance. Process-outcome research has increasingly focused on personality characteristics of therapists and clients: Studies have addressed therapists' and clients' attachment styles [6,10], therapists' professional experience [11], therapists' effectiveness [12-16], therapists' and clients' interpersonal skills and verbal capabilities [16], the role of treatment adherence [17,18], clients' initial symptom distress profiles [18,19], or the working alliance congruence between client and therapist [6,20-25].

Although many researchers have assessed the working alliance from either the therapist's or client's perspective

[18], there are reasonable arguments for investigating the quality of the working alliance as a collaboration between clients and therapists [26]. Researchers have just begun to understand the highly complex connections between single variables and their dynamic interactions within the context of the therapeutic alliance.

Research questions have been raised in recent years regarding methodological limitations and potentials in measuring the alliance experience on both sides of the therapist-client dyad [2,27-31]. There has also been increased research interest in the last 10 years in alliance ruptures and their repair [32-35].

In this study, we aimed at an integrative view of different client and therapist variables that have been found to be relevant in the alliance ruptures and repairs research. Among these are client variables, such as the degree of initial symptom distress, clients' chronicity of psychological problems, and therapists' characteristics—such as their professional experience, conceptual orientation, degree of treatment adherence, and effectiveness. Previous studies found therapists, as the professional part of the therapeutic dyad, to be a crucial variable in therapeutic processes for treatment outcome [16,37,38]. Researchers also found that clients' severity of psychological distress had a strong impact on the quality of the therapeutic alliance, with therapists seemingly adapting by lowering their degree of treatment adherence [17]. Also, more successful treatments were characterized by therapists' ability to adapt their own sense of therapeutic alliance by approaching their clients' level of alliance ratings as treatment progressed [5].

In this study we were interested in looking at the role of the working alliance in the therapeutic treatments using conceptually diverse treatment approaches. What are the impacts of unstressed working alliances, discontinuities in the working alliances, their possible repair, as well as alliance ruptures without repair on treatment outcome? Are there any client or therapist characteristics predictive of treatment outcome, e. g., clients' degree of psychological stress when entering treatment, clients' chronicity of their psychological problems, and therapists' theoretical orientation, professional experience, or differential effectiveness?

We used an indirect self-report method, a version of the naturalistic observation paradigm, by tracking the natural occurence of alliance ruptures and resolutions and examining their relationship to outcome [38]. The experience of the therapeutic alliance in psychotherapy is based on impressions on both sides of the therapeutic dyad, although the experience of the quality of the alliance might be quite different on either side. Most previous studies concentrated on measuring clients' subjective experience of the alliance quality which we think is only half of the truth. We therefore looked at both sides of the alliance experience. We thus used clients' and therapists' alliance rating differences at the end of the session. We built on results from previous research and ended up with the following hypotheses:

Hypothesis 1: Initial psychological distress as well as the chronicity of clients psychological problems significantly predict the emergence of alliance ruptures.
Hypothesis 2: More effective therapists have fewer alliance ruptures in their treatment cases than less effective therapists do.
Hypothesis 3: More effective therapists are more able to repair alliance ruptures than less effective therapists are.

Method

Participants

The data were derived from a nationwide naturalistic process-outcome psychotherapy study in Switzerland from 2007 through 2013 (PAP-S study), in which 379 patients with a variety of DSM-IV diagnoses [39] were treated by 586 experienced psychotherapists using 10 different conceptual approaches in their private practices. There were no restrictions on client inclusion regarding diagnosis, age, and so on. Each participating therapist was asked to work according to his or her usual practice routine. Starting from a time point in 2007, therapists were requested to ask all clients entering psychotherapy to participate in the study voluntarily. Each client was assured of having the right to not participate in the study and to receive treatment from the same therapist. Clients who participated signed a written informed consent form. A research application was submitted to the ethical committees in the relevant seven Swiss cantons (states) before the start of the project; the ethical committees approved all of the applications [39,40].

