CHAPTER 1

Alliance Theory and Measurement

Robert L. Hatcher

Alliance issues confront therapists in their practices every day. When things go as expected and the patient is engaged and responsive, we know we are working well together. Our patients blossom, making the approach we have offered them their own, moving forward with confidence and satisfaction. Our work is on track. And we know the work is off-course when our patient seems to be losing interest, becomes silent or angry with us, or seems to feel misunderstood. At these times, we look to our technique, or to our creativity in the moment, to find ways to help the patient reengage in the work of therapy. Alliance theory, and its precursors in early psychoanalysis, emerged as a way to think about and address these important issues in clinical work. Along the way, researchers developed ways to measure alliance, with valuable applications for research and practice.

The aim of this chapter is to develop a broad perspective on alliance theory and measurement, tracing its development over the years as therapists wrestled with issues like these. We will sift out the key features of alliance to help understand its place in our theories of therapy and in research, and to see how these features have been measured. Here is an outline of these key features. When conducting therapy, therapists bring their expectations for how the work should go, based primarily on the treatment method they choose to apply. Patients have their own goals and bring their own expectations for how therapy should go. Differences are continually negotiated

between the two. Across different therapeutic approaches, a good alliance means that patients and therapists are working well together toward the goals of therapy. Good work is expected to be purposeful and collaborative. Thus, alliance is a way to think about how the patient and therapist are working together. Alliance measures assess this working relationship. Over the years, therapists have expanded their techniques to address the problems that interfere with effective collaborative work. Often these new approaches have themselves become central to clinical work. In this chapter we will find how the recognition and use of these key alliance concepts help clarify some nagging issues in clinical theory and research, such as whether alliance is part of the relationship in therapy, how alliance is related to technique, and, more broadly, whether it is still useful to think in alliance terms.

THE ORIGINS OF ALLIANCE THEORY IN PSYCHOANALYSIS

Freud encountered alliance issues as soon as he began to use psychological methods to treat his patients. He expected his patients to submit to hypnosis, but they resisted his efforts to hypnotize them. After he abandoned hypnosis in favor of free association, they resisted free association. Later Freud recognized that the patient's transference to him interfered with the work of analysis, which included the task of remembering rather than repeating old pathogenic relationships and experiences. All of these phenomena he called "resistance," which meant that his patients were not participating in the work as expected; at worst, they left treatment. In current alliance terms, these were strains or ruptures in the alliance. Freud did not think in alliance terms and used the concept late, in 1937 (Freud, 1937/1964). Nevertheless, we can identify as alliance issues his struggles to engage and keep his patients in treatment. We can see that many of the techniques of analysis were designed to help patients become or remain engaged in the work of treatment. Analysis of resistance was designed to help patients get back to facing their conflicts more directly. Analysis of transference began when patients' feelings toward Freud as a helpful physician were eclipsed by other strong feelings toward him, interfering with the work of analysis.

The picture of the patient as a partner in the work of treatment is implicit in Freud's writing (1912/1958a, p. 104). His vision is of a person with a reasonable understanding of the goals and tasks of the therapy but whose participation is susceptible to interferences that lead to breaches in the working relationship. In response Freud modified his technique to help steer the patient back. This pattern is a recurring theme in the development of theories of treatment and alliance.

Freud was especially concerned about dealing with the obstacles to sustaining engagement and commitment, and gave relatively little attention to how patients become engaged in therapy and to what sustains their commitment when things are difficult. His few early comments on these issues, however, are cited by contemporary authors as the origin of alliance thinking (see Freud, 1913/1958b, pp. 139–140). Freud emphasized the personal tie—the bond—between patient and therapist, based on an "unobjectionable" positive (but not excessively positive) transference derived from earlier experiences of care from benevolent others (1912/1958a, p. 99). This bond keeps the patient in treatment, helps overcome doubt, and promotes cooperativeness. It is maintained by careful work on interfering interpersonal patterns (transferences) and on other avoidance moves (defenses/resistances). In Freud's early focus on the bond, there is less emphasis on the "reasonable" patient. But the purpose of the bond is clear: to help the patient participate effectively in the work of treatment.

As psychoanalysts took more interest in the ego, the rational, reality-oriented aspect of the person, Freud's picture of the patient as ally came more clearly into view. Sterba (1934) introduced the term "alliance" and expanded the idea that the patient has a rational, observing capacity with which the analyst can ally against the irrational forces of the patient's transference and defenses. In one of his last publications, Freud (1937/1964) discussed what he called the analytic "pact," noting that "the analytic situation consists in our allying ourselves with the ego of the person under treatment" (p. 235) and considering at length the limits placed on this pact by various features of the patient's personality and by the particular demands of psychoanalytic treatment on the patient. Over time, the idea of collaborative work became more prominent as compared to Freud's early emphasis on the emotional tie.

A number of important elements in our picture of the alliance came from this early work. The key issues are these: as clinicians, we want our patients to be engaged in and committed to the work of therapy as we and our theory define it, whether we are psychoanalysts or behavioral therapists. This engagement is a product of an alliance between the therapist and the patient's reasonable, realistic self around the goals of treatment and the particular therapeutic activities that are prescribed by our theories of therapy and technique. Patients make this commitment based on their determination that this therapist, and this therapy, can provide a treatment that will lead to desired changes. The patient's commitment and engagement in the work are also supported by an overall positive feeling toward the therapist, a sense of trust that enhances good will and suppresses doubt and hostility. When the patient's engagement and commitment falter, techniques need to be developed to help bring the patient back on track.

