29 THE THERAPEUTIC ALLIANCE RESEARCH AND THEORY

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One could argue that at its essence psychotherapy is, or at least always involves, an interpersonal process. Not surprisingly then, relationship concepts such as the therapeutic alliance have received considerable attention in the psychotherapy literature. Theorists from varied psychotherapeutic approaches have long recognized the client-therapist alliance as a crucial component of change. To our knowledge, all scholars who have attempted to identify variables that cut across theoretical orientations have highlighted the alliance as a common factor in psychotherapy (e.g., Frank, 1961; Garfield, 1980; Goldfried, 1980; Strupp, 1973). Reflecting its salience in the study and practice of psychotherapy, most current treatment manuals emphasize the importance of establishing and maintaining a positive alliance, including modalities that have not traditionally highlighted the patient-therapist relationship as a central change mechanism (see Castonguay, Constantino, McAleavey, & Goldfried, in press).

There also appears to be an increasing consensus in the field with respect to the characteristics that define the alliance. As we have written elsewhere, "It is generally agreed that the alliance represents interactive, collaborative elements of the relationship (i.e., therapist and client abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment" (Constantino, Castonguay, & Schut, 2002, p. 86). Empirically, the alliance has been the most frequently studied therapy process, a trend facilitated by the development of numerous psychometrically sound instruments to measure this construct from client, therapist, and observer perspectives (see Constantino et al., 2002; Horvath & Greenberg, 1994). Although several of the alliance scales

have been psychoanalytically anchored, at least one of them, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), captures a trans-theoretical perspective. Thus, the alliance can and has been measured in many forms of therapy.

The goals of this chapter are to review briefly what we see as the main empirical findings on the alliance to date and to highlight what we think are the most important future research directions for the alliance, to help us better understand this construct both theoretically and clinically.

ALLIANCE AND OUTCOME

It is now well established that the alliance correlates positively with therapeutic change across a variety of clinical problems, treatments, and theoretical perspectives (Castonguay & Beutler, 2006a; Castonguay, Constantino, & Grosse Holtforth, 2006). Based on multiple meta-analyses, the weighted *r* effect size for the alliance-outcome association ranges from .22 to .26 (see Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). Although the size of this relationship is not large, it appears to be robust. Furthermore, the effect might be considered substantial for a variable being measured within the complex entity of psychotherapy (Horvath & Bedi, 2002).

Evidence also suggests that the alliance is particularly predictive of outcome when measured early in treatment and that poor early alliance predicts client dropout (see Constantino et al., 2002). Additionally, although most therapists might feel that they are generally able to judge accurately the quality of the relationship that they have with their clients, research suggests that client and therapist views of the alliance diverge (especially during the early part of therapy), and that the client's perspective tends to be more predictive of outcome (again, this is most pronounced early) (see Horvath & Bedi, 2002). There is some evidence that similarity between client and therapist alliance ratings at the middle and late phases of treatment is positively linked with outcome (see Horvath & Bedi, 2002). Client perspectives of the alliance tend to be more predictive of outcome than therapist perspectives. Nonetheless, there is preliminary evidence indicating that the alliance-outcome association is primarily driven at the therapist level. Using multilevel modeling techniques, Baldwin, Wampold, and Imel (2007) found that differences between therapists in their average client-rated alliance accounted for more variance in the alliance-outcome correlation than differences between clients with the same therapist.

Although the alliance has been linked with outcome, the causal direction of this relationship has not been clearly established (c.f., Barber, 2009; DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999). However, the fact that the alliance measured early in treatment is the strongest predictor of posttherapy change increases the likelihood that its quality precedes, rather than follows, substantial improvement. More convincingly, some studies have found that the alliance predicts change subsequent to when it is measured and when controlling for previous change (e.g., Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Castonguay et al., 2008; Klein et al., 2003), further suggesting that the alliance-outcome association is not just an artifact of clients getting better over time (see also Baldwin et al., 2007). In several other studies, however, the alliance has failed to correlate with subsequent change when accounting statistically for prior symptom change (e.g., Barber et al., 1999; Gaston, Marmar, Gallagher, & Thompson, 1991).

A recently emerging direction is to examine the alliance as a mediator of other process-outcome associations. For example, analyzing data from the Treatment of Depression Collaborative Research Program (TDCRP; Elkin, 1994), Meyer and colleagues (2002) found that the alliance mediated the association between clients' pretreatment expectations for change and treatment outcome. Hardy et al. (2001), in a study of cognitive therapy for depression, found that the relationship between clients' underinvolved style and outcome was mediated through the therapeutic alliance. Because alliance quality in these studies was measured at a time between the process variable and outcome variable, the findings again suggest that the alliance precedes improvement as a potential mediator, or mechanism, of change (see Kraemer, Wilson, Fairburn, & Agras, 2002).

