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The Therapeutic Alliance and Intersubjectivity;  
A Relational View of the Therapeutic Alliance 
in Brief Relational Therapy

By

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Submitted to the Graduate Faculty of Political and Social Sciences of the New School for Social Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

This study focuses on evaluating the concept of therapeutic alliance from a relational perspective. It looks at 22 psychotherapy dyads who completed a treatment protocol of 30 session Brief Relational Therapy at Beth Israel’s Brief Psychotherapy Research Project. Participating patients and therapists provided after each session ratings on two suboutcome measures: the Working Alliance Inventory (WAI-12; Tracey & Kokotovic, 1989), a widely used alliance measure, and the Interpersonal Adjective Scale (IAS-16: Muran et al., 1991), an interpersonal affiliation measure based on Wiggins’ (1979) version of the interpersonal circumplex. Outcome measures, including Target Complaints (TC: Battle et al., 1996) and the Inventory of Interpersonal Problems (IIP: Horowitz et al., 1988) were administered as well. These measures were used as traditionally designed, combining raw scores to obtain several indices representing patients’ and therapists’ subjective perceptions of their affiliation and alliance. They were also used, through calculating the correlations between various constellations of raw scores, to create indices representing the intersubjective congruence between patients’ and therapists’ on various aspects of their affiliation and alliance. These indices were regarded as representing subjective and intersubjective components of the alliance.

An analysis of the intercorrelations between the various indices suggests that they capture four overlapping yet distinct constructs: subjective alliance, subjective affiliation, intersubjective alliance and intersubjective affiliation. It further suggests that 1) patients’ and therapists’ intersubjective congruence on their alliance is positively related to their subjective experience of alliance, 2) patients’ and therapists’ intersubjective congruence on their affiliation is positively related to their subjective experience of affiliation, 3) alliance and affiliation are closely related on the subjective level but unrelated in terms of intersubjective congruence. Regression analyses assessing the comparative predictive power of these indices reveals that intersubjective indices are for the most part superior to subjective indices in predicting psychotherapy outcome. Specifically, patients and therapists subjective experience of their affiliation is not predictive of outcome. Patients and therapists subjective experience of their alliance is, as generally reported, a moderate predictor of outcome. The congruence between patients and therapist on their alliance and some of the indices representing affiliative congruence are all strong predictors of outcome. The therapist’s subjective affiliative congruence is also a strong predictor of outcome.

The findings confirm the value of regarding the therapeutic alliance from a relational perspective, as entailing a significant intersubjective component. They also support the notion that the alliance is a complex interpersonal process best characterized as a dynamic balance of subjective and intersubjective components.
ACKNOWLEDGEMENTS

This dissertation happened almost by accident. At the time it was conceived, I had been working on another topic for two years, looking at least two more to go, and feeling both courageous and hopeless. I was an intern at New York’s Beth Israel Medical Center, on a research rotation at the Brief Psychotherapy Research Project, supervised by the project’s director and Beth Israel’s Chief Psychologist Dr. J. Christopher Muran. I had been exposed to the work being done at the project before, as a student of Dr. Jeremy Safran at the New School for Social Research. I chose the research rotation because I was curious to learn more. This dissertation is the result of my curiosity.

I am first and foremost indebted and deeply grateful to my guide and mentor in this project, Dr. Chris Muran. Chris has been the most consistent, thoughtful, open minded and generous mentor I could have ever hoped for. He is one of those rare people who can see the forest from the trees, yet appreciates every shade of green; who is fascinated by the great scheme of things but no less by any single person’s utterance. Moreover, he is one of those even less common who have found a way of making it all work together. It is thanks to Chris’ guidance and inspiration that I have come to see and truly believe in the value of psychotherapy research to clinical psychology. It is the result of his mentoring and support that I am now deeply invested in adding on the researcher’s hat as I proceed in finding my own place and way of making things work together in this great field.

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Chapter I

LITERATURE REVIEW

1. Prolog

The relationship between patient and therapist has become over the past two decades a focus of attention in both psychotherapy theory and research. While awareness of the significance of this relationship to the process and outcome of psychotherapy is almost as old as the practice itself, recent years have seen it become the core of a newly defined psychological school. Most commonly labeled “relational,” this school holds that the therapeutic relationship is more than a significant component of psychotherapy. It is its essence. “If Freud’s analytic situation,” writes Mitchell (1993, p. 24.), summarizing his version of the relational perspective, “consists of a patient caught up in the push and pull of emotions encountering the objective scrutiny of a more rational observer, the contemporary analytic situation is generally depicted as consisting of a patient with a collapsed, weakened, or absent center of personal experience encountering a more receptive, more facilitating human environment.” The relational perspective gives this human environment conceptual and clinical priority. It regards the experience and inner dynamics of its participants, traditionally the primary focus of clinical work, as secondary in the sense that they are not independent of it but rather constructed in it. It promotes the view that any understanding of individual experience requires the understanding of the environment where it is constructed. This environment is created in the relationship between the patient and therapist. The relational perspective therefore sees the therapeutic relationship as the primary location of the therapeutic process and agent of therapeutic change. Both the practice and study of psychotherapy are in this view about understanding the vicissitudes of this relationship as it develops, reflects and impacts its participants.
The relational perspective questions and casts doubt on many of the concepts and formulations developed over the past century in psychology and psychoanalysis. One of these is the concept of the therapeutic alliance. First defined by Sterba (1934) and then further developed by Zetzel (1956) and Greenson (1967, 1971), the concept of the therapeutic alliance became first central in ego psychological circles. With the advent of psychotherapy research and more specifically, the search for the "general factor" that could explain the comparable efficacy of different psychotherapy types (see Lambert & Bergin, 1992, 1994) it gained increasing empirical attention as well. The concept of alliance was criticized from its inception from both the direction of traditional psychoanalysis and that of interpersonal theory. From the analytic perspective, it suggested reality where only fantasy (transference) mattered; from the interpersonal perspective it promoted artificial relatedness where only reality counts. All the same, for the most part, the alliance remained a central construct in psychotherapy theory and research.

This might not be the case in the present. The concept of alliance served traditionally to illuminate some of the relational elements in an otherwise one-person psychology world and to provide clinicians with a rational for pragmatic thinking. From a different angle it might have also safeguarded the practice of psychology from extremes of mutuality and relativity. However, in a world that is no longer traditionally analytic and where the interpersonal perspective has matured and developed means of centering on the therapeutic relationship while maintaining necessary differentiation and balance, is the concept alliance still relevant (Muran & Safran, 1998)? This review aims to study and suggest possible answers to this question.
2. Freud

The idea that the therapeutic relationship is a crucial element of psychotherapy emerges directly from Freud's thinking (Freud, 1895d, 1905e, 1912b, 1940a). One of Freud's earliest insights was that patients' symptoms could be understood as coded messages intended to reveal something the patient could not say to someone they could not face. As he stepped in to decipher these messages, Freud realized that he was becoming their addressee. The fear and hope encapsulated in the symptoms were played out and experienced by the patient in the immediacy of the therapeutic situation. Freud called this phenomenon "transference." He initially considered it as a form of displacement, an expression of resistance to the psychoanalytic process through remembrance of things past. He noticed that transferred experiences, that is, experiences that could not be understood as emanating from the present situation, always emerged on the verge of an important recollection. He concluded that transference was a disturbance, and one unrelated to the therapeutic relationship (Laplanche and Pontalis, 1973). However, as his thinking developed, Freud came to see transference as a crucial aspect of the therapeutic relationship. He postulated that in any therapeutic situation there develops an overall relationship of the patient to the therapist based on and reflective of the patient's past relationships with significant others. The patient transfers elements characteristic of these past relationships including thoughts, feelings, beliefs and expectations into the present and onto the person of the therapist. According to Freud, this import of (unconscious) past into (experienced) present is key to understanding and resolving the patient's trouble, as it makes his historic struggle with past fears and desires, the same struggle that resulted in the his symptoms, emotionally and cognitively immediate to both himself and the therapist. The therapist's role is to understand the patient's transference and interpret it to him. As the patient becomes aware of the constituents of his present experience and their relations with the past he is freed from the compulsion to repeat their expression in distorted forms. Transference was therefore seen as a crucial element of the therapeutic process and cure. It provided direct access to unconscious and past experiences and enabled the patient and
therapist to explore them in the here and now of the therapeutic situation. "For when all is said and done," Freud concludes his thoughts about the subject, "it is impossible to destroy anyone in absentia..." (1912b, p. 108).