The discussion of alliance was relatively dormant in psychoanalysis

from the 1940s to the mid-1960s, when Greenson's (1965, 1967) contributions appeared. In an extensively documented clinical discussion, Greenson used the term "working alliance" to emphasize what he called the "outstanding function" of the alliance, which is "the patient's ability to work in the analytic situation" (1965, p. 202). Greenson focused strongly on the collaborative aspect of the alliance, which he felt, following Sterba (1934) and Freud (1937/1964), was gradually achieved through interpretation of interfering transferences and the patient's identification with the analyst's ways of working in the treatment. He tried to separate the working alliance proper from its roots in transference and attachment, recognizing though that the alliance is sustained by a base of trust and goodwill. An innovative part of Greenson's approach was to talk directly with his patients about alliance issues, seen as more than manifestations of transference or defense. When needed, Greenson discussed the goals, methods, and purposes of the psychoanalytic work with his patients (1965, 1967). He explored their ideas about and reactions to the expectations that psychoanalysis sets for patients and analysts. It is true that Greenson's definition of the working alliance refers only to the patient's ability to work in treatment. But his technical advice and his many examples of analysts' failed efforts to work effectively with patients, point to the therapist's as well as the patient's ability to work together. As we shall see, Greenson's contributions evoked strong reactions from many different quarters within psychoanalysis.

Up to this point, alliance was mostly of interest to psychoanalysts. In the mid-1970s they were joined by several major psychotherapy researchers. Of these, Bordin developed the most comprehensive theory with his innovative (1979, 1980, 1994) working alliance theory. This work stimulated a vast array of research studies on the alliance that continue to this day. Bordin (1979) saw the alliance concept as a unifying theoretical framework for all types of interpersonal change processes, including the psychotherapies that were then proliferating at an alarming rate. His core idea was this: Every form of therapy has a set of expectations or demands for the patient and therapist and how they will work together. These are the rules of treatment that follow from the clinical theory, and they vary in degree and kind, depending on the approach.

Bordin recognized that clinical theories demand specific work from patients and therapists, which he called "embedded working alliances" (1979, p. 253). We might better call these "embedded working alliance expectations." In any case, Bordin's alliance theory is a theory of therapy as work, which is why he called it the working alliance. His alliance theory was designed to account for how clinical theory (e.g., psychoanalysis, gestalt therapy, cognitive-behavioral therapy) gets translated into a clinical change process: theory prescribes the work expected of patient and therapist to effect change; to the extent they work together as expected, change will

occur. This broad theory is accompanied by a set of hypotheses about the work. These hypotheses are that the alliance is strong to the extent that patient and therapist can jointly negotiate and carry out the expected work, as negotiation of expectations is required for effective engagement in the work; that the stronger the alliance, the better the result of treatment; and that strong alliances result from good matches between the treatment's alliance expectations and the personal characteristics of the patient and therapist (1979, p. 253).

The negotiation of the alliance between patient and therapist begins at the start of therapy and continues throughout. This negotiation is between the expectations of the therapist, as guided by clinical theory, and those of the patient, reflecting the patient's understanding of the problems and the best means to solve them, conditioned by the patient's level of trust, and so on (Bordin, 1979, p. 255; see also Safran & Muran, 2006). Bordin saw three elements of this negotiation: agreement on goals, collaboration on tasks, and establishment of the bond. These categories are compelling, and many clinicians and researchers take them to be Bordin's alliance theory. But these are simply operational parts of his broader theory of alliance, which concerns the work required by the type of therapy being engaged in. Bordin's alliance theory gives us more than a way to think about how alliance is built and maintained through negotiation of goals, tasks, and bonds. It opens a broader perspective, enabling us to raise questions about therapy as collaborative, purposeful work. The full theory begins with the idea that work is an activity directed toward a goal—it is purposeful. Two people working together toward a goal requires collaboration. Thus, this work is anchored in agreement on goals, collaboration on tasks, and supported by an appropriate bond. If, however, we think only in terms of implementing the alliance through agreement on goals and tasks, and the supporting bond, we can lose sight of the broader perspective that Bordin's theory offers of alliance as collaborative, purposeful work.

Bordin's work has been enhanced by later contributors. His view of alliance as negotiated and dyadic was a significant contribution, ahead of its time. However, Bordin underplayed the client's active contribution to the negotiation process, stressing instead the role of the therapist in creating consensus and collaboration (e.g., Bordin, 1979, p. 254). His valuable concept of alliances embedded within therapeutic approaches underemphasizes the fact that patients have their own ideas about how therapy should work and these ideas play a significant role in the negotiation of work in therapy. In a series of important contributions, Safran and Muran (e.g., 2000, 2006) and colleagues have highlighted the negotiation process in forming and maintaining the alliance, paying particular attention to the issue of openly and effectively countering the client's disagreement or doubt about the treatment.

INTERNAL WORKING ALLIANCE MODELS

The concept of an internal working alliance model can help anchor these ideas. Patients and therapists both come to therapy with their own ideas about what good work consists in. This is the starting point for their negotiation of the alliance. The patient judges his or her experience of the work with the therapist based on this initial model. If the experience does not meet expectations, the patient will withdraw temporarily or permanently (or perhaps endure submissively); a mismatch for the therapist leads to a search for methods to address the problem. These working models, reflecting the cumulative and ongoing evaluation of the quality of the work in therapy, are an important part of the working alliance. In this sense, the working alliance model is an active ingredient in therapy—it provides a sustaining rationale and basis for participating in the work of treatment. It is also, in this sense, the glue of therapy, holding things together, providing an organizing, motivating perspective for the patient. Because the patient can see where the therapy is going and what the value of therapy is even when the going gets tough, the model keeps the patient from abandoning the project. Bordin's ideas would suggest that direct negotiation directed toward these models would help advance therapy. But since the models are the result of the patient's evaluation of the work, the quality of the work will have a significant effect on the model as well, as we shall see.