In recent developments, experimental trials have implicated a positive impact of training on and implementation of alliance-fostering interventions (e.g., Crits-Christoph et al., 2006; Grawe, Caspar, & Ambühl, 1990) and alliance-repair strategies (e.g., Castonguay et al., 2004; Constantino et al., 2008; Muran, Safran, Samstag, & Winston, 2005), thus lending additional support for the causal influence of the alliance. These experimental trials, while promising, are generally preliminary and require replication in both controlled research and real-world settings to determine more convincingly that such techniques have direct, unique, and causal effects on client improvement.

As reviewed above, researchers have begun to address the issue of the direction and nature of the alliance's impact on treatment process and outcome. It is probable, however, that if and when a resolution is achieved, the consensus will be more complex than an "either/or" type of answer (e.g., "the relationship is, above all, the only factor that counts in therapy" or "alliance is only an artifact of client improvement"). The process of change, in our view, involves the synergistic relationships among different variables.

ALLIANCE PATTERNS

Some evidence suggests that different patterns of alliance development may be linked with positive outcome (Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997; Stiles et al., 2004; Tracey & Ray, 1984). However, these findings have demonstrated some inconsistency (c.f., Bachelor & Salamé, 2000; Krupnick, Sotsky, Simmens, & Moyer, 1996) and, thus, more studies are needed to form more definitive conclusions regarding such dynamic patterns. These studies would provide useful information to clinicians who could use different types of alliance patterns as feedback on the progress of therapy. For example, if a high-low-high alliance pattern reliably predicts good outcome, then a therapist need not be alarmed by a decrease in alliance scores during treatment. Instead, it may reflect that things have to get worse before they get better, including in the client-therapist relationship. Findings from such studies may in turn generate investigations to determine if and how different alliance patterns may be a cause, an effect, and/or a reflection of improvement.

Additional research should also be conducted on the effect of tracking and responding to the alliance during therapy. In an innovative study, Whipple et al. (2003) examined the impact on treatment outcomes of providing therapists with feedback on various client-rated dimensions (including alliance quality) and recommending clinical strategies (Clinical Support Tools; CSTs) to address potential problem areas. Compared to a no-feedback control group, clients in the feedback plus CSTs group attended more sessions and demonstrated more symptom reduction. These promising findings should generate further studies on the effects of helping therapists to monitor and react therapeutically to alliance feedback.

ALLIANCE DEVELOPMENT

Related to the issue of alliance patterns is the question of how the alliance develops. There is preliminary evidence that therapists who undergo a structured clinical training (including strategies for building rapport, developing collaboration, making empathic

connections, and exploring clients' relational problems, including as they manifest in the client-therapist exchange) establish better alliances than therapists with unstructured training (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002). However, more research is needed to determine the impact of specific alliance-fostering guidelines defined both within and across therapy approaches.

In our efforts to better understand how the alliance develops, it might be wise to pay particular attention to its very first step. Some researchers have argued that the early alliance may distinguish itself from later alliance in terms of the impact, manifestations, and sources of alliance ruptures that tend to occur (MacEwan, Halgin, Constantino, & Piselli, 2009; Maramba, Castonguay, Constantino, & DeGeorge, 2009). Furthermore, it is important to understand how client and therapist characteristics might influence the development of a collaborative engagement and positive attachment early in treatment.

PREDICTORS OF ALLIANCE

Research indicates that alliance quality correlates positively with some client characteristics and behaviors (e.g., psychological mindedness, expectation for change, quality of object relations) and negatively with others (e.g., avoidance, interpersonal difficulties, depressogenic cognitions) (see Constantino, Castonguay, Zack, & DeGeorge, in press; Constantino et al., 2002). Furthermore, some of these associations hold even when accounting for symptom change prior to when the alliance is measured, suggesting that the variance explained in the alliance is not solely attributable to symptomatic improvement (e.g., Connolly Gibbons et al., 2003; Constantino, Arnow, Blasey, & Agras, 2005).