This initial model of the therapeutic relationship as represented by the notion of transference was strictly unidirectional. It assumed that the transference was completely of the patient's doing, drawing solely on his inner world, and emerging independently of the actuality of the therapeutic situation or the person of the therapist (except for that the situation and person enabled it). The therapist's role was to serve as a receptor and objective interpreter of the transferred materials. He was not considered to be implicated or influenced by them in any way, and he was definitely not regarded as possibly contributing to their contents. This model was in accord with the empirical positivistic zeitgeist of Freud's time, and it was so on several grounds. It suggested that the therapist was an objective observer, independent of the phenomena he was observing and in essence unable to affect it. It suggested that a rigorous and objective method would yield a "truth," in that case about the patient's unconscious desires and fears and that the truth would free the patient of his past. And it promoted a vision where the patient internalized and learned to use this type of epistemology in his own experience of self. This was a rational and optimistic model, and Freud tried to hold to it throughout his career.

But he also soon came to see its limitations. For one, it became clear that therapists were not always remaining objective but rather often developed strong and specific reactions to their patients. Freud defined these reactions as unconscious responses to the patient's transference and labeled them "counter-transference." From the little he wrote about the concept emerge two competing views. On the one hand, Freud regarded the therapist's counter-transference as similar to the patient's transference in that it was independent of the specifics of the therapeutic situation and while triggered by the patient, originating in the therapist's inner world. "No psychoanalyst goes further than his own complexes and internal resistances permit," he wrote (Freud, 1910d, p. 144). Counter-
transference is in this view a distortion and hindrance to the therapist’s desired objectivity. The therapist’s goal should therefore be to eliminate it, and the appropriate way to do so was in his own personal analysis. However, in another place (Freud, 1913i, p. 320) Freud suggested that “everyone possesses in their own unconscious an instrument with which he can interpret the utterances of the unconscious in other people.” This remark has been commonly taken to indicate the potential contribution of the therapist’s counter-transference to his understanding of the patient’s transference (Laplanche and Pontalis, 1973). In this view, counter-transference is case specific and closely related to the therapeutic process. Something to be explored rather than worked away.

The duality in Freud’s conceptualization of counter-transference has, in turn, made unclear his notion of transference. If the therapist’s counter-transference could be regarded as responsive to specific, idiosyncratic (and often unconscious) elements in the patient’s presentation, and was therefore a phenomenon directly related to the therapeutic process, why should one think that the patient’s transference was inherently different, and for the most part internally generated and non-responsive to the situation. Could a view be defended that the therapist was capable of relational experiences while the patient’s attitude throughout the therapeutic process remained in essence projective and non-relational? This, and other related questions, reverberated through the psychoanalytic offices of the Austro-Hungarian empire with major consequences, but Freud, remaining loyal to the empirical positivistic paradigm, held on to his original thought. For Freud, the transference remained an essentially projective phenomenon determined solely by the patient’s inner process.

But if this was the case, how was it possible that patients ever listened to their analysts, and even when unable to do so because of particularly hostile or fearful transferences, kept on coming to their appointments. Faced with this challenge, Freud conceded that some elements in the patient’s regard of the therapist must transcend or at least balance those that might otherwise push him away. He defined the distinction with the terms positive and negative transference (Freud, 1909d). The patient’s negative
transference included his hostilities and fears, those remnants of the Oedipal complex which had to be confronted and interpreted to their ultimate elimination. His positive transference included projections on the person of the therapist of benevolent and hopeful wishes. These projections were not to be analyzed as they provided the patient with the necessary motivation to continue his participation in the therapeutic process despite his hostilities and fears. While still postulated as projective in nature, the positive transference was to be colluded with by the therapist. It was a subjective construct of the patient that the therapist must agree to retain, accept and mirror so that treatment could continue. It was a relational structure acknowledged de facto if not as a rule. An admission, in fact, that the patient's beliefs and attitudes towards the therapist had significance much beyond their serving as "materials" for analysis. Freud stopped there.

3. Ferenczi

But the question of the transference and counter-transference remained open and continued to preoccupy Freud’s contemporaries. It received perhaps the most thorough and radical attention from Freud’s disciple Sándor Ferenczi (1928, 1931, 1933). Ferenczi departed from Freud’s psychoanalytic paradigm in his understanding of the advocated neutral and objective analytic stance. For Freud, this stance captured the scientific rigor of psychoanalysis and was the most crucial element in its claim for acknowledgment and legitimacy. Ferenczi, on the other hand, came gradually to believe that it was a subjective construct, one heavily laden with specific kinds of counter-transference that have been canonized, and in many cases actually harmful to patients. Ferenczi’s beliefs grew out of his work with severely disturbed patients, those often regarded by other analysts as unanalyzable. Working with such patients, he came to believe that their trouble originated not in fantasy (which is the essence of the Oedipal Complex paradigm) but in actual trauma, and that cure could not be achieved by the patient’s recalling his fantasies but through corrective experience. Ferenczi saw his patients as individuals whose core trauma was
excessive past denial of their conflict and suffering. For such patients, the traditional analytic stance would amount to nothing less than a reenactment of that experiences and re-traumatization. According to Ferenczi, what those patients needed was a different kind of experience. They needed emotional availability and honesty. This included the therapists thought and feelings triggered by, and centering on the patient. In Freud’s terms, they required that the therapist’s counter-transference be acknowledged and used explicitly in the therapeutic situation.

This, at the time radical view on the role of counter-transference was related in Ferenczi’s thinking to an equally radical view of the transference. If the analyst’s feelings and their articulation were not only relevant, but crucial to the understanding and progress of the therapeutic process, so must be the patient’s. In Ferenczi’s office, the patient’s narrative of his experience was therefore increasingly taken as indicating real and present interpersonal process rather than past determined and projected personal one. Treatment was conceived of as a process where patient and therapist developed a mutually respectful relationship based on reciprocal acknowledgement and exploration of their experiences. According to Ferenczi, only a relationship of mutuality and reciprocity supported the kind of trust that could undo the patient’s trauma and provide the conditions for therapeutic cure.

Ferenczi’s ideas were considered dangerous at their time, and were mostly ignored by the psychoanalytic mainstream for decades. Even under today’s relational paradigm Ferenczi is often criticized as going too far. Aron (1996), for example, suggests that he mistook mutuality for symmetry and lost track of his role as analyst (p. 173). However, despite the controversy, Ferenczi’s thinking had a significant impact on the development of psychoanalysis, and through it, clinical theory in general. The primary route for his influence in the early years of psychoanalysis was his own patients. Ferenczi worked with Balint, Jones and Klein, and through them influenced the school of British object relations. He also worked with Thompson, Roheim and Rado, who went on to participate in the conception of the American interpersonal school. Ferenczi’s thinking anticipated and likely
inspired many of the ideas that became pivotal in the development of these schools. His understanding of the patient’s and therapist’s transferences as “real” and significantly reactive to each other precipitated Klein’s notion of projective identification and her increased focus on pre-verbal, pre-oedipal phenomena (Klein, 1932, 1946). His attention to the nature and possible uses of counter-transference and his focus on the therapeutic process as an ongoing curative relationship became central features in the interpersonal “participant observer” paradigm (Sullivan, 1953, 1954; Thompson, 1955). His insistence on departure from the detached analytic stance found much resonance, decades later, in Kohut’s self psychology and its view of empathy as crucial for the therapeutic process (Kohut, 1971, 1977, 1984). Finally, recent years have seen an unprecedented acknowledgement and revival of his ideas under the umbrella of the new relational school (Aron, 1993, 1996).

Freud and Ferenczi debated nothing less than the nature of the therapeutic relationship, and to an extent the nature of human relationship in general. They both believed that the ultimate goal of the therapeutic endeavor was to free the patient from the grasp of past trauma, real or fantasized, and that the therapeutic relationship was the only vehicle to achieve that goal. But they differed greatly in their beliefs about what that relationship was and how it worked to achieve its goal. Freud’s view remained in essence that individuals in relationships do little more than project their past hopes and fears on a contemporary and often arbitrary other, and that relationships between individuals persevere as long as the good projections outweigh the bad ones. Consequently, he grudgingly accepted the distortion of what he called positive transference, that is the positive projections of the patient on the therapist, as a necessary condition for the maintenance of the therapeutic relationship. In Freud’s thinking, the patient’s positive transference allowed him to listen and accept the therapist’s privileged (because more rational) point of view. Ferenczi on the other hand, while accepting the notion of transference, also believed that the individual’s transference, negative or positive, is greatly challenged by the reality of relationships. This challenge results in a continuous struggle
within the individual and between individuals that over time can tip the balance from fantasy to reality and from past determined repetition compulsion to shame-free living in the present. Ferenczi privileged reality rather than rationality. He viewed the therapeutic relationship as an arena where the fantasy that is transference could be met, challenged and rejected for the sake of relational realities. The articulation and experience of these realities was therefore of paramount importance in his thinking.

