INFLUENCE OF THERAPIST BEHAVIORS ON THERAPEUTIC ALLIANCE

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ABSTRACT: A number of recent studies have investigated the relationship between therapist and client gender and conversation in marriage and family therapy. There has also been recent empirical investigation of therapeutic alliance and its influence on therapy outcome in marriage and family therapy. However, there has been limited investigation of the influence of interactional patterns on therapeutic alliance. It seems probable that therapy conversation (which seems to be influenced by gender) will influence therapeutic alliance and subsequent outcome.

KEY WORDS: therapy process; therapeutic alliance; family therapy; theoretical orientation.

RELEVANT LITERATURE

Therapeutic relationship seems to be addressed in most approaches to marriage and family therapy, but it has been conceptualized differently across traditions.

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Systemic Conceptualizations of Therapeutic Relationship

Systemic family therapy theories such as structural-strategic and family of origin suggest that therapists should serve as leaders in therapy. Structural family therapy, which refers to the process of cultivating therapeutic relationship as "joining," encourages a partnership with the family in which the therapist acts as a leader: "The therapist is in the same boat with the family, but he must be the helmsman" (Minuchin & Fishman, 1981, p. 29). The Bowen (1978) perspective suggests that therapists should coach clients to achieve differentiation. In these systemic therapies, the therapist is an active participant who is likely to challenge clients and give them advice.

Post-Modern Conceptualizations of Therapeutic Relationship

Challenging and advice giving have been referred to pejoratively by post-modern theory as "taking an expert stance," which is discouraged. The post-modern tradition emphasizes collaboration with clients. In solution-oriented therapy, the joining process is described as attempts by the therapist to make the client feel comfortable: "Our goal during the joining period is to show nonjudgmental interest in them and help them feel comfortable" (O'Hanlon & Weiner-Davis, 1989, pp. 81–82).

Individual Psychotherapy Conceptualizations of Therapeutic Relationship

The discrepancy between conceptualizations of therapeutic relationship is also demonstrated in individual psychotherapy. For example, psychoanalytic theory suggested that therapy features transference and countertransference between therapist and client, while client-centered therapy emphasized unconditional regard (Bordin, 1994).

A Pan-Theoretical Conceptualization of Therapeutic Relationship

Despite these different conceptualizations about the role of therapeutic relationship, Bordin (1979, 1994) suggested that the therapeutic relationship was influenced by an alliance between therapist and client that transcended theoretical orientation (he referred to it as a "pan-theoretical" perspective). Bordin suggested that both the therapist and

the client play active roles in therapy; this conceptualization of alliance featured three dimensions: goals, tasks, and bond (Bordin, 1979, 1994). Therapeutic goals are the negotiated outcomes for therapy; tasks are the behaviors and cognitions which occur during therapeutic process; and bond refers to the quality of attachment between the therapist and client (Bordin, 1979, 1994). Distinguished family therapy scholar Lyman Wynne (1988) suggested that the therapeutic alliance should be a central feature of empirical research in marriage and family therapy.

Empirical research seems to support Bordin's (1979, 1994) and Wynne's (1988) propositions because therapeutic alliance is associated with positive outcomes in therapy. For example, results from a meta-analysis of 24 studies that evaluated various measures of working alliance to treatment outcome suggested that quality of the working alliance predicted positive therapy outcome (Horvath & Symonds, 1991). Further, the relationship of working alliance to therapy outcome does not seem to be influenced by type of treatment, length of treatment, or number of participants who participate in the research study (Horvath & Symonds, 1991).

Factors Associated with Alliance in Marriage and Family Therapy

Although evidence seems to suggest that therapeutic alliance predicts outcomes, less is known about factors that contribute to developing it. Much of the writing about influences on therapeutic alliance—especially in marriage and family therapy—has been conceptual and speculative rather than empirical. Relying on an explanation of factors that contribute to therapeutic alliance based on theory rather than empirical evidence returns us to the problem we described earlier–competing notions about therapeutic relationship. This seems to be problematic since no single therapy orientation seems to influence development of therapeutic alliance (Werner-Wilson & Davenport, 2003).

One empirical investigation of therapeutic alliance in marriage and family therapy suggested that gender and therapy modality influence development of alliance (Werner-Wilson, 1997). Women and men clients at a university clinic completed a measure of therapeutic alliance following their third therapy session. Results suggested that women clients developed a stronger alliance in marital therapy while men clients developed a stronger alliance in family therapy (Werner-Wilson, 1997). This study was based on client self-report so the authors were unable

to identify specific factors that contributed to differences in women and men.

Another, more recent, investigation of factors associated with alliance suggested that different theoretical perspectives contributed to different aspects of therapeutic alliance (Werner-Wilson & Davenport, 2003). Women and men clients, who were participating in couple therapy with therapists in private practice, completed a measure of therapeutic alliance while therapists answered questions about theoretical orientation. Structural family therapy was the only theoretical orientation that seemed to influence more than one dimension of therapy alliance.

