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HAS THE CONCEPT OF THE THERAPEUTIC ALLIANCE OUTLIVED ITS USEFULNESS?

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In this article, we provide a brief summary of our current thinking about the constructs of the therapeutic alliance and ruptures in the therapeutic alliance. We speculate about some of the factors that have led to sustained interest in these constructs by psychotherapy researchers and discuss some of the conceptual problems associated with them. We also consider the question of whether the therapeutic alliance continues to be a meaningful construct, and we delineate more and less promising avenues of research for the future.

The therapeutic alliance has, for many years now, been one of the most popular topics of psychotherapy research. It is interesting to speculate briefly about the factors responsible for its popularity. One factor is probably the failure to find consistent evidence that some forms of treatment are superior to others, along with the related search for common factors of change (see, e.g., Lambert, 2004). Another is probably the consistent evidence that the quality of the therapeutic alliance predicts treatment outcome (Horvath & Symonds, 1991; Martin et al., 2000). It is difficult, however, to account for the popularity of the construct on the basis of the research evidence alone. To be frank, correlations in the area of .25 (approximately 6% of the outcome variance) do not indicate a whopping effect. Therapist allegiance effects seem to account for much more of the outcome variance, up to 10% (Robinson et al., 1990), but this finding does not provide much in the way of intriguing leads for psychotherapy researchers. The finding that the individual therapist variable accounts for as much as 9% of the outcome variance (Wampold, 2001) provides a more intriguing lead, suggesting potentially productive research avenues.

So, why then does the therapeutic alliance remain such a popular topic among psychotherapy researchers? We believe that this sustained interest can be accounted for, at least in part, by a paradigm shift in many (if not all) psychotherapeutic traditions that emphasizes the importance of relational factors in treatment. This is true even within those traditions that have traditionally been least interested in empirical research, such as psychoanalysis and humanistic psychotherapies. To take psychoanalysis as a case in point, it would be a stretch to argue that the ascendance of the relational tradition (with its emphasis on the quality of the therapeutic relationship rather than technique) within North American psychoanalysis (Mitchell & Aron, 1999) has been influenced by evidence emerging from psychotherapy research.

It is interesting, as we have pointed out elsewhere (Safran & Muran, 2000), that the concept of the therapeutic alliance has become marginalized within contemporary relational psychoanalytic thinking, despite the fact that that the concept originated within the psychoanalytic tradition. In fact, the concept of the therapeutic alliance has pretty much become marginalized or

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We thank Lisa Wallner Samstag, who has been a longtime collaborator of ours for inviting us to contribute an article to this special section on the therapeutic alliance and for giving us the opportunity to summarize some of our current thoughts on the topic and to point to future directions that we believe are important. We are also grateful to have this opportunity to briefly address some of the questions that people often ask us about our thinking on the topic of the therapeutic alliance and alliance ruptures.

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declared to be of questionable value within psychoanalytic thinking in general (see, e.g., Levy, 2000), although there are exceptions (e.g., Meissner, 1996). What are the reasons for this marginalization? Historically, the concept of the alliance served an important function at a time when psychoanalytic theory tended to emphasize the technical aspects of treatment and deemphasize the importance of the authentic human aspects of the relationship between therapist and patient. The concept of the therapeutic alliance also provided theoretical sanction for greater therapist flexibility at a time when classical psychoanalytic prescriptions about the nature of the therapist's stance and the therapeutic frame provided little room for therapists to adapt in a responsive way to the unique needs of different patients. Finally, the concept of the therapeutic alliance was particularly useful at a time when psychoanalysts tended to understand everything that transpired in the therapeutic relationship as a reflection of the patient's transference rather than as a product of mutual influence (both conscious and unconscious) between patient and therapist (see Safran & Muran, 2000, for elaborations of these points). With the shift in relational thinking that emphasizes themes such as the mutual influence between therapist and patient, the importance of therapist flexibility and spontaneity, and the importance of the authentic aspects of the therapeutic relationship, the concept of the alliance has thus come to be superfluous.