4. The Concept of Therapeutic Alliance

Sterba (1934) offered a certain integration of Freud's and Ferenczi's positions. According to Sterba, the patient and therapist could not maintain a long lasting working relationship if they always remained within the parameters of the patient's transference. For the relationship to persevere, they needed to achieve a perspective that transcended the dynamics of transference and allowed them to have a more objective and realistic appreciation of the therapeutic process. He called this particular perspective or position within the therapeutic relationship "ego alliance." Sterba's "ego alliance" was different than what Freud conceptualized as positive transference. It entailed the rejection of all projected fantasy, good or bad, for the sake of sober observation and a resulting "reasonable" dialogue. It entailed that the patient had an ability to identify with the therapist and his point of view and maintain a "split in the ego" that allowed this identification to survive even when negative transference was engaged. It required both patient and therapist to keep in mind some elements of the reality of their relationship at least some of the time. While emanating from Freud's emphasis on ego development and functioning, the notion of ego alliance suggested a conceptualization of the therapeutic relationship outside the dynamics of transference. According to Sterba, this relationship included both transference dynamics and rational beliefs, both relational fantasy and reality. It was in fact, to a significant extent, characterized by a struggle between the two. In this regard, Sterba was closer to Ferenczi's ideas than to Freud's.
The concept of ego or working alliance, as Sterba later called it, received further consideration from Zetzel (1956) who expanded it to include not only the patient’s ability to observe the reality of the therapeutic relationship but also his ability to trust it. Emphasizing the significance of trust in the bond between patient and therapist, Zetzel added to Sterba’s ‘rational’ formulation of the alliance an affective component. Alliance for Zetzel was not only about a certain freedom of thought but also about certain kinds of feelings. Greenson (1967, 1971) integrated Sterba’s and Zetzel’s views of the alliance and offered additional mapping of its place within the context of the therapeutic relationship. According to Greenson, the working or therapeutic alliance included the patient’s ability to work with the therapist on a rational basis as well as his positive and trusting feelings towards the therapist. Both emanated from the patient’s and therapist’s realization and agreement about the specific definitions and roles characterizing their relationship. In Greenson’s thinking, this element of the relationship was different from the patient’s transference as already indicated by Sterba and Zetzel. But it was also, unlike previously conceived, different from their “real” relationship. As opposed to the alliance which depends on the prescribed roles in the therapeutic relationship, and entails the attitudes and beliefs they trigger, “the real relationship refers to the mutual human responses of the patient and therapist to each other, including undistorted perceptions and authentic liking, trust and respect for each other, which exist along with the inequalities inherent to the therapy situation.” (Muram & Safran, in press). It is about those thoughts and feelings that are neither projected fantasy, nor role appropriate attitudes and beliefs, but simple personal and interpersonal perceptions and reactions. It is about two individuals, recognizing each other and having thoughts and feelings about each other as such.

While the boundary between transference and alliance was drawn before, Greenson drew an additional one between the alliance and reality. Suggesting this, he recaptured both Freud’s and Ferenczi’s ideas about the therapeutic relationship, but in a sense marginalized both in favor of his idea of the therapeutic alliance. In Greenson’s formula, the alliance is the mediating factor in the therapeutic relationship. It keeps the relationship stable against
the challenges of transference on the one hand, and plain reality on the other. While both transference and reality contribute the materials, affect and motivation to the therapeutic process, neither facilitate this process or its desired outcome. There could be no therapy based on sheer fantasy or on plain relational reciprocity. There could be neither insight, nor curative experience without their being embedded in the specific structure of psychotherapy and the therapeutic alliance.

Greenon’s view that the therapeutic alliance is the central factor in mediating the therapeutic process, was reciprocated and further elaborated outside the psychoanalytic world by Bordin (1979). Attempting a transtheoretical concept of the alliance, Bordin suggested that it consisted of three independent elements: 1) an affective bond between patient and therapist, 2) an agreement between them on the goals of therapy, and 3) an agreement on its tasks. According to Bordin, different types of therapy have different goals, involve different tasks, and imply different kinds of bonds. However for any kind of therapy to succeed, these goals and tasks must be negotiated and agreed upon, and a bond between patient and therapist must be maintained. The agreement and bonding are mutually constructive. The patient and therapist’s agreement about their mutual goals and tasks serves to build the bond between them. Conversely, their affective bonding often facilitates an agreement that could be otherwise difficult to achieve. In Bordin’s view, the therapeutic alliance is the sum total of the dynamic relations between these components.

The concept of alliance as perfected by Greenon (and Bordin) drew much criticism from both traditional and interpersonal psychoanalytic quarters. On the traditional side, Brenner (1979) continued to champion the primacy of the transference, arguing that there is no conflict-free zone in the relationship between patient and therapist and therefore no such thing as independent therapeutic alliance. According to Brenner, all aspects of the relationship between patient and therapist should be conceptualized within the framework of transference, counter-transference and resistance. Psychotherapy is a process where all these are understood and interpreted away. On the interpersonalist side, Levenson (1992)
and others, emphasizing the therapeutic relationship as a whole, objected to the privileging of its rational and objective elements designated by Greenson as the constituents of the alliance, arguing that all aspects of the therapeutic relationship are equally significant in facilitating the therapeutic process. This view is amplified by contemporary relational theorists (Mitchell, 1988; Aron, 1996) who drawing on constructivist and post structural theory, have began to contest the very possibility of a permanent and transcendent agreement about reality as implied in the concept of alliance. In its extreme, this perspective seems to have all but render the concept of alliance meaningless.

5. The Interpersonal Alternative

The interpersonal tradition, and particularly Sullivan’s work (1953, 1954), inspired an alternative, more “Ferenczian” paradigm for the study of the therapeutic relationship. In Sullivan’s thinking, human experience and behavior were not, as he saw classical psychoanalysis claiming, determined by individual needs and agendas. Rather, they are in essence interpersonal and can be understood only in the context of human interaction and relationships. For Sullivan, interpersonal situations and relationships were not a consequence or by-product of individuals meeting but the basic unit of human experience. There is no experience or behavior independent of actual, fantasized or historical interpersonal context. Psychology is therefore the study of the forms, patterns and contents of these contexts.

The factor distinguishing the concept of interpersonal behavior from that of individual behavior is that a behavior conceptualized in interpersonal terms is not simply a response to stimuli but also an action geared to elicit a desired reaction. Consequently, from an interpersonal perspective, the basic unit for observation and study is not an isolated unit of individual behavior but a sequence of behaviors, or in other words, an interaction. Sullivan, and following him Murray (1951) and Leary (1957) hypothesized that the most
common motivation behind interpersonal action is the desire to elicit in the other a validating reaction. They further suggested that because of this basic characteristic of human interaction, all interpersonal exchanges are governed by the principle of complementarity: action and reaction complement each other in the service of mutual validation.

Adding to these notions, Leary (1957) argued that all interpersonal dynamics can be seen as representing two basic human concerns: control and affiliation. In any interpersonal context, individuals negotiate the degree in which they assert themselves or submit to others (control), and they behave and experience themselves and others in varying degrees of friendliness and hostility (affiliation). These two basic components of interpersonal dynamics are governed by two different patterns of complementarity: correspondence and reciprocity. On the dimension of affiliation, one type of behavior normally leads to the same from the other; friendliness is responded to with friendliness, hostility triggers more hostility. On the control dimension the pattern is opposed; assertiveness is often responded to by complacency, submission by dominance.

Leary summed up his thinking with the interpersonal circle, a circular diagram arranged around the two axes of affiliation and control, and detailing a variety of personal characteristics or interpersonal tendencies representing different combinations and degrees of the two. Any individual presentation or unit of behavior could be represented by a specific point on the circle, capturing its essence as a combination of affiliation and control. The circle could thus serve as a tool for defining and studying the patterns comprising interpersonal units of any length, from brief interactions to extended sequences. It could be used by observers to rate interpersonal sequences as representing an unfolding of affiliative and control oriented behavior units. It could also be used by participants in the interaction to capture the essence of their own behavior as well as the behavior of others. The obtained ratings could be used to follow and study the patterns that guide such interactions. Leary's was the first in several circumplex models. Lorr and McNair (1965), Wiggins (1979a,
1979b, 1981), Kiesler (1983) and particularly Benjamin (1974, 1983, 1993) all offered elaborations and modifications to his model. However, except for Benjamin who added to Leary’s two dimensions a third, focusing on autonomy, all existing circumplex models retain Leary’s two dimensional, control and affiliation, structure.