PURPOSE

The two studies that investigated influences on therapeutic alliance (Werner-Wilson, 1997; Werner-Wilson & Davenport, 2003) were based on self-report measures of alliance completed by clients so it was not possible to identify specific factors that contributed to alliance during the therapy session. The present study features observation of therapy sessions—with attention to gender of the therapist and client since it seems to influence therapeutic alliance—to investigate the influence of therapist behaviors on therapy alliance in marriage and family therapy in order to answer two research questions:

1. How is therapeutic alliance influenced by gender of therapist and client?
2. What therapist behaviors contribute to therapeutic alliance for men versus women?

METHODS

Participants

The sample for the present study included clients ($n = 106$) and therapists ($n = 42$) from two sources: (a) doctoral student therapists ($n = 12$) and clients ($n = 76$) at a non-profit marriage and family therapy clinic at a major southern university that was accredited by the American Association for Marriage and Family Therapy's Commission on Accreditation for Marriage and Family Therapy Education, and (b)

"master" therapists (n = 30) and clients (n = 30) from the Master Series video collection distributed by the American Association for Marriage and Family Therapy. "The Master Series presents the world's most respected marriage and family therapists conducting live, unedited therapy sessions at AAMFT annual conferences" (AAMFT Catalog, 1993, p. 4). Including tapes from two sources provided us with an opportunity to expand our sample. In each case, the session was the initial consultation with either the student therapist or the master therapist and it featured both an adult woman client and an adult man client who were romantic partners.

Procedures

We examined the first therapy session (n = 106) to control for treatment duration. Therapy sessions have predictable stages (e.g., social, engagement, information collection, intervention, closure), so we examined multiple time points in the session. Three five-minute segments were coded for every client from early, middle, and later stages in the session: (a) 10:00 to 15:00 minute segment; (b) 25:00 to 30:00 minute segment; and (c) 40:00 to 45:00 minute segment. Two senior-level undergraduate students, who were unaware of the purpose of this research, coded videotapes from the first therapy session.

Coder training. Coders learned the coding scheme by practicing on tapes not featured in the sample until they achieved 80 percent agreement. A graduate student, who was also unaware of the purpose of the present study, coded every sixth session; these tapes were used to calculate inter-rater reliability. The coders maintained an acceptable level of interrater reliability throughout the coding process: intraclass correlations were .68.

Coding scheme. The transcripts were arranged with codes adjacent to each spoken turn to promote reliability by eliminating the need for coders to memorize codes: the coders viewed the video with the transcript and circled the appropriate code as they occurred during each speaking turn. A distinct set of codes was printed next to each speaker (e.g., therapist, woman client, man client) but each set of codes featured the same possible codes. In addition to enhancing reliability, this coding arrangement disguised the nature of the research project because coders identified conversational strategies used by each speaker, not just the therapist.

Therapist Behavioral Codes

Positive statements. Statements that are directed toward a target that have a direct or implied approval.

Negative statements. Statements that are directed toward a target that have a direct or implied disapproval.

Challenging/confronting statements. Statements that are interpreted as disagreements, providing alternatives, or requests for an explanation.

Advice giving. Examples include: "I think you should . . ." and "he needs to . . ."

Measure of Therapeutic Alliance

The Working Alliance Inventory, Observer Version (WAI-O) was used to measure the degree to which the therapist and individuals within the session seem to have developed a sense of therapeutic alliance. The WAI-O, which is completed by an independent observer, is theoretically rooted in Bordin's (1979, 1994) conceptualizations of the therapeutic alliance (Horvath, 1994). Its scores have been shown to share a significant amount of common variance with other measures of working alliance and it is familiar to psychotherapy process researchers, as well as to clinicians (Hanson, Curry, & Bandalos, 2002). It has been demonstrated to be both reliable and valid for measuring therapeutic alliance by observation, with reliability score estimates that are uniformly high, ranging from .79 to .97. These estimates easily meet professional standards of acceptability (Hanson, Curry, & Bandalos, 2002). The scale shows a .98 Cronbach's alpha, demonstrating high internal consistency, and an inter-rater reliability estimate of the total scores (Hanson, Curry, & Bandalos, 2002).

Like the self-report measure of working alliance developed by Horvath, the WAI-O has three subscales: (a) goal, (b) task, and (c) bond. The goal subscale measures negotiated outcomes for therapy. The task subscale measures behaviors and cognitions that occur during the therapeutic process. The bond subscale measures the quality of attachment between therapist and client.

RESULTS

Multivariate Analysis of Variance

A multivariate analysis of variance (MANOVA) was conducted that featured the goals, tasks, and bond dimensions of the WAI-O as the dependent variables with client gender and therapist gender as independent variables. Results of the MANOVA include two statistically significant findings: client gender and therapist gender significantly affect the bond subscale of the WAI-O (means and standard deviations for influence of client and therapist gender on each WAI-O subscale are reported in Table 1). The scores on the bond dimension of the WAI-O were higher for women clients ($M = 5.47$, $SD = .38$) than men clients ($M = 5.30$, $SD = .51$) which was statistically significant, $F\ (1,\ 105) = 3.83$, $p < .05$. The scores on the bond dimension of the WAI-O were higher for women therapists ($M = 5.53$, $SD = .46$) than men therapists ($M = 5.31$, $SD = .44$) which was statistically significant, $F\ (1,\ 105) = 5.38$, $p < .05$.