Within contemporary ego psychological thinking (although less emphasis is placed on therapist spontaneity and authenticity), there has been an important shift in the direction of recognizing the role that unconscious mutual influence plays in the patient–therapist relationship. These periods of unconscious mutual influence are designated by ego psychologists as *enactments* (e.g., Chused, 1991; Jacobs, 1991), a term that has come to be adapted by relational analysts as well. Although both traditions emphasize the importance of enactments, relational analysts tend to assume that they are more ubiquitous than ego analysts. In fact, from a relational perspective, treatment is conceptualized as an ongoing series of unconscious enactments or as one big enactment. A major focus in both contemporary relational and ego psychological work is on the exploration of these enactments. For those who find the concept of enactment useful, the notion of exploring or analyzing transference–countertransference enactments has come to replace the idea of analyzing the transference, because it is assumed that the therapist's contribution to what is taking place in the therapeutic relationship is just as important as the patient's. Now, although it may seem to some that this brief digression into certain developments in psychoanalytic theory is self-indulgent, it serves as a useful background for addressing some of the questions that people commonly raise about our work on therapeutic alliance ruptures.

How Best to Conceptualize the Therapeutic Alliance?

As previously mentioned, the concept of the alliance has been controversial from the outset. Traditional conceptualizations of the alliance (e.g., Sterba, 1934; Zetzel, 1956) assume that a distinction can be made between the distorted or transferential aspects of the therapeutic relationship and the more rational or mature dimension of the collaboration between therapist and patient, even though there has been some acknowledgement that this distinction is a heuristic one and that transference and alliance always overlap in reality (e.g., Greenson, 1967). Critics, however, argue that all aspects of the therapeutic relationship are transferential, insofar as the perception of the present is always shaped by one's past. Although this critique may seem like a purely theoretical one, without any practical consequences, critics believe that the danger of distinguishing between the alliance and the transference is that the therapist may leave some aspects of the therapeutic relationship unanalyzed (e.g., Brenner, 1979). For example, the therapist may fail to recognize that what looks like an alliance may, in fact, be a subtle form of compliance on the patient's part, motivated by various unconscious factors. One way in which we have dealt with this concern in our own work is by distinguishing between two types of ruptures: (a) confrontation ruptures, in which the patient deals with concerns about the relationship by directly confronting the therapist; and (b) withdrawal ruptures, in which the patient deals with concerns by withdrawing, deferring, or complying. Thus, what looks like an alliance may actually be a subtle withdrawal rupture (Safran & Muran, 1996, 2000).

This solution does not, however, directly address the concern that traditional conceptualiza-

tions of the alliance may overemphasize the role of conscious or rational collaboration between therapist and patient and underestimate the pervasive role of unconscious factors in both patients' and therapists' participation in the relationship. In some respects, Bordin's (1979) conceptualization of the alliance, which has become particularly influential among psychotherapy researchers, avoids this problem by simply sidestepping the question of whether or to what extent the collaborative process is conscious or unconscious, rational or irrational. From Bordin's perspective, the quality of the alliance is a function of the extent to which the patient and therapist are able to collaborate on therapeutic tasks and goals, as well as the quality of the bond (the extent to which the patient feels understood, respected, etc). Another advantage of Bordin's conceptualization is that it implicitly highlights the interdependence of technical and relational factors by making it clear that different patients will be predisposed to find different tasks and goals meaningful as a function of their unique developmental histories and relational schemas. This implies that it is problematic to think of the quality of the alliance and the specific intervention used as additive or interactive dimensions (as is done, for example, in studies that use statistical techniques to investigate the joint contributions of alliance and technique). Instead, it follows that the usefulness of an intervention is always mediated by its relational meaning and that any attempt to disentangle technical and relational dimensions is conceptually problematic, even if it is possible to do so statistically.