Research also suggests that certain therapist characteristics and behaviors are positively associated with quality alliances (e.g., warmth, flexibility, trustworthiness; see Ackerman & Hilsenroth, 2003). In a study on the early alliance, Constantino et al. (2005) found that alliance quality was positively associated with clients' perceptions of their therapists treating them as they tend to treat themselves (perhaps meeting the clients' need to have their self-concepts verified by others). Certain therapist characteristics and behaviors may also contribute to alliance difficulties (e.g., rigidity, criticalness, inappropriate self-disclosure; see Ackerman & Hilsenroth, 2001). In a theoretically driven study examining interpersonal history and in-session behavior, Henry, Strupp, Butler, Schacht, and Binder (1993) showed that therapists who are hostile toward themselves appear to be particularly at risk for countertherapeutic interactions with their clients. Similarly, Rosenberger and Hayes (2002) examined in a single-case study how the alliance can be affected if the material discussed in the session touches the therapist's own unresolved issues.

GENERAL GUIDELINES FOR FUTURE RESEARCH

Despite the many alliance-focused studies mentioned above, much more research is required to more fully understand its determinants, correlates, and consequences. As one future direction, more conceptual and empirical efforts are needed to clarify the relationship between the alliance and other relational constructs. For example, how distinct is the alliance from therapist empathy, and how much of the outcome variance explained by each of these two constructs is common to both or unique to each (e.g., DeGeorge et al., 2008)? More studies are also needed to clarify the relationship between the alliance and techniques prescribed by different orientations. For example, based on their review of the literature, Crits-Christoph and Connolly Gibbons (2002) concluded that too few studies have been conducted on the relationship between interpretation and alliance to derive reliable conclusions.

Whatever future research reveals, the technique-alliance relationship is likely to be complex. This has been underscored in several qualitative studies suggesting that when faced with alliance ruptures or therapeutic impasses, therapists' increased or rigid adherence to prescribed techniques or the therapeutic rationale may not only fail to repair such ruptures, but also exacerbates them (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Piper et al., 1999). These qualitative analyses are consistent with Schut et al.'s (2005) findings that a higher concentration of interpretations not only related negatively with outcome, but also corresponded to disaffiliative interpersonal processes before and during interpretations.

We also believe that the field should pay attention to specific therapist and client populations. Perhaps one route to better understanding alliance development, maintenance, and negotiation is to study expert therapists to determine, for example, how they first establish a good alliance, the flow of the alliance during treatment with more or less responsive clients, how they attempt (successfully and unsuccessfully) to repair breaches of alliance, how they find balance between the skillful use of techniques and the provision of therapeutic acceptance and support, and how they address all of these complex issues with different types of clients.

More research also needs to be conducted with minority clients. For example, it seems important to explicate culture-specific markers of alliance rupture (Constantino & Wilson, 2007). Furthermore, although there is a small literature that suggests that ethnic minority clients are more likely to terminate therapy prematurely than Caucasian clients (especially when being treated by Caucasian therapists), the reasons for this phenomenon are not well known. It is possible that the link between ethnicity and dropout is mediated by alliance quality.

More alliance research is also needed with personality-disordered clients (Bender, 2005). In their review of the literature, Smith, Barrett, Benjamin, and Barber (2006) found that studies with personality-disordered clients have suggested that the alliance is linked with outcome, and that alliance repair techniques appear to be promising. Many questions, however, remain open for exploration. Interpersonal dysfunction, for example, is a core component of most personality disorders. Although quality of object relations has been shown to predict the alliance (Piper et al., 1991), results of studies attempting to link clients' pretreatment interpersonal relationships with alliance quality have been mixed (Clarkin & Levy, 2004). Some authors have hypothesized that the relationship between attachment and outcome is mediated by alliance quality (Clarkin & Levy, 2004). Related to this hypothesis, client attachment has been linked with treatment response in borderline personality disorder (Fonagy et al., 1996), and has elsewhere been found to predict alliance rupture frequency (Eames & Roth, 2000). Thus, future research should focus on testing hypothesized mediators more directly in order to increase our understanding of potential change mechanisms in the treatment of personality disorders. For example, how do interpersonal factors specifically influence alliance development? Other pertinent research questions might include: Do different types of alliance ruptures and alliance patterns tend to emerge for different types of personality disorders? Are different strategies of intervention required for different personality disorders with regard to the establishment and repair of the alliance?

It also seems important to determine the type of clients for whom the addition of alliance repair techniques might not be necessary, or not sufficient to improve the effectiveness of therapy. Given that many clients benefit from treatment protocols that do not explicitly prescribe alliance repair interventions, the addition of such interventions may not show significant incremental change for these clients. Furthermore, alliance ruptures may not be the reason (or at least not the only reason) that some individuals fail to respond to empirically

supported treatments. With such clients, alliance ruptures, if and when they emerge, may be a reflection of other issues, or may simply be less important than other treatment difficulties. For example, the recognition of empathic failure may not add much to a therapist's effectiveness when treating a person with substance abuse who is not willing to change his/her drinking behavior.