Correlation Analyses

Correlation analyses were completed to investigate the relationship between therapist behaviors and therapeutic alliance. Several therapist behaviors were significantly correlated with the bond (but

TABLE 1
Influence of Therapist and Client Gender on Alliance

	Woman Therapist (n = 34)		*Man Therapist (n = 72)*	
	Mean	*(SD)*	*Mean*	*(SD)*
Woman Client (n = 53)				
Goal	5.78	(.39)	5.65	(.50)
Task	5.55	(.63)	5.57	(.45)
Bond	5.63	(.42)	5.39	(.34)
Man Client (n = 53)				
Goal	5.66	(.55)	5.60	(.53)
Task	5.55	(.50)	5.47	(.50)
Bond	5.42	(.47)	5.24	(.52)

not goal or task) dimension; there were differences between women and men clients (see Table 2). Specifically, bond scores increased for women and men clients when therapists made challenging statements or advice-giving statements. Bond scores also increased for men clients when therapists made positive statements about them.

There are two findings from the present study related to gender: women clients seemed to have higher bond scores than men clients and women therapists seemed better able than men therapists to create a therapeutic bond with clients. The bond score on the WAI-O might be systematically lower for men clients than women clients because men clients are often reluctant "customers" since their women partners are much more likely to initiate therapy and because of masculine socialization (e.g., men are raised to eschew help-seeking). Therapists could directly inquire about these factors with men as a way to strengthen the bond dimension. The finding that women therapists were better able to cultivate a therapeutic bond suggests that men therapists might pay particular attention to this dimension of therapy. This finding could also be related to masculine socialization: emphasis on problem solving to the exclusion of relationship, which is a common masculine characteristic, may interfere with cultivating a therapeutic relationship.

There were also findings that transcended gender. Results from the present study suggest that alliance for both women clients and men clients was positively influenced by therapists who gave advice and challenged them. This seems to support systemic approaches to therapy that encourage therapists to accept a leadership position. For therapists who are inclined to incorporate post-modern ideas about

TABLE 2
Correlation Between Therapist Behavior and Bond

	Bond for Woman Client (n = 53)	*Bond for Man Client (n = 53)*
Positive Statements	r = .24	R = .28*
Negative Statements	r = .04	R = .16
Challenging Statements	r = .42**	R = .27*
Advice Giving Statements	r = .33*	R = .30*

*$p < .05$; **$p < .01$.

marriage and family therapy, offering advice and challenges could still be done collaboratively. For example, therapists can tentatively offer advice or challenges. Even if therapists eschew leadership and emphasize collaboration, clients perceive therapists as being in charge. This was exemplified in an intensive single-subject design study in which the investigator asked a client to identify meaningful moments in her therapy with a therapist who practiced narrative therapy.

> Moira [the client] seemed to believe that Nick's [the therapist] knowledge helped guide her. She appeared to implicitly trust that he knew the territories she needed to cross, and she counted on his guidance to help her successfully negotiate these new and unfamiliar places. For example, while watching part of one therapy session, Moira said, 'I see him move like he has something to say and so I kind of just drop that thing because I know he knows . . . what is important' (Gaddis, 1998, p. 44).

CONCLUSION

Therapeutic alliance remains, as Bordin (1979, 1994) and Wynne (1988) suggested, an important aspect of therapy. The present contribution to the literature identifies additional gender influences on alliance.

REFERENCES

American Association for Marriage and Family Therapy Catalog (1993), Washington, DC, 4.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16,* 252–260.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp.13–37). New York: John Wiley & Sons.

Bowen, M (1978). *Family therapy in clinical practice.* New York: Jason Aronson.

Gaddis, S. R. (1998). *The adventure: One client's narrative about narrative therapy.* Unpublished master's thesis, Colorado State University, Fort Collins.

Hanson, W. E., Curry, K. T., & Bandalos, D. L. (2002). Reliability generalization of working alliance inventory scale scores. *Educational and Psychological Measurement, 62,* 659–673.

Horvath, A. O. (1994). Empirical validation of Bordin's pan theoretical model of the alliance: The working alliance inventory perspective. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 109–128). New York: John Wiley & Sons.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques.* Cambridge, MA: Harvard University Press.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy.* New York: Norton.

Tichenor, V. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26,* 195–199.

Werner-Wilson, R. J. (1997). Is therapeutic alliance influenced by gender in marriage and family therapy? *Journal of Feminist Family Therapy, 9*, 3–16.

Werner-Wilson, R. J. & Davenport, B. R. (2003). Theoretical purity versus theoretical layering in marriage and family therapy. *Contemporary Family Therapy, 25,* 77–88.

Wynne, L. C. (1988). An overview of the state of the art: What should be expected in current family therapy research. In L. C. Wynne (Ed.), *The state of the art in family therapy research: Controversies and recommendations* (pp. 249–280). New York: Family Process Press.