A total of 86 therapists cooperated in the study. They were affiliated with 10 different theoretical concepts, including psychodynamic approaches (psychoanalysis, analytical psychology, newer psychoanalytic concepts), humanistic concepts (Gestalt therapy, Bioenergetic therapy, Transaction Analysis), body oriented therapy, art and expression therapy, or Existential Psychotherapy and Logotherapy, or an integrative concept. Based on complete data sets, in this study 60 of the initially 86 therapists were included. Therapists were very experienced and had nearly 14 years of professional practice (see Table 1). Two thirds of them (N = 40) were clustered as more effective therapists, and one third (N = 20) were ascribed to the less effective therapists' group [17].

Clients	
Sex	
Female	124 (70.1)
Male	53 (29.9)
Age	
Mean	40.1
Chronification	
None	120 (67.8)
Prior outpatient or inpatient treatment(s)	57 (32.2)
Marital Status	
Single	90(50.8)
Married	49(27.7)
Separated/divorced	34(19.2)
Widowed	3(1.7)
Living with a Partner (married or unmarried)	58(32.8)
Children	
None	105(59.3)
1 child	20(11.3)
2 children	34(19.2)
3 children	14(7.9)
More than 3 children	4(2.3)
Education	
Schooling completed	3(1.7)
Elementary school	9(5.1)
Training qualification	58(32.8)
University entrance diploma	28(15.8)
College or higher education	33(18.6)
University degree	46(26.0)
Employment Situation	
Full-time job	78(44.1)
Part-time job	57(32.2)
In training	15(8.5)
Unemployed	6(3.4)
Certified unfit for work	7(4.0)
Retiree	7(4.0)
Homemaker	7(4.0)
THERAPISTS	
Sex	
Female	43(71.7)
Female	17(28.3)
Age	
Mean	54.1
Therapists' Effectiveness	
Good	40(66.7)
Poor	20(33.3)
Theoretical Orientation (treated cases)	
Body oriented	68(38.4)
Humanistic	65(36.7)
Psychodynamic	37(20.9)
Integrative	7(4.0)
Professional Experience (in years)	
Mean	13.8
Treatment outcome (treatment cases)	
Successful treatments	124 (70.1)
Unsuccessful treatments	53 (29.9)

Table 1: Demographic Data n (%).

Outcome Measures

The outcome battery was administered by independent, trained psychotherapists (not identical with clients' therapists and not involved in the study). Three tests were completed by the clients: The first was the Brief Symptom Inventory (BSI), which consists of 53 items comprising a broad range of psychological symptoms and nine subscales. We used the Global Severity Index (GSI) as a global measure for psychological distress. The scales have satisfactory high internal consistencies, ranging between .70 and .89 for the GSI. Convergent and concurrent validities were established by high positive correlations with different clinical self-rating scales [41].

The second outcome measure, the Outcome Questionnaire (OQ-45.2) [42], measures symptom load, interpersonal relationship functioning, and the quality of the social integration. The German version has internal consistencies ranging from .59 to .93 for the different scales (Cronbach's alpha). Validation studies showed convergent and concurrent validities between .45 and .76.

The third outcome measure was the German version of Beck's Depression Inventory (BDI-[43]). All scales have an excellent internal consistency (Cronbach's alpha ≥ 0.84) and the retest reliability is .78 after 3 weeks as well as after 5 months. Convergent and discriminant validities range between .68 and .89, depending on the depression measures used such as the Patient Health Questionnaire-9, and the Montgomery-Åsberg Rating Depression Scale (both in the German versions) [44].

Global Outcome

Global outcome was calculated by a summation of all three outcome measures after T-score transformations of all scores at pretreatment (t1), post-treatment (t2), and follow-up (t3) measurement points. The total at t2/t3 was subtracted from the total at t1, resulting in a final outcome T-score. Rather than using a single outcome criterion, this strategy of multiple outcome criteria measures up to the complexity of therapeutic effects rather than using a single outcome criterion [45,46].

Quality of Treatment Outcome

Quality of treatment outcome was defined by using both statistical reliability and clinical significance (reliable change index [RCI] and cutoff score) [47,48]. Treatment success was defined by a change score greater than RCI and a score less than the cutoff score of the respective measure (remission) as well as a change score greater than the RCI and a final score greater than the cutoff score (responder). Treatment failure (no change) was defined by a change score less than

the RCI and still greater than the cutoff score of the particular test, or by a deterioration.