Following more traditional conceptualizations of the alliance, Bordin (1979) and many others (e.g., Hatcher, 1999; Meissner, 1996) have highlighted the importance of collaboration between patient and therapist. We have argued and continue to believe that that it is conceptually illuminating to think in terms of negotiation rather than collaboration (Safran & Muran, 2000). The idea that the alliance is negotiated between the therapist and patient on an ongoing basis highlights the fact that the alliance is not a static variable that is necessary for the therapeutic intervention to work but rather a constantly shifting, emergent property of the therapeutic relationship. Furthermore, we have argued that this ongoing process of negotiation between patient and therapist at both conscious and unconscious levels is an important change mechanism in and of itself, insofar as it helps patients learn to negotiate the needs of self and others in a constructive fashion, without compromising the self or treating the other as an object. This process of negotiation of needs in the therapeutic relationship thus plays an important role in helping patients to develop some capacity for intersubjectivity (i.e., the capacity to experience both self and other as subjects) and to develop a true capacity for intimacy or authentic relatedness (see Benjamin, 1990, 1995; Muran, 2001, in press; Safran, 1993, 1999).

What Is the Difference Between the Concept of an Alliance Rupture and Transference?

The concept of transference neglects the role that unconscious mutual influence between patient and therapist plays in the treatment process. Our conceptualization of the alliance rupture is more compatible with contemporary psychoanalytic thinking about therapeutic enactments, insofar as it emphasizes the role of unconscious mutual influence between patient and therapist. To our way of thinking, alliance ruptures are essentially transference–countertransference enactments. They always contain both patient and therapist contributions. Another way in which we have described ruptures is as indicative of relational matrices or configurations (Mitchell, 1988) comprising dissociated self-states and associated behavioral patterns contributed by both patient and therapist (see Muran, 2001; Safran & Muran, 2000; Safran, 1993, for more).

Is It Possible to Provide a Clear Definition of the Concept of the Alliance Rupture?

Although, on the face of it, this should be easy to do, the truth is that the alliance rupture is a very slippery concept. In the past, we have defined alliance ruptures in various ways, such as a breakdown in the collaborative process, periods of poor quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset. For research purposes, the distinction between confrontation and withdrawal rupture markers has proven useful, insofar as these markers can be reliably observed and tend to be associated with different resolution processes (Safran & Muran, 1996, 2000, 2005). All of these definitions, however, have problems

associated with them. For example, the definition of alliance rupture as "a breakdown in the collaborative process" retains the clearest link to traditional conceptualizations of the alliance, which emphasize collaboration, but from our perspective it fails to capture our interest as therapists in the process of exploring alliance ruptures as reflections of patients' difficulties in negotiating authentic relatedness. For this reason, we typically define alliance ruptures more broadly as "problems in quality of relatedness" or "deteriorations in the communicative process" (or at least define alliance ruptures as *both* "breakdowns in collaboration" and "poor quality of relatedness"). It is important, however, to acknowledge that in defining alliance ruptures in this fashion we are modifying the traditional conceptualization of the alliance as collaboration (especially rational collaboration).

How Intense Does a "Breakdown in Collaboration" or "Poor Quality of Relatedness" Need to Be in Order to Be Considered an Alliance Rupture?

The answer to this question really depends on both one's therapeutic and one's research goals. From a therapeutic perspective, even the most subtle fluctuation or limitation in quality of relatedness can be worth exploring and can pave the way for a resolution process that facilitates an important change in the patient's relational schema and self-defeating patterns of relating to both self and others. This does not mean that it is essential to explore all of these more subtle ruptures to have good outcome. It all depends on what one means by good outcome. At the same time, we do believe that failure to explore and work through more dramatic ruptures (and, in some cases, more subtle ruptures) can lead to treatment failure or dropout.