In contrast, the addition of alliance repair techniques might be particularly beneficial for some individuals. For example, cognitive behavior therapists treating depressed clients with high levels of reactance (i.e., reluctance to being controlled by others) should be aware that directive treatments do not fare well with these clients (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2005). However, it is possible that reactant clients might still benefit from cognitive behavioral therapy if it is used by a therapist who is mindful of, and ready to deal with, clients' potential negative reactions to perceptions of being controlled (see Castonguay, 2000; Goldfried & Castonguay, 1993). Alliance repair techniques may also be particularly beneficial for clients with moderate problems of attachment or interpersonal relationships. These strategies may pave the way for corrective relational experiences and the disconfirmation of cyclical maladaptive patterns.

CONCLUDING THOUGHTS

Although much more research is needed, enough studies have been conducted on the therapeutic alliance to derive one clear conclusion: it should no longer be viewed as a "nonspecific" variable, i.e., a variable for which the nature and impact is not yet understood (see Castonguay 1993; Castonguay & Grosse Holtforth, 2005). Contrary to the way relationship factors have been viewed for many years, the alliance has now been clearly operationalized. It is fair to say that it has been measured, in a reliable way, more frequently than most other process variables (including psychotherapy techniques). We also know that the alliance correlates with outcome, and that there is some suggestion that the alliance may have a specific, causal impact on client improvement.

As we mentioned earlier, however, the cause and effect relationship between alliance and outcome has not been firmly established. Scholars from different orientations have argued that there are two ways through which the alliance can contribute to client improvement (see Constantino et al., 2002). First, the alliance can have an indirect effect by facilitating the implementation of techniques. If clients feel respected by their therapists and/or agree with the proposed treatment goals and tasks, then they are likely to be engaged in the therapeutic process aimed at or required by the prescribed interventions. Second, the alliance can have a direct curative value. For example, psychodynamic and cognitive-behavioral scholars have argued that the therapeutic relationship provides an optimal context for corrective experiences, where the client is treated differently from the way he or she is treated by other significant persons, and can learn new ways of relating with self and others (e.g., Alexander and French, 1946; Castonguay et al., in press). This is also consistent with Rogers's (1951) assertion that if therapists genuinely accept their clients for who they are, clients will treat their experience with the same level of acceptance and, thus, integrate aspects of self that were previously denied (which in turn will result in decreased psychological suffering).

However, we believe that much more theoretical and empirical effort is needed to clarify further the relationships between alliance and improvement. As Horvath (2005) has argued, there needs to be heightened theoretical discourse and debate around the construct of the client-therapist relationship. There is also a dire need for more theory-driven research of alliance-outcome linkages. Hilliard, Henry, and Strupp (2000) provided one good example of a study that placed the hypotheses, measures, and findings within a specific (psychodynamically oriented) theoretical framework that involved early interpersonal histories, the quality of the therapeutic alliance during therapy, and treatment outcome. The authors found that the early interpersonal histories of both the clients and therapists had various types of direct or indirect influences on the process and outcome of treatment. More work of this nature is needed, along with investigations that recognize the complex interaction of relational, technical, and participant variables in the process of change (Castonguay & Beutler, 2006).

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30 INTERPERSONAL INTERVENTIONS FOR MAINTAINING AN ALLIANCE

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THERAPEUTIC INTERPERSONAL INTERVENTIONS: RESOLVING ALLIANCE RUPTURES

A substantial body of research has provided evidence that the therapeutic alliance is one of the most robust predictors of outcome (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). Over the past two decades, a "second generation" (Safran, Muran, Samstag, & Stevens, 2002) of alliance research has sought to clarify how the alliance develops, why strains or ruptures occur, and how the alliance can be repaired. In this chapter, we review theory and research on alliance ruptures and their resolution, summarize points of consensus, and suggest future directions for this growing area of study.

ALLIANCE RUPTURES

Theory and research on alliance ruptures have been strongly influenced by Bordin's (1979) conceptualization of the alliance as being composed of interrelated factors: the agreement between patient and therapist on the *tasks* and *goals* of treatment and the affective *bond* between patient and therapist. This definition highlights the interdependence of relational and technical factors: It suggests that the meaning of technical factors can only be understood in the relational context in which they are applied. It also highlights the importance of ongoing *negotiation* between patient and therapist on the tasks and goals of therapy. This negotiation is always taking place. When treatment is