Therapists' Effectiveness

Therapists' effectiveness was calculated via differences of the T-transformation scores between pretreatment and post-treatment/follow-up, which are based on the three outcome measures. A factor analysis of the change scores was carried out as in the Blatt, et al. [49] study to obtain factor scores (eigenvalue > 1) that served as a composite measure of the therapist's effectiveness. The total of the resulting scores for each therapist was then subjected to a hierarchical cluster analysis in order to find clusters of more effective and less effective therapists [15].

Process Measure

The therapeutic relationship was rated after each fifth session using the Helping Alliance Questionnaire (HAQ) [50-52]. The questionnaire consists of 11 items and comprises two scales: The first scale measures the therapeutic alliance as experienced by the client (and in the therapist version, the alliance as experienced by the therapist). The second scale measures treatment satisfaction, (again, in a client and a therapist version). This approach can be considered as an indirect self-report approach, as it uses clients' and therapists' alliance ratings of their subjective impressions of the quality of their working alliance in the preceding session [38].

We administered the HAQ in the client version (HAQ-P; $\alpha = 0.88$) and in the therapist version (HAQ-T; $\alpha = 0.89$). We applied the factorial solution by De Weert-van Oene et al. [52], which divides the 11 items into two subscales: alliance (client version [HAQ-A-P; $\alpha = 0.90$], therapist version [HAQ-A-T; $\alpha = 0.87$]) and treatment satisfaction (client version [HAQ-TS-P; $\alpha = 0.79$], therapist version [HAQ-TS-T; $\alpha = 0.80$]). We used the alliance subscale as a measure for the quality of the therapeutic relationship (alliance) as experienced by clients (HAQ-A-P) and therapists (HAQ-A-T) [5].

Data Analyses

Mixed model analyses were calculated to identify variables that predicted alliance rupture. The mixed model analyses were calculated with different relevant variables as fixed factors (mixed model analysis and fixed effects). Because of the nested data structure (some therapists treated different clients), therapists were included in the analyses as a random factor. T-tests, univariate analysis of variance, factor analysis, hierarchical cluster analysis, correlations, and linear mixed model analysis were all calculated using IBM SPSS Statistics Version 24.

Results

Complete data sets including continuous measurement of the therapeutic alliance on both sides of the therapeutic dyad across treatments (without knowing the other side's rating), as well as complete outcome data sets at t1 (pretreatment), t2 (post-treatment), and t3 (follow-up measurements one year after treatment had finished), were available for 177 treatments, conducted by 60 therapists affiliated with 10 different theoretical approaches. Table 1 shows basic demographic characteristics of clients and therapists.

Clients' age ranged from 17 to 72 (M = 40.1, SD = 11.2). The sex distribution mirrors the typically found 2:1 distribution: 70% of the clients were women and 30% men. Approximately one third of the sample was labeled 'chronic' because of one or more preceding psychiatric or psychotherapeutic treatments in inpatient and/or outpatient settings. Surprisingly, more than 70% of all clients lived alone (as single, separated/divorced or widowed). Noticeable was the relatively high educational level: More than 60% had at least a university entrance diploma and fewer than 4% were unemployed. Regarding DSM-IV diagnoses, 81% of the clients had an Axis I diagnosis (mood disorder, anxiety disorder, or adjustment disorder), and approximately 34% had an Axis II diagnosis.

More than 70% of the therapists were women. Therapists' age ranged from 35 to 79 (M = 54.1, SD = 8.0). Therapists were very experienced (nearly 14 years of professional experience on average). The clustering of therapists' effectiveness into two groups (more and less effective) is described elsewhere in detail [17]. This sample comprised 124 successful and 53 unsuccessful treatments treated by 40 more effective and 20 less effective therapists. The 10 different theoretical orientations of the therapists were clustered in four main theoretical orientations (humanistic, psychodynamic, body oriented, and integrative). About 75% of the total sample were treated following either body oriented or humanistic approaches; 21% were treated with a psychodynamic and 4% with an integrative treatment approach.

Treatment Outcome

Therapists provided approximately 2 to 5 clients on average; clients per therapist ranged from 1 to 8. The general treatment outcome across the sample of this study (N = 177) (effect sizes [ES]) in the BSI were .93 at post-treatment and 1.22 at 1-year follow-up (Cohen's d), the effect size for the OQ-45.2 was 1.04 at post-treatment and 1.53 at 1-year follow-up, and the effect size for the BDI-II was .96 at post-treatment (missing values at follow-up). As the effect sizespre-FU showed, clients continued to improve substantially after

treatment had ended. All therapeutic gains were achieved by an average of 58.2 therapy sessions (*s* = 37.3). Thus, the effect sizes were consistently in the upper range compared to values reported in the corresponding literature. Conceptual orientations/psychotherapy approaches did not differ substantially in treatment outcome [17].