The circumplex model could be applied to all interpersonal contexts, psychotherapy among them. It therefore offered an additional venue for the study and understanding of the therapeutic relationship. Unlike the concept of alliance, which particularly as developed by Greenson, refers only to the conscious, rational and collaborative aspects of the therapeutic relationship, the circumplex offered a perspective that is both more inclusive and more specific. It could capture, it was argued, every aspect of the therapeutic relationship, overt or covert, rational or irrational, collaborative or rejecting, and thus provide a more general framework for its study. At the same time, in providing concrete dimensions and degrees for the evaluation of each unit of analysis, it enabled greater accuracy and specificity than the concept of alliance. Finally, in emphasizing micro rather than macro analysis of relationships, it allowed for a more detailed understanding of the dynamics that might govern it. According to its proponents, the circumplex was a less hierarchical and prescriptive, more balanced and descriptive model of the therapeutic relationship. It promised better description, explanation and prediction of relational patterns than any theoretical framework before it (Henry, 1997).

6. The Alliance in Psychotherapy Research

Both the concept of therapeutic alliance and the circumplex model in its different versions were used extensively in psychotherapy research. Much of their initial use was in the context of the search for the “general factor” (Lambert & Bergin, 1994) responsible for therapeutic change and success. Psychotherapy research was perhaps initiated by, and in response to Eysenck (1952) who suggested in a landmark review of psychotherapy
outcome studies of the time that psychotherapy was in essence ineffective. This challenge led to a gradual and steady improvement in psychotherapy research methodology, particularly in the definition and measurement of psychotherapy outcome. It also led to a consensus that psychotherapy was in most cases an effective treatment mode for a variety of psychological problems (e.g., Bergin & Lambert, 1978; VandenBos, 1986; Lambert & Bergin, 1992, 1994; Strupp, 1993). However, while the psychotherapeutic endeavor received general support, it was also consistently found that for the most part, there were no significant differences in the effectiveness of different psychotherapy types (Lambert and Bergin, 1992, 1994). This surprising finding was given several explanations. It was suggested that general outcome measures were not sensitive enough to the varied influences of different psychotherapy forms. It was also suggested that different psychotherapy forms achieved the same outcome through different means. Finally, it was reasoned that if all psychotherapy forms were equally effective, their effectiveness could be accounted for by certain components or factors they all shared. The therapeutic relationship was the strongest candidate for such a factor, and its assessment and evaluation became circa 1980 a major concern in psychotherapy research. The concepts of therapeutic alliance and the interpersonal circumplex were adopted at that time as primary frameworks for the description and explanation of the therapeutic relationship and its effects.

The first attempts at empirical study of the therapeutic relationship were efforts at observing, mapping and identifying some possible underlying patterns or dimensions. They were process oriented, and for the most part used clinical judges to observe and rate segments of psychotherapy to be used in exploratory statistical analyses. The first of these studies was conducted by Gomes-Schwartz (1978). Gomes-Schwartz used four ten-minute long psychotherapy segments which she asked judges to observe and rate using the Vanderblit Psychotherapy Process Scale (VPPS), an 84 Likert-type items questionnaire. The results were analyzed with principal component analysis yielding seven components. Gomes-Schwartz suggested that these components represented three major factors in the therapeutic process: exploratory processes, patient involvement and therapist-offered
relationship. With a similar goal in mind, Hartley and Strupp (1983) developed a measure targeted specifically at capturing the therapeutic alliance: the Vanderblit Therapeutic alliance Scale (VTAS). Using a similar method to Gomes-Schwartz's, where therapy segments were rated by judges and subjected to principal component analysis, their findings suggested a more reciprocal, more interpersonal process where both therapist, patient and interactional factors could be identified as contributing to the therapeutic processes. Luborsky et al. (1983) conducted another clinical judgment based study where judges assessed psychotherapy segment using the Penn Helping Alliance Scale. This scale (consisting of 10 Likert-style items) was developed to capture Luborsky's view of the therapeutic alliance as a patient centered construct, composed of two distinct factors: the patient's bonding with the therapist and his perceived helpfulness of the therapist. The study, however, found a very high correlation between these factors, suggesting that only one inclusive patient centered alliance dimension could be identified. Marmar et al. (1986) studied a much wider concept of the alliance, which they defined as including positive and negative contributions from both patient and therapist. Developing the Therapeutic alliance Rating System (TARS) (1986) and the California Therapeutic alliance Rating System (CALTARS) (1989), a 41 item questionnaire rated by clinical judges, Marmar et al. found that the process they observed revealed five underlying components. They interpreted these components as reflecting 1) patient commitment, 2) patient working capacity, 3) therapist understanding and involvement, 4) patient hostile resistance, 5) therapist negative contribution (Gaston, 1990). Confirming their initial model, they further interpreted the two positive patient components as reflecting the conceptual difference between therapeutic alliance and working alliance. The therapeutic alliance represented, they suggested, the patient's attitude and affective stance, the working alliance was about his actual collaborative behavior.

The first study to use patient and therapist ratings of alliance was conducted by Marziali (1984). Marziali developed parallel forms for the TARS which he used to obtain alliance ratings for psychotherapy segments from clinical judges as well as patients and
therapists. A principal component analysis revealed in that study two alliance dimensions, a positive factor and a negative factor, each encompassing both patient and therapist contributions. Marmar, Gaston, Gallagher and Thompson (1989) expanded the CALTARS to include Bordin’s (1979) conceptualization of the alliance as including the factors of 1) bond between patient and therapist, 2) agreement on goals, 3) agreement on tasks. Retitled the California Psychotherapy Alliance Scale (CALPAS) this new measure was also used to obtain patient and therapist rating of alliance. However, as opposed to Marziali’s results, analysis of CALPAS data suggested significant differences between patient and therapist’s contribution to the alliance. In the therapist CALPAS, all items were highly correlated, indicating a single alliance dimension. Analysis of the patient CALPAS indicated on the other hand five components, mirroring with only marginal variations the results obtained in Marmar et al. (1986) CALTARS study. These components were titled 1) patient commitment, 2) patient working capacity, 3) therapist understanding and involvement, 4) therapist negative contribution and 5) disagreement on goals and strategies. It was only this last component, stemming from Bordin’s conceptualization of the alliance, that was added to the previous picture. Interestingly, this relational component replaced in the patient’s CALPAS the one representing the patient’s hostile resistance obtained from judges’ ratings on the CALTARS.

Bordin’s conceptualization of the alliance was also studied by Horvath and Greenberg (1989) who developed for that purpose the Working Alliance Inventory (WAI). The WAI had patient and therapist versions, and included 36 items designed to cover Bordin’s three hypothesized alliance components of bonds, agreement on goals and agreement on tasks. However both Horvath and Greenberg (1989) and Tracey and Kokotovic (1989) found the three WAI scales to be highly correlated and suggested therefore that they measured one general alliance concept.

In summary, the empirical effort to map and identify the possible dimensions underlying the concept of the therapeutic alliance yielded five, possibly six alliance
components. The first distinction arrived at was in regard to the patient's part in the alliance. Gomez-Schwartz (1978), Hartley and Strupp (1983) and Marmar et al. (1989) were all able to distinguish between the patient's affective stance towards the therapist, often named the therapeutic alliance, and his actual collaborative behavior, often titled the working alliance. Further examination of the patient's part revealed a patient negative contribution, encompassing both affective and behavioral elements, as well. As studies began examining the therapist's participation in the alliance, therapist contributions, both positive and negative were also identified (Marziali, 1984; Marmar, Weiss & Gaston, 1989; Marmar, Gaston, Gallagher & Thompson, 1989). Finally, studies incorporating Bordin's alliance concept suggested the possibility of a separate, more relational alliance dimension reflecting the degree of agreement between patient and therapist (Marmar et al., 1989).

7. The Alliance and Psychotherapy Outcome

As mentioned above, the extensive interest in research on the concept of the therapeutic alliance was motivated to a large extent by a search for the general factor behind the apparent similarity in efficacy between different psychotherapy types. As a result, developments in the conceptualization and measurement of alliance were certain to be followed closely by efforts to study the association between alliance and outcome. Gomez-Schwartz (1978) who pioneered the effort to characterize the alliance using the VPPS, also found that the VPPS accounted for 27% to 38% of outcome variance measured by global ratings of therapeutic gains. Gomez-Schwartz did not find an association between the VPPS and MMPI scores. Hartley and Strupp (1983) were however unable to link the VPPS with any outcome measure. Morgan et al. (1982) found the Penn, rated by clinical judges, significantly predictive (20%) of residual gain scores of several psychological adjustment measures. Patients ratings of the Penn were also predictive of some outcome measures (Luborsky et al., 1985). The predictive validity of the TARS (Marmar et al., 1986) was studied by Marziali (1984) as well as Eaton et al. (1988), with favorable
results. Marziali reported that TARS ratings of alliance accounted for 9% to 14% outcome when measured by symptomatic change. It accounted for 9% to 35% of outcome when evaluated by patients and therapists. These results were replicated by Eaton et al.. Marmar et al. (1989) found the CALTARS predictive of 9% change in symptoms and 16% change in interpersonal functioning. Horvath and Greenberg (1989) found the WAI predictive of 18% variance in patient rated outcome measure and 27% variance in therapist rated outcome measure. However, the WAI did not predict outcome when measured by certain residualized gain scores. Finally, in a study assessing the predictive validity of the VTAS, Penn, WAI and CALPAS, rated by clinical judges, (Tichenor & Hill, 1989) all except for the Penn, accounted for at least 36% in outcome variance as measured by patient self concept. Therapists’ rated WAI accounted for 50% of the variance in symptomatic change. The VPPS and Penn were found not predictive of outcome when measured by both clinical judges and symptomatic change (Johnson, 1988).