From a research perspective, ruptures can be identified from either patient, therapist, or third-party observer perspectives (as is true with the alliance as well), and the perspective the researcher chooses will be guided by the questions in which he or she is interested. For example, if one focuses on rupture events that have been identified by both patient *and* therapist, one is more likely to identify more dramatic ruptures. If one focuses only on the patient's perspective (without regard to the therapist's perspective), instances in which the therapist has not consciously attempted to address the rupture will be included in the sample. This may or may not be desirable, depending on one's research objectives. With respect to the question of how intense a rupture event should be in order to warrant being sampled for research purposes, our experience is that it is worth establishing some minimum criterion of intensity to reduce noise in the sample, thereby increasing the possibility that we are sampling a meaningful rupture event. For example, a rupture event rated 2 on a 5-point scale by a patient or a dip in the patient's rating of the session therapeutic alliance score of less than one standard deviation from his or her other session alliance ratings may not yield a rupture event that is particularly interesting.

Is There Any Point in Retaining the Concept of the Alliance Despite the Various Conceptual Problems Described Above?

Previously, we have argued that it is worth retaining the construct of the alliance, despite the conceptual problems identified above, and despite the fact that the construct becomes superfluous if one assumes that technical and relational factors are interdependent and recognizes the importance of therapist flexibility (Safran & Muran, 2000). We have argued that the concept of the 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 a refined conceptualization of the alliance as an ongoing process of negotiation between patient and therapist at both conscious and unconscious levels highlights the intrinsic role that this type of negotiation plays in any change process.

Nevertheless, we believe that, in some respects, the concept of the alliance, as conventionally defined, may have outlived its usefulness among psychotherapy researchers in the same way that it has within psychoanalytic theory. The alliance construct played an important role among psychotherapy researchers in bringing the therapeutic relationship back into focus at a time when the person-centered tradition with its emphasis on the core conditions had become marginalized by the mainstream, and the cognitive–behavioral tradition was in the ascendance. From our perspective, however, it is unlikely that studies that continue to examine the predictive valid-

ity of the alliance, or the relative or additive importance of technical and relational factors, will yield much new knowledge in the future. We do not believe that it will be particularly valuable to develop new measures of the alliance or to attempt to refine the alliance construct further either through conceptual or empirical means or some combination. Also, we do not think that it will be particularly productive to attempt to distinguish between alliance and transference either conceptually or empirically, nor do we believe that it will be particularly productive to continue to look at patent or therapist characteristics that are predictive of a good therapeutic alliance.

For those who believe that the therapeutic relationship plays a central role in the change process, the critical task is to continue to clarify how and in what way. For those who do not believe in the centrality of the therapeutic relationship to the change process, we think that it is unlikely that more research on the therapeutic alliance will play much of a role in changing their minds. To be frank, the research evidence is modest, not overwhelming. Does this mean that we intend to stop using the concept of the therapeutic alliance in our work? Probably not. Given the central role that it has come to play in discourse among psychotherapy researchers, we think it makes more sense at this point to allow the meaning of the term to evolve rather than abandon it altogether. A parallel can be found in the evolution of the meaning of the concept of countertransference over time, from its original conceptualization as therapist reactions motivated by unresolved conflicts to the broader contemporary conceptualization as the totality of the therapist's feelings and reactions. Thus, it is fair to see us as ambivalent about the usefulness of the alliance concept.

We are not, however, ambivalent about the importance of focusing our research efforts more broadly on understanding the role that relational factors play in the change process and keeping in mind the relational context in which all other aspects of the therapeutic process unfold. For example, how does the patient's idiosyncratic relational schema mediate the meaning and impact of a specific intervention? How does a therapist's relational schema mediate the impact of a specific intervention that he or she uses? How does the negotiation between the needs and concerns of a specific patient and the subjectivity of specific therapist lead to change? How does the mutual recognition of various patient and therapist identities (gender and sexual, racial and cultural) relate to change? What role does the patient's internal representation of therapeutic relationship play in the change process? What role does mutual regulation between patient and therapist play a role in the change process? How does the process of mutual regulation between patient and therapist influence the patient's capacity for affect regulation? Some of these questions will be easier to investigate than others, and we imagine that a range of different methodologies will be required from hypothesis testing to discovery-oriented investigations, including single-case designs and various types of qualitative analysis.

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