Alliance Ruptures

To identify significant shifts in the alliance ratings-compared to minor fluctuations [53]- we calculated the mean of the differences between clients' and therapists' alliance ratings across treatments for the whole sample similar to the study by Strauss, et al. [32]. However, we took the peaks of the differences in the alliance ratings of therapist and client in each treatment and calculated the mean of these 177 peaks. The mean was 1.37 (*SD* = 0.52). We ended up with 82 treatments with peaks in the alliance differences that were well beyond the mean of the whole distribution (46.3%). Thus, 82 treatments out of 177 showed alliance ruptures.

Twenty therapists out of the total of 60 therapists (not identical with the less effective group of therapists) treated 85 clients and had alliance ruptures in 55 treatments (64.7%; darkened lines in Table 2), whereas 40 therapists had a total of 27 treatments with alliance ruptures (29.3%) and 65 treatments without ruptures in the working alliance (70.7%) in the remaining 92 treatments. Twenty-five (30.5%) of the 55 therapies with alliance ruptures ended prematurely within 15 sessions after the rupture in the alliance experiences of both therapist and client had occurred.

Therapist Nr	Cases in the Study (N)	Cases with interrupted alliance (N) and causation of alliance rupture	Cases without interruption (N)
1	2	-	2
2	5	1	4
3	2	1	1
4	7	3	4
5	3	2	1
6	4	2 (T is disconnecting in 2 cases)	2
7	5	1	4
8	2	-	2
9	2	-	2
10	4	2 (T and client are both disconnecting in 2 cases)	2
11	2	1	1
12	1	-	1
13	4	1	3
14	3	2 (T is distant in 2 cases)	1
15	5	4 (T is distant in 4 cases)	1
16	2	-	2
17	1	-	1
18	1	-	1
19	1	-	1
20	2	1	1
21	4	1	3
22	6	-	6
23	1	-	1
24	3	2 (T is distant in 2 cases)	1
25	4	3 (T is distant in 2 cases)	1
26	3	2 (T is distant in 2 cases)	1

27	6	4 (T is disconnecting in 2 cases)	2
28	1	1	-
29	4	4 (T is distant in 3 cases and disconnects in 1 case)	-
30	3		2
31	1	-	1
32	2	-	2
33	4	1	3
34	4	2 (T is distant in 1 case and disconnects in 1 case)	2
35	4	2 (T is distant in 2 cases)	2
36	4	2 (T is distant in 1 case and disconnects in 1 case)	2
37	5	4 (T is distant in all 4 cases)	1
38	3	2 (T is distant in 2 cases)	1
39	2	-	2
40	3	2 (T is distant in 2 cases)	1
41	6	4 (T is distant in 2 cases and disconnects in 2 cases)	2
42	1	1	-
43	2	1	1
44	5	3 (T is distant in all 3 cases)	2
45	8	4 (T is distant in 3 cases and disconnects in1 case)	4
46	2	1	1
47	1	1	-
48	3	1	2
49	1	1	-
50	4	1	3
51	3	3 (T is distant in all 3 cases)	-
52	4	2 (T is distant in 2 cases)	2
53	2	-	2
54	3	1	2
55	2	-	2
56	1	-	1
57	1	1	-
58	1	1	-
59	1	1	-
60	1	1	-
Total	**177**	**82**	**95**

Note: Therapists with more alliance ruptures are highlighted in gray (at least half of their treatments or more suffer from ruptures).

'Distant': Therapist's scores on the HAQ-A-T scale are continuously > 1.37 lower than those of the client.

'Disconnects': Therapist's scores from a certain session are > 1.37 lower than those of the client and do not return to higher scores on the HAQ-A-T scale for the rest of the treatment.

Table 2: Assignment of Therapists and Their Treatments with Respect to Alliance Rupture.