In the remainder of this chapter, we discuss the relationship between alliance and the therapeutic bond. We examine how alliance is measured and discuss several key conceptual issues in alliance from this working alliance point of view, including some of the major objections to the use of alliance as a concept. We review how the working alliance viewpoint relates to technique and to the overall relationship between patient and therapist. And finally we discuss the issue of the alliance as a curative agent in its own right. During the course of this discussion we suggest some modifications to alliance theory.

THE THERAPEUTIC BOND

Looking back at Freud's early reports (1910/1957, 1912/1958a, 1913/1958b), we see him struggling with what keeps patients in treatment and how to deal with interferences in the alliance. One positive force he identified was the patient's "unobjectionable" positive transference—the bond in alliance terms. The important feature of this bond is that it facilitates the working alliance. Alliance-facilitating bonds are bonds that support the work of treatment. They are not bonds for bonds' sake, but rather they facilitate the work. In the "unobjectionable" positive transference, Freud identified what

he saw as an optimal alliance-facilitating bond for psychoanalysis. Bordin generalized this point by asking, what level or type of bond is required by a given treatment approach in order for it to work properly? (1979, p. 254). He suggested that psychoanalysis requires a very different level of trust and attachment than a brief symptom-oriented therapy (p. 254). Many interesting points about the role of the bond follow from this approach. A patient's positive idealizing bond, which might well support a cognitive-behavioral treatment, may interfere with a process–experiential treatment's efforts to explore angry feelings toward the therapist. Similarly, a high level of care and concern from a therapist may facilitate some types of treatment or be suitable to some kinds of patients but not to others. Overall, there may be an optimal level of liking and trust for a given therapy, where too little may inhibit effective engagement while too much may as well (Hatcher & Barends, 2006).

These considerations point to a "work-supporting" bond that is distinct from the overall level of liking, respect, and concern (Hatcher & Barends, 2006). It would be valuable to take a closer look at the components of the work-supporting bond. To help build collaboration on the tasks of therapy, Bordin (1979, p. 254) recommended building the patient's confidence that the therapeutic method will lead to the desired outcome. Providing the patient with good evidence-based information aids in this task, but conveying the therapist's engagement and optimism in the work helps too. This emotional appeal may lead to what Hatcher and Barends called the "potentiating bond." These authors also identified an "appreciating bond" that is fostered by the therapist's genuine interest and appreciation for the patient as a person, showing empathy and a desire to understand the patient's experience. These two aspects of the work-supporting bond may be important to the early remoralization stage of therapy, promoting confidence, optimism, and commitment to the treatment (Howard, Lueger, Maling, & Martinovich, 1993). Of course, Rogers's extensive work on therapist-facilitating conditions (e.g., 1957) overlaps especially with the "appreciating bond." However, Rogers's idea was that providing these conditions was what brought desired change to the patient; the idea presented here is that these conditions contribute to making collaborative, purposeful work possible. These are not incompatible views, but they can easily be confused with each other.

Bordin (1979) did not consistently distinguish between the overall bond as mutual liking, respect, etc., and the work-supporting bond that is linked to purposeful work. This delinking has persisted in contemporary accounts of the alliance. For example, in their meta-analysis of alliance outcome research, Martin, Garske, and Davis (2000) described "the affective bond between patient and therapist" (p. 438) as a common feature across current alliance theories. This very broad definition of the bond is problematic

because it embraces a wide range of relationship features such as respect, liking, appreciation, attachment, and warmth without linking them to the work of treatment. In most circumstances, the bond is likely to facilitate the therapeutic work, but it cannot be assumed that this is always so. As noted, some types of positive bonds may interfere with treatment, and some may be unrelated to effective work, as one can like and respect another person despite being unable to work productively together (Hatcher & Barends, 1996).

ALLIANCE MEASUREMENT

As interest in the alliance grew during the 1970s and '80s, researchers worked to translate the years of accumulated clinical indicators of alliance into reliable and valid alliance measures. Important advantages come to researchers and practicing clinicians from standardized alliance measurement. Standard measures allow researchers to compare alliance across therapist–client pairs and over time, and thus to investigate the role of alliance in therapy process and outcome. Clinicians can objectify their own clinical sense of the alliance and add to it the perspective of the client, whose views of the alliance may at times be quite divergent. Lambert and colleagues have demonstrated that use of routine client ratings of the alliance, along with other variables, can significantly reduce the rather large percentage of clients who deteriorate during treatment (Harmon et al., 2007).