In a central contribution to the debate over the role of alliance in therapeutic change, Horvath and Symonds (1991) conducted a meta-analysis of 24 selected studies examining the relation between alliance and outcome. The studies reviewed used different alliance measures, including 1) the Pennsylvania family of alliance scales (HAr, HAcS, HAQ, Penn), 2) the Venderbilt psychotherapy process scales (VTAS, VPPS), 3) the British Columbia Scales (WAI), 4) the California family of scales (TAS, CALTRAS, CALPAS) and 5) the University of Toronto scales. They included multiple outcome measures. They also included multiple perspectives, that is patient, therapist and observer perspectives, on both alliance and outcome measures. Summarizing their findings, Horvath and Symonds concluded that alliance is a “relatively robust variable linking therapy process to outcome” (p.146). Horvath and Symonds’ analysis also yielded several specific findings about the assessment of alliance and its effect on outcome. First, they found that patient and observer ratings of alliance were overall significantly more predictive of outcome than therapist ratings. This finding is further validated by the fact that in their review, homogeneous study designs (where both alliance and outcome were rated by the same source) did not
produce substantially higher effect sizes than heterogeneous study designs (where alliance and outcome were rated by different sources), suggesting that patient and observer ratings are independently strong.

Horvath and Symonds found in addition that different alliance measures showed substantial heterogeneity in their ability to predict outcome. This, in contrast with previous research (Hansell, 1990; Sarfan & Wallner, 1990; Tichnor & Hill, 1989) which showed strong correlations between all significant alliance measures. Horvath and Symonds conclude on this issue that different alliance measures are likely tapping into somewhat different constructs. They suggest that there might be “another variable involved in the casual link between alliance and success in therapy.” (p. 147) If that is the case, each alliance measure “may capture a portion of this linking variable plus other, divergent aspects of the therapy process.” Reviewing multiple definitions of the alliance, Horvath and Symonds speculate that this variable is likely related to the concepts of “mutuality, collaboration and engagement.” Finally, in finding that the quality of alliance is equally significant and predictive of outcome in all different psychotherapy modes included in their meta analysis, Horvath and Symonds provide further support to the idea that the therapeutic alliance is the general factor behind therapeutic change.

8. The Circumplex in Psychotherapy Research

As mentioned above, the only major challenge to the notion that the therapeutic alliance is the general factor behind the efficacy of psychotherapy emerged from the direction of interpersonal theory and the development of the interpersonal circle (Leary, 1957; Wiggins, 1979a, 1979b, 1981; Kiesler, 1983, 1985; Benjamin, 1974, 1983, 1993). While the thinking and research presented from this perspective did not normally reject the notion of alliance, it often de-emphasized it, suggesting that the therapeutic alliance was a byproduct of more basic interpersonal dynamics in the therapeutic relationship. In most
circumplex models, these dynamics revolve around the dimensions of affiliation and control, and their different patterns of complementarity in interaction.

The first inventory developed to capture the interpersonal circle model was “The Interpersonal Check List” (ICL) (LaForge & Suczek, 1955; Leary, 1957). This inventory consists of 128 items, in both adjective and verb-phrase formats, and yields 16 different segment scores designed to represent the full range of Leary’s two dimensional - affiliation and control - interpersonal circle. Each of these scores is measured by eight items, weighted according to the degree of intensity demonstrated by the behaviors they capture. The ICL also exists in an eight segment version that was more extensively used to obtain a wide range of measures from individuals’ self report and ratings of others, to observer ratings. The ICL was criticized on two major counts. It was found to contain serious measurement gaps (For example: Chartier & Conaway, 1984; Kiesler, 1983; Lorr & McNair, 1965), resulting in a 25% deficit in coverage of the full possible range of two dimensionally rated interpersonal behavior. It was also shown to be deficient in lacking much of the opposing item polarity required by its circumplex premise (Wiggins, 1982). On both these counts the ICL fell short of demonstrating full circumplexity and was eventually abandoned (Kiesler, 1996). Lorr and McNair (1967) developed an alternative to the ICL, the Interpersonal Behavior Inventory (IBI). Designed to fill the gaps in ICL coverage as well as improve its accuracy by substituting its heavy reliance on adjectives with rating based on action items, the IBI includes 140 items yielding 15 segment scores. It was used primarily to obtain therapists’ ratings of their patients and observer ratings.

One explanation suggested for the ICL’s failure to demonstrate sufficient coverage and circumplexity was that it did not differentiate properly between interpersonal traits and other psychological variables such as temperament, mood and cognitive style (Kiesler, 1996). An attempt by Wiggins to construct a specific trait descriptive inventory that achieved such differentiation resulted in the Interpersonal Adjective Scale (IAS) and the Revised Interpersonal Adjective Scale (IAS-R). The IAS consists of 128 adjective format
items and yields 16 segments. The IAS-R consists of 64 adjective format items rated by subjects on 8 point likert scale and yields eight scales. Both inventories demonstrate excellent coverage and fit with circumplex criteria (Kiesler, 1996) and have become the standard for interpersonal circumplex measures. They have also been related to a variety of individual difference measures in the field of personality theory (Wiggins & Broughton, 1985), including the big-five dimensions of current personality research (McCrea & Costa, 1989; Trapnell & Wiggins, 1990). The IAS and IAS-R were used extensively for self reports as well as interactants and observers ratings of others.

Kiesler (1987) developed a 16 scale circumplex inventory based on 96 act-form items rated with simple yes or no. With two versions titled Check List of Interpersonal Transactions (CLOIT) and Check List of Psychotherapy Transactions (CLOPT), this inventory was used to obtain both interactant and observer reports of interpersonal situations. Inadequacies in achieving full circumplexity resulted in the development of CLOIT-R and CLOPT-R. These revised versions remained problematic on a 16 scale level, but demonstrated improved circumplexity when reduced to an eight scale design (Kiesler et al., 1986; Kiesler, Schmidt & Larus, 1988, 1989). Alden et al. (1990) developed a circle version of the Inventory of Interpersonal Problems (Horowitz, 1988) titled the Inventory of Interpersonal Problems - Circumplex (IIP-C). The IIP-C demonstrated excellent circumplex properties (Kiesler, 1987). It has also shown a strong relation with the IAS-R in that the two primary dimensions of the IIP emerged as problem versions of the two dimensions of the interpersonal circle as portrayed by the IAS-R (Alden et al., 1990).

The ICL, IBI, IAS-R, IIP-R and CLOIT/CLOPT are all based on the traditional interpersonal circle with its two dimensions of affiliation and control. They all provide eight to 16 scales formulated to capture the full range of interpersonal behavior in a circumplex design. And whether obtaining self report or ratings from other interactants and observers, they are all designed to measure overt behavior. Benjamin's Structural Analysis of Social Behavior (SASB) (Benjamin, 1974, 1983), adds to the traditional model a third dimension,
as well as an additional plane designed to capture a covert dimension of interpersonal behavior. According to Benjamin (1974), the traditional two dimension circumplex fails to capture the full variability characterizing interpersonal situations. In Benjamin's view, human interaction ranges not only from dominance to submission, but also displays different degrees of differentiation, ranging from autonomy to enmeshment. In a two dimensional circle, autonomy is the mid point between dominance and submission. The basic assumption underlying the SASB and distinguishing it from all other circumplex models is that autonomy is a separate dimension. The SASB therefore adds a third dimension to the model. The SASB's three dimensions are used to capture three levels of interpersonal phenomena: 1) behavior that is transitive (enacted by one person towards another, 2) behavior that is intransitive (reactive to an other's) and 3) behavior directed towards the self, representing the level of individuals' introjects. This third level captures covert elements of interpersonal phenomena. SASB assessment is derived from INTREX questionnaires that include 144 verb phrase and sentence format items rated on a scale of 0 to 100. Different versions of the questionnaire are used to obtain self report and other interactant ratings. While the SASB presents a more sophisticated and possibly better theoretically embedded conceptualization of interpersonal behavior, and has achieved significant following (See Henry, 1997), its level of complexity prevented it from becoming a standard in circumplex research.