The 85 treatment cases of the 20 therapists with more alliance ruptures were significantly less effective compared to the 92 treatment cases of the 40 therapists with few ruptures in their working alliances (Scale HAQ-A-T; T =-2.036; df = 175; $p < 0.043$), and therapists with lower alliance ratings scored highly significantly lower than therapists with fewer alliance ruptures (T- 3.323; df = 72; $p < 0.001$). Treatments with premature endings (N = 22 of the 85 treatments) because of alliance ruptures were highly significantly less effective than treatments without ruptures (N = 95) (T = 2.882; df = 115; $p < .005$).

The 20 therapists with more alliance ruptures treated 85 clients and scored also highly significantly lower on the HAQ treatment satisfaction scale (HAQ-TS-T) (T = - 3.043; df =72; $p < 0.003$). From the very start of treatments, these therapists were significantly less emotionally connected (mostly "distant" in the average level of their alliance scorings) with their clients and were at the same time less optimistic with regard to treatment perspectives (treatment satisfaction scorings on the HAQ-TS-T scale). Treatments with repaired alliance ruptures were not less effective than treatments without alliance ruptures (T = 1.591: df = 175; $p < 0.113$).

In total, 95 treatments (53.7%) had alliance difference ratings under the critical difference score of 1.37 and were taken as treatments without an alliance rupture. This seemed to us to be a conservative approach, as we took only the highest alliance difference ratings of each of the 177 therapies as the basis for further calculations.

The return to an alliance rating difference under 1.37 for at least three further session ratings (which in fact were based on a minimum of 15 more sessions) served as the criterion for a rupture repair. No recovery in the alliance rating difference and a discontinuation of the treatment within the next three session ratings (at least 15 treatment sessions) was defined as a premature ending and a demolition of the treatment.

Alliance Ruptures and Clients' Characteristics

Clients' degree of psychological distress at treatment entry as well as the degree of their chronicity of psychological problems did not predict alliance rupture. This was the case also for demographic variables and diagnostic classifications.

Alliance Ruptures and Therapists' Characteristics

Both therapists' professional experience and their effectiveness cluster were not significant predictors of alliance ruptures. Regarding therapists' adherence to their treatment approach, 56 treatments were process analyzed by objective ratings by trained blind raters of treatment adherence using a newly devloped manual [15,17]. The degree of therapists' adherence to their theoretical treatment concept did not predict alliance ruptures in general. However, treatments with alliance ruptures were associated with less treatment adherence by more effective therapists (R = .306; N = 36; p = .022), whereas treatments with alliance ruptures were not associated with changes in treatment adherence by less effective therapists' (R = .204; df = 20; p = .388).

Treatments with interruptions in the working alliance that were repaired did not occur significantly more often in treatments by effective therapists than in treatments by less effective therapists. Thus, hypothesis 3 was not supported. However, more effective therapists had fewer premature treatment ruptures (10.3% of their treatments) than less effective therapists (21.7% of their treatments).

Prediction of Alliance Ruptures

Table 3 shows results of a mixed model analysis with clients' chronicity and severity of their psychological problems, therapists' effectiveness, therapists' degree of professional experience, therapists' average alliance ratings, and therapists' modus of alliance as independent variables, and treatment rupture as a dependent variable. The only highly significant predictor of alliance rupture was therapists' attitude (ability or inability to bond with their client) in the working alliance (p < .001). Nearly all alliance ruptures were caused by therapists' attitudes: They either discontinued the treatment (in 12 treatments) or they scored significantly below their clients' level of alliance ratings ("distant" in 40 treatments) (Table 2). The fact that some therapists treated more clients than others (nested data) had no effect.

Estimates of fixed effects							
						95% Confidence interval	
Parameter	Estimate	SE	df	t	p	Lower bound	Upper bound
Intercept	1.27	0.24	171	5.365	0	0.81	1.75
Clients' chronicity of psychological problems			171	-0.431	0.667	-0.19	0.12
Clients' severity of psychological problems			171	0.259	0.796	0	0

Therapists' effectiveness			171	-0.169	0.866	0	0
Therapists' professional experience			171	-0.13	0.897	-0.01	0.01
Therapists' alliance relationship			171	4.707	0	0.2	0.49
Test of random effects							
Parameter			Estimate	SE	Wald Z	p	Explained variance
Residual			0.25	0.03	8.165	0	0%
Therapist			0	0.02	0.027	0.978	

***p < .001

Table 3: Mixed Model Analysis (Dependent Variable: Alliance Rupture).