The precursors of alliance measurement first appeared during the 1960s, and alliance measures multiplied extensively following Bordin's call for a research focus on alliance (Bordin, 1979). Important early developments included scales created by Luborsky (Alexander & Luborsky, 1986), Horvath (Horvath & Greenberg, 1989), and the Vanderbilt group (Hartley & Strupp, 1983; see Elvins & Green, 2008, for a comprehensive history and catalog of alliance scales). Many scales were designed for use with adult psychotherapy outpatients. More recently, others were developed for use with children, adolescents, inpatients, groups, couples, and families and in such diverse settings as medical offices and inpatient centers. Nevertheless, the bulk of alliance-related research is conducted with a few core measures: the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989); the California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994), which have therapist-, patient-, and observer-rated versions; and the observer-rated Vanderbilt Therapy Alliance Scale (VTAS; Hartley & Strupp, 1983). These scales, with the exception of the WAI, were developed on the basis of an eclectic conceptualization of the alliance. However, for the most part they contain items that refer to issues that have a fairly clear link to the state of the collaborative, purposeful working alliance. For example,

the VTAS includes the item "Patient and therapist relate in honest, straightforward way." It can be argued that this item reflects an "embedded alliance" requirement present in virtually every form of psychotherapy. Most other VTAS items are very clearly related to the expected work of therapy, such as "Patient makes effort to carry out therapeutic procedures." Thus, available alliance questionnaires do a creditable job in assessing patient, therapist, and observer perceptions of the quality of the working collaboration—with the exception of a few overly general bond items (e.g., WAI: "I believe my therapist likes me") and questions that reflect tasks of specific types of therapy (e.g., CALPAS: "When your therapist commented about one situation, did it bring to mind other related situations in your life?"). The WAI has the clearest conceptual footing, as it was developed on the basis of Bordin's (1979) conceptualization of the alliance as constituted by agreement on goals and tasks and supported by the bond. The WAI includes no items referring to specific treatment methods, although as mentioned it has a number of bond items not linked to the work of treatment. This clear theoretical link may account for the commanding popularity of the WAI in alliance studies (Martin et al., 2000). Short forms for many of these measures have been developed, exhibiting good psychometric properties and validities (e.g., VTAS—Shelef & Diamond, 2008; WAI—Hatcher & Gillaspy, 2006). These measures give a general overall reading of the state of the working alliance at the session level. Although there is some evidence that these measures tap discernible dimensions of alliance (e.g., Hatcher & Gillaspy, 2006), a compelling argument can be made that these measures are like room thermometers in that they give an overall reading of the quality of the working alliance without being very localized or specific about it.

Measurement of specific alliance features can be guided by examining the "embedded alliances" that exist in particular therapies. Different treatments demand different alliances, as Bordin (1979) pointed out. This aspect of alliance measurement remains largely unexplored. It appears likely that for particular treatment approaches some components of the collaborative work will have greater influence on the outcome or may even be critical to success. For example, a study of depressed patients in cognitive therapy by Brotman (2004) showed that "patients who facilitated therapists' adherence to concrete techniques demonstrated significantly more improvements in the following session," citing as an example "patients who were able, interested and/or willing to provide specific examples of events or cognitions" (p. 33). Brotman suggested that therapists' "encouraging active involvement in their patients will improve patient adherence" (p. 35). Although encouraging active involvement is a general alliance-enhancing technique, here the focus is quite specific: patients should facilitate therapist adherence to concrete techniques, and therapists should do whatever they can to encourage patients to participate in this way. This approach demonstrates the close

link between productive work and alliance and may be a rich and rewarding area of growth in alliance research and clinical work. A good alliance measure for this therapy would include items related to this specific treatment feature. Further, we can see research potential in determining exactly which work requirements are critical to a given treatment's success. This line of investigation would bridge "unpacking" research that determines which components are most critical to success (e.g., exposure vs. cognitive restructuring for anxiety) with research aimed at determining what the work requirements are for the participants so as to maximize implementation of these components.

THE RELATIONSHIP BETWEEN TECHNIQUE AND ALLIANCE

Differentiating Alliance and Technique

The relationship between technique and alliance has been much discussed. We define technique as the therapist's deliberate planful tactics to effect desired changes in the patient. Technique is based on and guided by clinical theory. For example, the technique of exposure to anxiety-provoking situations is based on the theory that anxiety is extinguished by blocking avoidance processes and permitting graded exposure to the anxiety-provoking situation. Technique is the therapist's effort to structure what the patient and therapist do together in the treatment so as to achieve desired change. Alliance deals with how the patient and therapist are working together. Good alliance is good collaborative work. If the therapist, using technique, effectively engages the patient in the work, there is a good alliance. (We recognize that there are times when it is the patient who, taking the initiative, engages the therapist in good work.) When patients are actively, collaboratively engaged with the therapist's techniques in pursuit of shared goals, a good alliance exists, and in fact the alliance is seamless. When there is a disruption in the work, alliance issues appear, as we have seen with Freud and Greenson and, in fact, as we see in our daily work with patients. When alliances falter, a treatment approach should have additional techniques available to restore the collaborative work. If these methods are absent or if they fail, the technique is incomplete and should lead to the development of new technique, designed to deal with the problems in the collaborative work. We recognized this process in Freud's (1912/1958a) developing his technique of transference analysis. Patterson and Forgatch (1985) gave an example of alliance problems in behavioral therapy at a time when it had not yet developed alliance-repairing techniques, due largely to the fact that its clinical theory of resistance and alliance was quite sketchy. In this instance, the practitioners in their study simply stuck to the same techniques that first

led to the alliance problems, making the problems worse. Issues of this sort have led cognitive and cognitive-behavioral clinicians to develop additional techniques based on expanded clinical theory (e.g., Leahy, 2001; Safran & Segal, 1990).