A review of psychotherapy research conducted from a circumplex perspective (Kiesler, 1996) reveals several major areas of study: 1) an effort to map and evaluate the role of general interpersonal factors in patients complaints and their engagement and improvement in therapy, 2) a more specific effort to evaluate the validity of circumplex models and the dimensions of affiliation and control in describing interpersonal phenomena, 3) studies designed to evaluate the validity and extent of the principle of complementarity, and 4) those focusing on the relationship between the notions of affiliation, control and complementarity and psychotherapy outcome. The current consensus is that interpersonal factors play a major role in both presenting problems and
responsiveness to psychotherapy (Alden & Capreol, 1993; L. M. Horowitz, Rosenberg et al., 1988; L. M. Horowitz et al., 1989, 1992; Maling et al., 1995; Mohr et al., 1990). In addition, despite various methodological inadequacies revealed in early circumplex models in providing full circular coverage and circumplexity, and despite indications to the limitations of the principle of complementarity (Oxford, 1986), some current versions of the interpersonal circumplex are valid and useful (Berzins, 1977; Kiesler, 1983, 1986a, 1986b, 1988, 1991, 1996; Wiggins, 1980, 1982). This consensus is well summed up by Wiggins and Broughton (1985) who write: “The principal advantage for the Interpersonal Circle is that it provides a theory based definition of the universe of content of interpersonal behavior within which the expected relationship between a given vector of interpersonal behavior and all other vectors of interpersonal behavior may be specified with geometric precision with reference to the two orthogonal coordinates of status (power, agency, dominance) and love (solidarity, communion, affiliation). As a consequence, measures derived from circumplex methodology permit assessment of the full range of interpersonal behavior in a non-redundant fashion...” (In Kiesler, 1996, p.11).

9. The Circumplex and Psychotherapy Outcome

Circumplex research offered two major alternatives to the the notion that the alliance was the general factor behind psychotherapy outcome. First, it hypothesized that outcome is influenced by the specific occurrence of positive versus negative affiliation, or in other words; by the affective content of the therapeutic relationship. In this view, positive affiliation (friendliness) leads to positive outcome, negative affiliation (hostility) leads to poor outcome. Second, it hypothesized that rather than the content of the relationship, it is the process or more specifically, the degree of complementarity in the relationship that influences outcome. In this view, the more complementarity between patient and therapist, the better the outcome will be. This hypothesis was, however, often qualified by another, suggesting that at different stages of the therapeutic process, different contents as well as
degrees of complementarity are appropriate and therefore predictive of good outcome.

The findings regarding the relations between affiliative content and outcome are mixed. For example, Rudy et al. (1985) found using the SASB Intrex Questionnaires that patients evaluating their therapists as friendly reported more satisfaction with therapy and their therapists rated their therapy as more successful. However, this perceived friendliness was not related to symptom reduction or therapist rated change in target complaints. On the other hand, therapist hostility was predictive of poor outcome in that study as well as in Henry et al. (1986) and Henry et al. (1990). Strupp (1980) found poor outcome related to hostile interactions between patient and therapist. Muran (1993) found that friendliness was related to alliance, but not outcome, whereas hostility was negatively related to both. Hostility was found to be not only a predictor of poor outcome but a characteristic of it as well. In McMullen and Conway (1994), Poor outcome patients tended to describe themselves in more hostile terms. Good outcome patients tended to see themselves in a more friendly way. In sum, the findings regarding the relations between the contents of the therapeutic process and its outcome suggest an uneven picture where friendliness is not predictive of good outcome but hostility is predictive of poor outcome. Explanations to this general finding note a possible bias in perception (Kiesler & Watkins, 1989), as well as patient traits (Wagner, 1995). However, these findings and others alerted researchers using the circumplex model that “it was crucial to differentiate patient-therapist match up of hostile side versus friendly side behaviors” (Kiesler, 1997).

The asymmetry found between the effect of friendliness versus hostility on therapy outcome might perhaps be explained by the findings of research focusing on the general principle of complementarity. According to the theory behind all circumplex models, interpersonal complementarity functions at the service of mutual interpersonal validation. It therefore also functions, for the person who is interpersonally problematic, at the service of maintaining his problems. If such person pursues psychotherapy, and in his psychotherapy the therapist complements his behavior throughout, there is no therapeutic change to be
expected. For therapy to produce change and have good outcome, the principle of complementarity must be at some point abandoned. Carson (1969) suggested that while initial complementarity is necessary to achieve a working alliance between patient and therapist, this must change as the therapy proceeds. Kiesler (1996) concludes on this matter that "In the case of successful psychotherapy, the patient and therapist will move from rigid and extreme complementary transaction early in therapy, to non-complementary positions in the change oriented middle phase of therapy, to a later transactional pattern that exhibits mild and flexible complementarity. In contrast, in unsuccessful therapy, the patient therapist relationship will remain bogged down in various degrees of complementarity throughout the entire therapy course." (p.261). This formulation received significant empirical support from Tracy and Ray (1984), Tracy (1986, 1987), Tasca (1988; Tasca & McMullen, 1993), Coulter (1993) and Laird and Vande Kemp (1987). Tasca (1988; Tasca & McMullen, 1993) found in addition that successful therapies were characterized by friendly complementarity whereas poor outcome therapies demonstrated more hostile complementarity. It is possible that this pattern, namely that good outcome cases are characterized by varying degrees of complementarity which is mostly friendly and some hostility in the middle phase, whereas poor outcome cases are characterized by steady hostile complementarity, underlies the finding that friendliness does not predict good outcome while hostility predicts poor outcome. There might simply be more hostility in poor outcome cases than there is friendliness in good outcome cases.

In general, the research on the relations between different circumplex variables and psychotherapy outcome portrays a complex and somewhat confusing picture. In terms of affiliative content, it appears that overall positive affiliation does not normally predict good outcome while negative affiliation is a likely predictor of poor outcome. On the other hand, when outcome is studied in relation to complementarity, it appears that positive outcome is often associated with complementarity on the friendly side of the circumplex whereas negative outcome is more often related to complementarity on the hostile side. This is further complicated by the general finding that in terms of contents independent process,
positive outcome is promoted by different degrees of complementarity in different stages of the therapeutic process while a steady level of complementarity assures poor outcome. It is therefore quite possible to state that overall, the body of research based on the circumplex model does not provide a simple alternative to the concept of alliance in explaining psychotherapy outcome.

10. Discussion

This review opened in pointing out to the increased attention given these days in psychological quarters to the therapeutic relationship. It traced the beginning of that attention to the debate between Freud and Ferenczi about the nature of this relationship. It followed through the development of the concepts of the therapeutic alliance and the interpersonal circumplex, emerging from Freud’s and Ferenczi’s respective positions, and their becoming a focus of both theory and research in recent years. As detailed above, the interest and extensive study of these constructs emerged in the context of a scholarly effort to understand the nature of the therapeutic relationship as well as an empirical motivation to find the elusive ‘general factor’ suggested by the consistent finding that overall different types of psychotherapy show no significant difference in efficacy. While relational theory marches on to provide increasingly elaborate accounts of the therapeutic relationship, research in the field cannot be said to have matched up the pace. The general factor behind the work of psychotherapy is still to a significant extent at large.

However, two decades of intensive research provided important clues to its nature. First, it is clear at present the concept of the therapeutic alliance captures a significant aspect of what makes the therapeutic relationship work. To recapitulate, this concept has developed from Sterba’s suggestion that for a therapeutic relationship to persist, the patient must be able to maintain a general objective appreciation of the therapeutic situation and its ‘real’ characteristics. He has to be able to remember, even when flooded with transference
anxiety or rage, that the therapist is a benevolent professional out to provide him with help. He has to be able to keep a part of himself objective and separate from his transference at all times. Zetzel added to that formula an affective element, suggesting that for such a belief system to persist the patient must like and trust the therapist as well. Greenson suggested that the patient’s alliance was distinguished not only from his transference, but also from the “real” relationship. Bordin, changing the focus from the person of the patient to his relationship with the therapist suggested an element of agreement between patient and therapist on goals and tasks.

Alliance research has established that the alliance was, indeed, not only up to the patient; that both patient and therapist participate in contributing to the therapeutic process and its outcome. Research has singled out attitudinal, affective and behavioral elements participating in both patients’ and therapists’ contribution to the alliance. It has also supported Bordin’s relational construct of agreement between them. All these elements have been shown to contribute to psychotherapy outcome. However, different studies suggested different levels of heterogeneity between these elements, compelling Horvath and Symonds to conclude that the concept of alliance with its different elements taps into several underlying constructs and only partly into the sought after general factor. Speculating that this factor could be described as related to “mutuality, collaboration and engagement,” Horvath and Symonds hinted that future study of the alliance will benefit from adopting a more relational perspective.