No client characteristic played a major role in alliance ruptures. Hypothesis 1 was therefore not supported. Hypothesis 2 had to be rejected as well: More effective therapists did not have fewer treatments with ruptures than less effective therapists did.

Alliance Ruptures and Prediction of Treatment Outcome

As the results of a further mixed model analysis showed, treatment outcome was predicted by clients' severity of psychological problems at treatment entry ($p < .001$) and by therapists' effectiveness ($p < .002$; Table 4). Again, the nested data structure had no influence on the results; the person of the therapist per se did not play an important role. Treatments without any alliance rupture or with repaired alliance ruptures did not predict treatment outcome. Thus, treatments with alliance ruptures were not necessarily less effective in the end compared to treatments without any alliance rupture. Only treatments with alliance ruptures without repair and followed by a premature ending were less effective.

Estimates of fixed effects							
						95% Confidence interval	
Parameter	**Estimate**	**SE**	**df**	**t**	**p**	**Lower bound**	**Upper bound**
Intercept	-190.85	42.85	67	-4.454	0	-276.37	-105.32
Clients' chronicity of psychological problems	8.72	5.3	67	1.645	0.105	-1.86	19.3
Clients' severity of psychological problems	0.41	0.1	67	4.035	0	0.21	0.62
Therapists' effectiveness	19.94	6.3	67	3.165	0.002	7.37	32.52
Alliance rupture	4.07	5.48	67	0.744	0.46	-6.86	15
Client's average alliance across sessions	6.7	5.08	67	1.321	0.191	-3.43	16.83
Therapist's average alliance across sessions	14.35	7.38	67	1.945	0.056	-0.37	29.08
Test of random effects							
Parameter			Estimate	SE	Wald Z	p	Explained variance
Residual			721.203	92.866	7.96	0	41.05 / 774 = .05
Therapist			57.271	64.47	1.006	0.314	approximately 5%

**p<0; *p<.01

Table 4: Mixed Model Analysis (Dependent Variable: Treatment Outcome).

Discussion

The results of this study provide insights into a complex picture of the therapeutic process. Client variables did not play a major role in ruptures in the therapeutic working atmosphere in our sample of 177 treatments. Based on our data, therapists' conceptual orientation and the degree of their adherence to their treatment approach did not play significant roles in the causation of breaks in the therapeutic alliance in psychotherapy or in treatment outcome. This last-mentioned finding is in line with the corresponding research literature [17,54].

We also found that diagnostic categories did not contribute to an understanding of ruptures in the working alliance in therapy. As discussed also in other studies [32,55,56], our findings support the suggestion that ruptures in the therapeutic alliance do not necessarily worsen treatment outcomes. There is discussion that the emergence of clients' typical interpersonal patterns, manifested in the therapeutic transference, might even give clients a chance for an emotional realization of their own unconscious schemata. Thus, a rupture in the working alliance might "disconfirm maladaptive schemata and provide 'corrective experiences'" to disconfirm maladaptive schemata [32].

In our study, breaks in the therapeutic alliance were not predicted by clients' chronicity of their psychological problems or their current degree of psychological distress. However, we found that clients' initial psychological distress predicted treatment outcome highly significantly, thus confirming results of other studies [15,19], but the degree of clients' psychological burden at treatment entry did not predict breaks in the working alliance.

As far as the quality of treatment adherence is concerned, an interesting finding of the study is that only more effective therapists lowered their degree of adherence to their therapy concept when there was a rupture in the therapeutic alliance. This was not the case with less effective therapists. They did not lower their degree of adherence to their conceptual orientation with alliance ruptures.