These observations point to the fact that technique and alliance are not at the same conceptual level. Technique is part of the work, and alliance considers how the work is going. Some researchers (e.g., Bedi, Davis, & Williams, 2005) have blurred the distinction between techniques designed to address alliance issues, such as building an alliance-supporting bond, and alliance itself, reserving the term "technique" for interventions aimed at distal treatment outcomes. This approach divides therapist actions into alliance actions and technical actions, placing alliance and technique on equal conceptual levels. As noted earlier, it is important to distinguish between the method of forming an alliance and alliance itself, which refers to the nature and quality of the collaborative work. In Bedi et al.'s (2005) study, patients were asked what therapist actions contributed most to their engagement in treatment. Bedi et al. were surprised when patients reported that techniques addressing symptoms played a more important role in enhancing their commitment to therapy than actions specifically aimed at developing the alliance (p. 320). The major point here is that any activity, including technique, that enhances the collaborative work will contribute positively to the quality of the alliance. Therapists are responsive (Stiles, Honos-Webb, & Surko, 1998) to the particular clinical situation, shaping their technique to maximize productive, purposeful work with their client. In this way, as we saw with Freud early on, therapists are attentive to maximizing the alliance with their patients.

These observations imply that although alliance and technique are on different conceptual planes, they are not independent variables. We would expect effective use of technique to correlate highly with good alliance, because a technique that engages the patient in therapeutic work already has alliance considerations built into it, while technique that does not engage the patient has failed to incorporate alliance considerations. Furthermore, if the therapy is seen to be effective, both patient and therapist will (usually) become or remain more deeply engaged in the work. Thus good outcome (or progress) will promote good alliance, and deeper or continuing engagement in work that has been productive so far is likely to continue to be productive.

Goldfried and Davila (2005) have proposed viewing alliance as a principle of change, grouped with other principles including facilitation of expectations, offering feedback, encouragement of corrective experience, and emphasis on reality testing. These latter principles are composed of technical interventions. Alliance as described in this chapter is not a set of technical activities but rather a way of looking at these activities. Thus,

working alliance theory places alliance one conceptual level above Goldfried and Davila's grouping of techniques into principles of change, asking of each of them, "Are the patient and therapist actively and collaboratively engaged in these activities?"

The Interplay between Alliance, Technique, and Clinical Theory

When Freud altered his technique to include analysis of transference, he also modified his clinical theory to include the value of transference analysis in helping the patient change. This change in theory and technique in turn led to new expectations for what patients and therapists should be doing in analysis. Thus, analysts should be alert to transferences, and patients should be able to understand and work with a transference way of thinking. Some years later, Gill (1982) extended psychoanalytic clinical theory to include these expectations, describing "resistance to the transference," where patients resist becoming aware of their transference feelings toward their therapists, and adding the corresponding technique, analysis of transference resistance. From this sequence we can recognize an ongoing dialectic between technique, theory, and alliance, where difficulties in working collaboratively with the therapist lead to new clinical theories and associated techniques to deal with these difficulties, which then lead to new difficulties when patients have problems working with these new techniques. We will see more how this progression plays out when we discuss the links between alliance and the relationship in therapy.

Techniques to Address Alliance Issues

We have seen that techniques have evolved over the years to deal with alliance difficulties. In recent years explicit attention has been given to alliance-addressing techniques, with the expectation that this emphasis would lead to better alliances and better outcomes. Crits-Christoph et al. (2006) trained clinicians to be more aware of signs of alliance strains and to implement specific alliance-enhancing techniques to address them. This approach resulted in patients reporting increased alliance scores and possibly better outcomes (the number of respondents was too small to be certain). Summers and Barber (2003) demonstrated how building alliances is a measurable clinical skill. These efforts are valuable expansions of technique for the treatments involved and seek to engage more directly what we have called the patient's internal working alliance model. But perhaps this effort would be better framed in the broader recognition that alliance is always being addressed in treatment through good use of technique designed to help patients with

their problems, which, since Freud, have included problems in working with the therapist. Safran and Muran (2000) have taken this process a step farther, proposing a relational treatment that is centered on addressing alliance issues. But the working alliance point of view still remains: we would still ask whether the patient and therapist are working well together as they address alliance issues in treatment. Is the patient resisting the therapist's effort to work on the alliance?

CRITIQUES OF ALLIANCE THEORY: TWO WAYS TO SEE ALLIANCE AS IRRELEVANT

Working alliance is centered on a powerful fault line within psychoanalysis, and Greenson's contribution has been attacked and misunderstood by both classical psychoanalysts and contemporary relational analysts. This fault line parallels a similar one in contemporary psychotherapy practice and research. It will be helpful in understanding the current theoretical status of the alliance concept to elaborate on this point.

Alliance and Technique as Rival Concepts: Alliance Loses

Classical analysts objected strongly to the alliance concept (e.g., Brenner, 1979), believing that accepting any interpersonal connection with the patient as real fails to examine its transference features, considered at that time to be the core curative activity in analysis. These critics followed Freud's early assertion (1912/1958a) that analysis of transference will deal with any problems in the relationship. They thought that alliance repair is an unneeded concept, because it is just another way to describe the major technical activity of psychoanalysis, transference analysis. These critics saw this as an either–or situation, where alliance competes with other concepts for primacy as a way of understanding the clinical situation. Further, classical analysts such as Brenner tended to think that any disagreement about the therapy on the patient's part was due to irrational transference-based ideas. Contemporary analysts (e.g., Gill, 1982) apply both perspectives, honoring the patient's objections in their own right while remaining alert to possible transference influences. These analysts do not see an either–or choice, leaving room to think of alliance as an assessment of the quality of the collaborative work. A parallel to the classical analysts' objection is expressed by some contemporary cognitive therapists, who, like the classical analysts, stress the primacy of their core techniques in effecting change and see the alliance with the therapist as a sidelight that diverts attention from true curative processes (e.g., DeRubeis, Brotman, & Gibbons, 2005).