Circumplex research has also established both individual and relational angles to the study of the therapeutic relationship. From the individual angle research focused mostly on the contents of the relationship, mapping participants’ ongoing experience in terms of affiliation and control and attempting to link these with outcome. From the relational angle, research focused on both content and process, trying to map the levels of affiliation and control as well as the patterns of their sequential unfolding and their relation to the principle of complementarity. The findings of circumplex research are complex. In terms of contents
The picture is unbalanced: it appears that in most cases positive affiliation (friendliness) does not predict good outcome while negative affiliation (hostility) predicts poor outcome. In terms of process it was generally found that stable complementarity, likely because it perpetuates problematic interpersonal patterns, predicts poor outcome while differing levels of complementarity over time predict good outcome. In terms of their interaction it was found that complementarity of positive affiliation is a predictor of good outcome while hostile complementarity predicts poor outcome.

While confusing, these findings can hardly be discarded. First, because they do illuminate significant aspects of the therapeutic relationship and its effect on the individuals participating in it. Second, and more specifically, because when considered in the context of the alliance research, they offer further support Horvath and Symond’s relational conclusion and provide significant clues as to the nature of the therapeutic alliance and its place in the therapeutic relationship. Perhaps most prominent in this context is the circumplex finding that positive affiliation is not predominant in good outcome cases. This suggests that affective content alone does not predict outcome and casts a doubt on the traditional view of the therapeutic alliance as a stable individual stance consisting of mostly positive attitudes and affect towards the other. However, circumplex research also indicates that no simple process variable can predict outcome on its own. Concentrating on the concept of complementarity, this body of research shows that stable complementarity actually predicts poor outcome, while good outcome is predicted by a pattern of changing complementarity, and one that is related at different time points to different affiliative content. More specifically, the pattern most supportive of good outcome seems to be an initial friendly complementarity, followed by decreased complementarity with more isolated hostile content, and developing into a flexible, multi-content relationship. But what is it that holds the relationship intact as complementarity and affiliation decrease and hostility increases? The answer to this question is perhaps provided by Bordin’s notion of the alliance as encompassing an element of conscious agreement on goals and tasks in addition to an affective bond between patient and therapist. As suggested by Muran and Safran
(1998) these two components of the alliance support each other. A working agreement facilitates an affective bond which, in turn, takes over and sustains the relationship when the agreement is challenged and requires renegotiation and change. If the circumplex construct of affiliation is to an extent parallel to Bordin's concept of an affective bond, then it is possible that when affiliation and complementarity decrease, it is the conscious sense of agreement on goals and tasks that maintains the relationship on track.

In general, it seems that when examined together, the thinking and research that have been generated under the paradigms of the therapeutic alliance and the circumplex combine to offer a wider picture of the therapeutic relationship and a clearer view of the therapeutic alliance. Specifically, they seem to suggest that the alliance is best characterized as a relational process that transcends the particular contents of the relationship, does not require a constant perpetuation of any specific attitude or belief, but rather a dynamic balance of a number of elements that allows the process to proceed. These elements likely include positive and/or negative attitudes and beliefs about the other participant and the process in general, an affective stance and bond, a conscious agreement or disagreement between the participants about their endeavor, and a more unconscious or non articulated varying sense of mutuality, engagement and collaboration.

The therapeutic relationship is the framework in which all these elements emerge and manifest. The therapeutic alliance is their ongoing dynamic balance. It includes in any given moment different levels of intensity and prominence of both patient’s and therapist’s attitudes and beliefs, positive and negative affect, agreement and sense of engagement and collaboration. A sufficient alliance exists when this overall balance provides enough relationship sustaining elements to enable the tolerance and processing of other elements that are more challenging to the relationship. Examples for such balance could be a relationship where a conscious agreement between patient and therapist about the parameters of their endeavor enables them to experience and process hostility, a relationship where at some point a strong affective bond allows for extensive disagreement.
between patient and therapist, a relationship where positive attitudes and beliefs facilitate the therapeutic process despite poor affective bonding and so on. The crucial factor is that for the most part, process sustaining elements outweigh others.

As described above, this view of the alliance as a relational and process oriented rather than a static content centered construct is indicated by Horvath and Symond in their seminal review of alliance research as well as by the findings emerging from circumplex research. However, Muran and Safran (1998) make the most explicit argument for such notion of the alliance. Drawing on both classical and relational considerations, and utilizing Bordin’s conceptual framework, Muran and Safran argue that the therapeutic alliance remains a crucial concept for the understanding and practice of psychotherapy, provided it is regarded as a dynamic, relational process. In Bordin’s view, the alliance consists of both an affective bond and an agreement between patient and therapist about the goals and tasks of their mutual endeavor. Elaborating on this framework, Muran and Safran demonstrate how different types of therapy rely on different types of alliance in terms of the goals and tasks they entail, but share a common relational component. In other words, while concentrating on varying agendas, all therapies occur within an interpersonal context. According to Muran and Safran, there is no meaning for any goal, task, or for that matter any form of therapeutic communication, independent of this context. The alliance is therefore to be found neither in just the goals or tasks agreed upon by the participants, nor only in the affective bond between them, but in the dynamic between these two levels of the phenomena. It is the synergy or balance between them.

Muran and Safran’s view of the alliance elaborates on Bordin’s. It therefore concentrates exclusively on the alliance components of affective bond and agreement on goals and tasks. The framework offered above attempts to account for a somewhat wider range of the elements that have been previously associated with the concept of the alliance. Specifically, it adds to the equation the attitudinal component promoted by some traditional definitions of the alliance, as well as a more general relational factor. The distinction
between a general relational factor and a more specific affective bond exists de-facto in the body of research on the therapeutic alliance. However, it is offered also in order to potentiate a differentiation between conscious and unconscious relational dimensions. In this framework, an affective bond would be something that the participants in a relationship are aware of and can report, something parallel to the dimension of affiliation proposed by the circumplex paradigm. The general relational component attempts to capture the more elusive underlying construct referred to by Horvath and Symond as "mutuality."

This review opened with Freud and Ferenczi and their debate about the nature of the therapeutic relationship. It suggested that the concept of the therapeutic alliance emerged as a sort of compromise, increasingly pointing to the significance of "real" relationship issues while at the same time maintaining the lines beyond which the hierarchical and positivistic nature of the therapeutic endeavor blur beyond recognition. It then described at length the vicissitudes of this concept, as well as its circumplex alternative, throughout decades of research. From Freud and Ferenczi to today's researchers, it seems the question remains: what is it in psychotherapy that works. This has boiled down in some regards to another question, that of "the general factor": what is it that all types of therapy share that makes them all similarly effective. This review suggests that the therapeutic alliance remains the best answer to these questions. However, it also suggests, following Horvath and Symonds as well as Muran and Safran, that the alliance is not a simple variable. Rather than a stable content related construct, the alliance is likely a complex construct best described as a balance of several relationship oriented content and process elements.
Chapter II

METHOD

1. General Research Strategy

As described above, the body of research on the therapeutic relationship suggests that the alliance is a complex construct best described as a balance of several relationship oriented content and process elements. There has been much research done on content oriented elements of the alliance such as patient and therapist affect, attitudes and beliefs. Most of it attempted to establish the existence of such contents in the subjective perception of patients and therapists and relate it to outcome, with the purpose of establishing the theoretical validity and clinical relevance of the construct of alliance. While findings were often seen as indicating relational phenomena, there has been virtually no attempt to study this phenomenon directly. Instead, research continues to focus on individuals’ subjective assessment of the therapeutic relationship. The suggestions that the alliance rests on relational, process oriented patterns such as mutuality (Horvath & Symonds, 1991) or dynamic balance (Muran & Safran, 1998; Safran & Muran, in press), remain therefore in the realm of inference and speculation.

The study reported here attempted a direct examination of the therapeutic alliance as a process-oriented relational phenomenon. It has done so based first and foremost on a conceptualization of the alliance as something that occurs in the therapeutic relationship rather than, or in addition to something that exists in the minds of its participants. In other words, it was based on a distinction between the subjective and intersubjective aspects or registers of interpersonal phenomena. Each and every interpersonal encounter is constituted
by the behavior of the individuals participating in it and impacts these individuals’ subjective experience. It is in this sense a matrix of subjective experiences that are processed and can be later reported by the individuals involved. However, as noted by Sullivan (1953, 1954), there is also something in any interpersonal encounter that transpires in the space and process between individuals and cannot be reduced to the ways in which it is experienced by them. It is in this sense an intersubjective phenomenon and should be studied directly as such. As noted above, the therapeutic alliance has been mostly looked at through the eyes of individuals, that is, it was studied as a subjective phenomenon. This study was based on the notion that for the alliance to be studied as a relational construct it must be first defined as intersubjective, that is, as something that manifests between individuals.