Regarding alliance ruptures, we found one therapist feature to have a significant effect: The only therapist variable predicting ruptures in the therapeutic working alliance was a specific attitude on the part of some therapists. This attitude might be circumscribed as the ability or inability of the therapists to bond with their clients. In this study, 17 therapists were not able to bond sufficiently with their clients in 40 treatments, and 16 of these 40 treatments (conducted by 12 of the 17 therapists) ended prematurely. One might wonder whether this inability to bond sufficiently with their clients right from the beginning of treatment was due to an insufficient attachment style on the part of these therapists. Although Marmarosh, et al. [10] did not find an association between attachment styles of clients and therapists in the early alliance, our results are in favor of the hypothesis that therapists who seem to have difficulty establishing a good enough attunement early in therapy run an elevated risk for a burdened working atmosphere or even treatment failure. There is little research available on the question of whether psychotherapists with a secure attachment style have better helping alliances in their treatments. But some studies support the hypothesis that securely attached therapists have skills that might help them handle alliance ruptures or even help them to avoid ruptures [57-59].

The results of this study are completely in line with previous findings of our larger research project. In a recent paper we found that similar views on the part of therapists and clients seem to be an indispensable precondition for favorable treatment outcomes [5]. Successful treatments were conducted more often by therapists who showed significant convergence of their alliance ratings with their clients' ratings over time, whereas discrepant alliance ratings correlated significantly with unsuccessful treatments. Supplemented with the results of this study, it seems that successful psychotherapeutic treatments need a working atmosphere right from their beginning that is characterized by a very similar experience of 'belongingness' or 'emotional relatedness' on both sides of the dyad. And/or in case of initial discrepancies in the alliance levels, it is the therapist's task to soon establish the impression on part of the client that the therapist is actively and continuously approaching their-the client's-level of relationship experience.

We also found that the therapists with poor bonding, along with their low alliance ratings (scale HAQ-A-T scale), were obviously skeptical right from the start regarding the therapeutic endeavor and scored lower on the 'treatment satisfaction' scale (HAQ-TS-T). On the other hand, therapists whose alliance ratings were similar to their clients' ratings also scored significantly higher on the HAQ-TS-T scale and subsequently achieved better treatment outcomes.

As also described elsewhere [18], we did not find a direct relationship between clients' initial distress and the dyadic working alliance. Which clients benefit from higher treatment adherence is also still an open question. Are those clients who benefit from higher treatment concept purity more suitable for psychotherapy and those who do not are not? Do clients need the ability of introspection to benefit from psychotherapy? Research studies in this area are rare. Kivlighan, et al. [18] found that clients who were interested in a psychodynamic approach to treatment benefited from therapists' use of psychodynamic techniques. Such tentative first results may indicate that the motivation and

the capability to be helped by specific psychotherapeutic treatments substantially influence the working alliance substantially and, thereby, the treatment outcome.

Limitations and Strengths

Weaknesses of this study concern mainly the sometimes very small subsamples, so that the generalizability of the findings may not be warranted. The present results should be taken as an attempt to generate hypotheses on the complex interrelationship between presumably relevant variables in the therapeutic process, which is based on the working atmosphere between therapist and client.

Strengths of the study can be seen in several aspects. The results are based on 177 treatments that were carried out by 60 very experienced therapists coming from 10 different theoretical orientations in a naturalistic clinical setting. First, the results cannot be traced back to particular theoretical affiliations. Second, the empirical basis of 60 therapists and 177 clients with a typically wide range of psychological problems provides a solid ground for assumptions that should be investigated in further research. Third, the results are based on detailed process-outcome research that includes objective ratings of a subsample of therapists' true intervention behavior across the whole treatments and continuous ratings of the working alliance on both sides of the therapeutic dyad, independently of each other. Thus, although the empirical basis is occasionally very small, the precise and complex analyses from different perspectives in naturalistic clinical settings are significant and should have implications for future research.

Implications for Future Research

The results of this study are in favor of the idea that the person of the therapist plays a far more important role in psychotherapy than has long been assumed [13,16,38,60]. There have been research efforts only recently to study therapists from different angles and to consider methodological issues properly [60].

Our findings point to the differential effectiveness of psychotherapists beyond their theoretical orientations and regardless of clients' symptoms [15]. We found that more effective therapists are able to sense their clients' view and experience of the working alliance [5]. The results of this study support the view that some ruptures in the working alliance may be due to a fundamental incapability of therapists to bond sufficiently with their clients. If so, they are not able to catch up with their clients' alliance experience. Research in this domain has to address such topics as therapists' competence (whatever it may look like) and their capability to attune to their clients' feelings and experience (keyword 'attachment'). Also, studying the immediate effects of specific technical interventions [18,61] seems to be a rewarding goal.

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