Alliance as Relationship: Alliance Annexed

Relational analysts have tended to dismiss the value of thinking in alliance terms. Their focus is on the relationship between patient and therapist, with full acknowledgment of the real mutual effects each has on the other (Greenberg & Mitchell, 1983; Safran & Muran, 2006). Mainstream American psychoanalysis was slow to embrace a fully dyadic view of treatment. Until the 1990s its emphasis was chiefly on the patient's internal dynamics of conflict and defense, consistently viewing as transference the patient's interpersonal reach toward the analyst and emphasizing the analyst's neutrality or anonymity. Any needs that the analyst had for the patient were understood as (unwelcome) countertransference. Relational analysts point out (e.g., Greenberg & Mitchell, 1983) that the alliance concept was a beachhead for a relational viewpoint in psychoanalysis, because it at least implicitly acknowledged an ongoing set of interacting reality-based needs between analyst and patient, which required the analyst's attention in their own right, above and beyond analyzing the patient's transference. Once this acknowledgment was fully made, however, analysts believed that the special place Greenson gave the working alliance was no longer relevant—for relational analysts, all analysis is interpersonal work, so the alliance concept was no longer needed (Greenberg & Mitchell, 1983; Safran & Muran, 2000, 2006).

The view held by relational analysts is shared by a number of psychotherapy researchers as well. For example, Henry and Strupp (1994), using a detailed measure of the nature of the relationship in therapy, identified a critical role for hostile therapist responses in reducing (or even preventing) treatment success. They believed that this broad assessment of relationship quality was superior to alliance measures and recommended abandoning the alliance concept. Safran and Muran (2006) make the same point about contemporary psychotherapy that Greenberg and Mitchell (1983) made about psychoanalysis in the 1980s, suggesting that alliance had been important in keeping the relationship in focus at a time when cognitive and behavioral therapies gave it little attention. However, with increasing recognition of the importance of the relationship in contemporary theory and practice, they say, the need for thinking in alliance terms has passed. Safran and Muran (2006) noted that they had earlier stressed that alliance "highlights the fact that at a fundamental level the patient's ability to trust, hope and have faith in the therapist's ability to help always plays a central role in the change process" (Safran & Muran, 2000, p. 13) and that the alliance negotiation process is important to change more generally. But, overall, they feel that the alliance concept is not that useful.

The problem with the relational approach is similar to the problem we found when technique and alliance are equated. Alliance is a way of looking

at the relationship, not the relationship itself. Alliance asks, in what way and to what degree does this relationship demonstrate a working collaboration between the patient and the therapist directed toward therapy goals? Or, put another way, alliance is a feature or property of relationship, as characterized by its collaborative effort towards therapy goals. Therapists continually scan the relationship for indicators of their patients' level of collaboration and participation in the ongoing work. A frown at a question, a smile of relief at being understood—anything at all about the relationship might give an indication about the state of the alliance. Of course, the work of therapy is implicit in each of these researchers' clinical theories, and, like all working clinicians, they monitor whether patient and therapist are working together as expected. Thus, cognitive therapists, some of whom see alliance as an epiphenomenon (e.g., DeRubeis et al., 2005), still are actively concerned about engaging and sustaining their patients' participation in the techniques of cognitive therapy. Their focus on technique, like the relationalists' focus on relationships, eclipses the link between collaborative work and outcome, and they lose sight of their ongoing evaluation of the alliance. Along these lines, we can see how Henry and Strupp's (1994) focus on relationship deprives us of an alliance theory account of how therapist hostility leads to a poor outcome. Alliance theory would see therapist hostility as toxic to collaborative work. Therapist hostility undermines the client's collaboration in the work by criticizing the patient's effort to work in therapy. It betrays the therapist's implicit or explicit promise that the therapeutic work will help to open the patient to new positive self-views. It corrodes the levels of trust needed to sustain openness and depletes the client's sense of optimism that good things can result from therapy (Hatcher & Barends, 2006).

ALLIANCE AS A RELATIONSHIP COMPONENT

Some clinicians and researchers divide the relationship between the patient and the therapist into components, with alliance among them. The chief source for this way of thinking is likely Greenson's (1965, 1967) proposal to divide the relationship into the transference, the alliance, and the real relationship. This point of view has been taken up by many authorities, particularly by Gelso and his colleagues (e.g., Gelso & Hayes, 1998). As we have seen above, this stand got Greenson into trouble with his analytic colleagues, who complained that considering any portion of the patient's relationship with the analyst as "not transference" can lead to missing important transferences that are "hiding" behind apparently reasonable behavior. In fact, however, Greenson himself arrived at the working alliance concept as a result of numerous experiences of finding that behavior that appeared at first to be analytically appropriate and cooperative was actually based on

strong disruptive transferences, experiences that he described in detail in his writings on the subject (1965, 1967). Rather than taking patient behavior as raw data that can be evaluated from multiple points of view—examined in turn as transference features; as realistic sensible qualities; or as efforts to work analytically with the analyst—Greenson chose to divide up behavior in a way that was unstable from the very start. Efforts to draw these kinds of boundaries within the broad domain of the relationship are doomed to failure because the concepts used to draw the boundaries are not exclusive. If we persist anyway, the lesson from this encounter is parallel to that of the transference noted above; that is, if we restrict the domain of alliance to specific types of actions in or features of the relationship, we lose our grip on the ways that alliance plays out in all aspects of the therapy relationship. Putting it another way, anything that happens in the relationship can be evaluated from the alliance point of view, suggesting such questions as: In what way does this behavior, attitude, etc., indicate the quality of the work in therapy? Does this behavior, attitude, etc., promote or detract from the work?

ALLIANCE AS CURATIVE: RELATIONSHIP IN THERAPY

Bordin's (1979) hypothesis that "the effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance" (p. 253) basically claims that therapy will be effective to the extent that the patient and therapist are working collaboratively according to the expectations of the treatment method being employed. It is important to differentiate this idea from the idea that the process of developing, maintaining, and repairing the alliance is helpful in itself. Clinicians and researchers who use the concept "therapeutic alliance," as opposed to "working alliance," tend to mix these ideas. Generally speaking, those who focus on the helpfulness of the alliance also blur the distinction between alliance and the relationship as discussed above. Building an alliance is not the same as the alliance itself, any more than building or maintaining a car is the same as driving a car. This distinction does not mean that building and maintaining an alliance is not helpful. For example, the patient's relationship with an empathic, nonjudgmental, and perhaps affirming therapist can be seen as part of the work-supporting bond to the extent that it in fact supports the work. But the therapist's support can serve as a curative factor in its own right, as has been recognized for many years (Bibring, 1937; Rosenzweig, 1936; Wampold, 2001). The therapist's empathy, affirmation, and nonjudgmentalness can thus be considered to be curative techniques, although they are often seen as "common factors" (e.g., by Rosenzweig and Wampold) rather than theorized as techniques.

Many helpful aspects of the relationship are not well theorized in particular therapies. Some researchers have used the concept of "common fac-

tors" to describe these features, and others have simply mystified them as generic interpersonal processes. Both approaches have complicated thinking about alliance theory, because these researchers have identified certain relational activities as the alliance, which is then seen as a common factor or as murky "interpersonal processes" that are curative in their own right. However, there is no logical reason that common factors could not be effectively incorporated into clinical theory, thus shifting these factors from an untheorized state into deliberately applied techniques or evaluative criteria. An example would be therapist empathy, which is widely regarded as a common factor (Wampold, 2001). But empathy can be theorized as a helpful curative technique, applied and modulated responsively in any given case. This approach is one thrust of Safran and Muran's (2000) relational treatment approach. A similar problem is posed by Elvins and Green's (2008) definition of "treatment alliance" as "a summary term referring to a number of interpersonal processes at play in psychological treatment which can generally be considered to act in parallel to (and theoretically independently of) specific manualized treatment techniques" (p. 1168). On the one hand, it is not clear how these authors think that techniques can be theoretically independent of interpersonal processes, since application of technique is an interpersonal process. On the other hand, they equate helpful interpersonal process with the alliance rather than with technique. This muddle can be effectively resolved by recognizing that building, maintaining, and repairing the alliance all involve technical activity, which is separate from evaluating the nature and quality of the work involved.

Closely related to the idea of alliance as helpful in itself is the idea that work on difficulties in the alliance is curative. Proposed in his 1979 article, this idea became an increasing focus for Bordin in his later work (1994) and is the core idea in Safran and Muran's relational treatment approach (2000). Bordin noted that the patient's interpersonal problems often interfere with forming and maintaining the alliance and that the firsthand encounter with these problems in the therapeutic relationship brings these problems to life in a setting uniquely suitable to addressing them. This idea is a theory of therapy that joins the large set of theories of therapy. It is not a theory of alliance. It is basically a modern development of Freud's (1912/1958a) point about transference that has been transformed into the contemporary conceptual frame of relationship issues.

THE THERAPIST'S RELATIONSHIP TO THE EMBEDDED ALLIANCE

Bordin (1979) pointed out that alliances embedded in a treatment approach make demands on therapists as well as patients. In a given therapy, the

therapist works from within this treatment approach, and in that sense the alliance is embedded in the therapist. This situation leads to therapists' enjoying good work and feeling frustrated when the patient resists the treatment. However, therapists struggle to one degree or another with the expectations placed on them by their treatment method. Therapists may not fully embrace the theory or its related techniques. Adherence to the expected work can become difficult for the therapist, for example, when a patient evokes strong personal reactions, as often happens when working with child or spousal abuse cases. More generally, we can consider the therapist's alliance with his or her treatment method, which, like the alliance between patient and therapist, requires a productive collaboration, and is subject to negotiation of a sort, as the therapist shapes the particular demands of the treatment method to his or her own personality and ideas about what is helpful. Adherence and competence could be considered as indicators of this extended view of alliance.

THE PATIENT'S EXPERIENCE OF ALLIANCE

The alliance is built and sustained by ongoing negotiation between patient and therapist. Accordingly, the patient's experience of the alliance, organized into the patient's internal working alliance model, is an important focus for clinicians and researchers alike. Special attention has been paid to the patient's experience of being helped or cared for and of his or her growing trust in the therapist. This experience is emotional, but it is also an appraisal of the intentions of the therapist and of the value of the therapist's method. It is a reaction to the therapist's interest, concern, thoughtfulness, dedication, etc., and to the experienced value of the therapist's efforts to address the patient's problems. Thus the bond is an aspect of an evaluative process, based on the patient's ideas of what therapy should achieve and how the therapist should behave. How does this affect the "embedded alliance," the expectations of the therapist's clinical theory for the work to be done? Depending on the flexibility of the clinical theory and its associated technique, the therapist may be able to incorporate the patient's input as to how the therapy should be conducted into the larger framework of the treatment approach. If, for example, the phobic patient is uncomfortable with the generally expected *in vivo* exposure, imaginal exposure may be brought in as the first task for therapy.

CONCLUSION

For years, therapists and researchers have talked about "the alliance," conveying a sense of its being a demonstrable "thing"—distinct from

other components of therapy—like technique or transference. In this chapter, we have worked to establish a clearer understanding of the nature of the alliance, beginning with our everyday clinical experience of the patient's struggle to work with us as we hope and expect, together with our efforts to deal with these struggles with technique. We have argued that alliance is a way of talking about the quality of the collaborative work between patient and therapist. Thus alliance is an evaluative concept that can be and is applied by both patient and therapist to the moment-by-moment interaction in therapy, to a single session, to a week's worth of work, to the therapy as a whole—asking, "How well are we working together toward the goals of therapy?" The cumulative results of this evaluation lead to ongoing, continually updated internal working alliance models held separately by the patient and the therapist. Everything that happens in therapy can affect this cumulative working model, insofar as these things reflect or affect the quality of the work toward the goals of therapy. A good interpretation will contribute positively if the patient finds it helpful; a warm smile will contribute to the patient's evaluation of the quality of the work together. Thus good technique promotes good alliance. It may be that specific efforts to address the patient's internal working alliance model will be beneficial through, for example, explaining how a technique can be helpful or reassuring the patient of our respect. But it is most likely that good technique, technique that engages the patient in work that feels meaningful and goal-directed, is the best promoter of good alliance. Such technique includes that designed to address problems in the patient's efforts to work with us. We have discussed how alliance is not the same thing as the relationship. Rather, it is a way of looking at the relationship through the lens of effective goal-directed work. So we ask, does this or that element of the relationship promote and reflect good, collaborative work, or does it detract from it?

Measurement of the patient's and the therapist's perception of the quality of the work can be accomplished with current alliance measures and can be helpful to the treatment by identifying areas of strain and disagreement about the therapeutic work. Further advances in measurement and theory may come through identifying more specific kinds of work that are critical to good outcomes in specific types of therapies (e.g., concrete examples in cognitive therapy for depression) and assessing whether the patient and therapist are working well together in these specific areas. It may also prove useful to examine the patient's internal working alliance model more extensively—how these are formed, what it consists in for the given patient, and how best to modify or influence it, beyond simply doing good therapeutic work with the person.

REFERENCES

Alexander, L. B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325–366). New York: Guilford Press.

Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 311–323.

Bibring, E. (1937). Symposium on the theory of the therapeutic results of psychoanalysis. *International Journal of Psychoanalysis*, *18*, 125–189.

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. (1980, June). *Of human bonds that bind or free*. Presidential address to 10th annual meeting of the Society for Psychotherapy Research, Pacific Grove, CA.

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: Wiley.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association*, *27S*, 137–157.

Brotman, M. A. (2004). Therapeutic alliance and adherence in cognitive therapy for depression. *Dissertation Abstracts International*, *65*(3146), 6B. (UMI No. 3169565)

Crits-Christoph, P., Connolly Gibbons, M. B., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances?: A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research*, *16*, 268–281.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, *12*, 174–183.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, *28*, 1167–1187.

Freud, S. (1957). 'Wild' psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 219–228). London: Hogarth Press. (Original work published 1910)

Freud, S. (1958a). The dynamics of transference. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99–108). London: Hogarth Press. (Original work published 1912)

Freud, S. (1958b). Further recommendations on the technique of psychoanalysis: On beginning the treatment. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 122–144). London: Hogarth Press. (Original work published 1913)

Freud, S. (1964). Analysis terminable and interminable. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 209–254). London: Hogarth Press. (Original work published 1937)

Gaston, L., & Marmar, C. (1994). The California Psychotherapy Alliance Scales. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 85–108). New York: Wiley.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. Hoboken, NJ: Wiley.

Gill, M. M. (1982). *Analysis of transference: Vol. 1. Theory and technique*. New York: International Universities Press.

Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice*, *42*, 421–430.

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

Greenson, R. R. (1965). The working alliance and the transference neurosis. In Greenson, *Explorations in psychoanalysis* (pp. 199–224). New York: International Universities Press.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.

Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., et al. (2007). Enhancing outcome for potential treatment failures: Therapist–client feedback and clinical support tools. *Psychotherapy Research*, *17*, 379–392

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytical theories* (Vol. 1, pp. 1–37). Hillsdale, NJ: Erlbaum.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*, 1326–1336.

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, and Practice*, *43*, 292–299.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, *16*, 12–25.

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath & L. S. Greenberg, (Eds.), *The working alliance: Theory, research and practice* (pp. 51–84). New York: Wiley.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*, 223–233.

Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology*, *61*, 678–685.

Leahy, R. L. (2001). *Overcoming resistance in cognitive therapy*. New York: Guilford Press.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology*, *53*, 846–851.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, *22*, 95–103.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*, 412–415.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, *43*, 286–291.

Safran, J., & Segal, Z. (1990). *Interpersonal process in cognitive therapy*. Lanham, MD: Aronson.

Shelef, K., & Diamond, G. M. (2008). Short form of the revised Vanderbilt Therapeutic Alliance Scale: Development, reliability, and validity. *Psychotherapy Research*, *18*, 433–443.

Sterba, R. F. (1934) The fate of the ego in analytic therapy *International Journal of Psychoanalysis*, *15*, 117–126.

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, *5*, 439–458.

Summers, R. F., & Barber, J. P. (2003). Therapeutic alliance as a measurable psychotherapy skill. *Academic Psychiatry*, *27*, 160–165.

Wampold, B. (2001). *The great psychotherapy debate*. Mahwah, NJ: Erlbaum.