The strategy used to operationalize this approach to the study of the alliance involved a method for transforming some traditional content-oriented self-report measures of the therapeutic relationship and alliance into measurements of the alliance as an intersubjective phenomenon. The specific self-report measures used were the WAI-12 (WAI: Horvath & Greenberg, 1989; WAI-12: Tracey & Kokotovic, 1989), an alliance measure, and the IAS-16 (IAS: Wiggins et al., 1988; IAS-16: Muran et al. 1991), a circumplex derived affiliation measure. Both used by both the patients and therapists who participated in the study to rate different aspects of their relationships. As described in detail later, these measures were used in two distinct ways. They were used as intended, to capture patients’ and therapists’ subjective perceptions of their relationships. They were also used as a basis for creating a number of correlation indices designed to capture the congruence between patients’ and therapists’ perceptions of their relationships. These correlation indices served to approximate or get as close as possible to a direct measurement of the intersubjective component of the alliance.

In order to establish theoretical validity and clinical relevance, the construct and measurement developed were assessed in terms of their strength in predicting
psychotherapy outcome. As described in detail below, the assessment was based on a regression analysis approach developed by Liang and Zeger (1986).

Because of the overwhelming historical emphasis on content elements and subjective perception in alliance research, this assessment also included a comparison of the predictive power of the proposed intersubjective measurements with that of the subjective measures derived from the WAI-12 and IAS-16. It was hypothesized that if the alliance in fact lies not only in individuals' minds but in the patterns of their mutual relationships, and if, as suggested by Horvath and Symonds, most existing alliance measures tap into that level of the construct only partially, then a measurement based on a relational perspective and offering a more direct assessment of the alliance as an intersubjective phenomenon should prove superior.

2. Research Propositions

In summary, this study addressed the following propositions:

1. The therapeutic alliance is a construct that could be defined and measured on the level of the therapeutic relationship rather than that of patient and therapist perceptions. In other words, it could be defined and measured as an intersubjective rather than subjective phenomenon.

2. An intersubjective construct of the alliance can be approximated by using the correlations between patients and therapists ratings on parallel or related items of alliance and other relationship measures. Such correlations can be used to derive correlation indices. These indices can serve as measurements of the alliance in general and its intersubjective component in particular.
3. Such correlation indices will prove to be reliable and valid, as well as strong predictors of psychotherapy outcome.

4. Because they capture an intersubjective construct of the alliance directly, such correlation indices will also prove to be stronger predictors of psychotherapy outcome than traditional alliance and relationship measures.

3. Participants

The reported study is based on data derived from the psychotherapies of 22 outpatients (7 male, 15 female) who were accepted and completed treatment in the Brief Relational Therapy (BRT) mode at the Brief Psychotherapy Research Project in the department of psychiatry at New York’s Beth Israel Medical Center. The mean age of the patients involved was at the time of beginning treatment 42.5 (SD = 11.27), ten (45%) were married or living with a partner. Eighteen (82%) of the patients who participated in this study received DSM-III-R AXIS I diagnoses (Diagnostic and Statistical Manual of Mental Disorders 3rd ed., rev.; DSM-III-R; American Psychiatric Association, 1987) including anxiety, adjustment and unipolar mood disorders without psychotic features. Nineteen (86%) received AXIS II Personality Disorder diagnoses including Avoidant, Passive Aggressive, Obsessive Compulsive, Dependent and NOS (not otherwise specified). Exclusion criteria included 1) organic brain disorders and mental retardation; 2) symptoms of psychosis; 3) a diagnosis of bipolar disorder; 4) active substance abuse; 5) active AXIS III medical diagnosis; 6) history of violent behavior or impulse control disorder; 7) use of psychotropic medication within the last year. Treatment was provided by 13 therapists (5 male, 8 female) with the mean age of 33.5 (SD = 5.9) Nine (69%) of the therapists were married or living with a partner while participating in the study. Three of them held at the time of treatment Ph.D. degrees, the other 10 Ph.D candidates in Clinical Psychology.
4. Treatment

The treatment provided to the patients in this study involved a 30 to 40 session protocol (initially consisting of 40 sessions, the protocol was later reduced to 30) of Brief Relational Therapy (BRT) as developed by Safran and Muran (e.g., Safran, 1990a, 1990b; Safran & Segal, 1990; see also Safran & Muran, in press). BRT is a time limited therapy mode integrating interpersonal, experiential and cognitive principles around a focus on the therapeutic relationship as a tool for exploring and achieving change in patients' problematic interpersonal patterns. BRT is guided by the premise that individuals' problematic experience and behavior are greatly determined by cognitive-interpersonal patterns that have been established historically and continue to exist in sometimes vicious cycles of enactment and validation. These patterns are usually central in the patient's life and relationships. They are therefore very likely to manifest in therapy as well. BRT focuses on the patient's problematic interpersonal patterns as they appear in the interaction between patient and therapist. Rather than contemplate external contingencies, it encourages the patient to attend to his immediate experience and the thought and feelings it entails. Attending to the here and now of the therapeutic relationship often facilitates in the patient deep affective involvement, increased awareness of the parameters of his experience and behavior, and an extended range of possibilities for him to understand and direct them. (see Gill, 1982; Greenberg & Safran, 1987; Kiesler, 1988; Safran & Segal, 1990). This may, over time, extend beyond the therapeutic situation and come to play in other relationships, helping the patient to achieve increased interpersonal flexibility and satisfaction.

5. Measures - Process

All participants in this study (both patients and therapists) were required to complete a Post Session Questionnaire (PSQ) after each session. Presented in parallel forms for patient and therapist, the PSQ consisted of two measures to be used here:
**WAI-12**, is a 12 item version of the Working Alliance Inventory developed by Horvath and Greenberg (WAI: Horvath & Greenberg, 1989; WAI-12: Tracey & Kokotovic, 1989), to capture Bordin's (1979) concept of the therapeutic alliance. The WAI-12 yields 12 specific alliance ratings and one total alliance score. The total alliance score was used in this study as a subjective alliance measure.

**IAS-16**, is a 16-item version of the Interpersonal Adjective Scale developed by Wiggins (IAS: Wiggins et al., 1988; IAS-16: Muran et al. 1991). The IAS-16 is used in this study as a measure of interpersonal process. As described above, the original IAS (Wiggins, 1979) is a 128-item adjective checklist derived from an octant version of the interpersonal circumplex. Wiggins et al. (1985) developed the IAS-R, a 64-item eight-point Lykert-type version of the IAS which proved to be significantly correlated with the original IAS as well as to have superior psychometric properties. The shortened version used in this study, IAS-16, consists of 16, 7-point Lykert-type items. These 16 items divide into two identical 8-item groups. Each item includes four adjectives that were found to have high factor loadings (> .45) in a factor analysis of the original IAS (Muran & Safran, 1989). Each item represents one octant in Wiggins' (1982) circumplex. One 8-item group is used by the subject to rate himself, the second, to rate the other in the interaction. The subject is asked to assess the degree in which these adjectives apply to the object of his rating. Specifically to this study, the patient's IAS-16 form contains two 8-item groups, the first used by the patient to assess himself, the second to assess the therapist. The converse is true for the therapist's form.

The IAS-16 yields eight interpersonal indices: friendliness and hostility on the dimension of affiliation, and dominance and submission on the dimension of control, each for both self and other. A test of the convergent validity between the IAS-16 and the IAS-R yielded a mean Pearson correlation coefficient of .83 (Muran et al., 1997).
IAS-16 indices are calculated based on weighting the relevant items according to their circumplex position. The items measuring pure friendliness and hostility are weighted with a value of 1.00 on their respective affiliation indices and with a value of zero on the control indices. The converse is true for the items measuring pure dominance or submission on the control dimension. The four items measuring a combination of affiliation and control load on the indices with a 0.50 factor. Specifically, each index consists of the three items on its half of the circumplex. For example, the friendliness index equals the sum of the ratings on the items concerning friendly dominance, friendliness and friendly submission, as multiplied by their respective weights: 1.00 for the item measuring pure friendliness, 0.50 for the other two.

The WAI-12 and IAS-16 were used in this study in two ways. First, as designed: the WAI was used as a source for a general alliance index representing the participant’s subjective perception of the alliance in a particular session; the IAS-16 as a source for eight interpersonal indices representing the participant’s subjective perception of friendliness, hostility, dominance and submission in the self and other. Second, the scores obtained from the WAI and IAS were used to create additional, intersubjective measures. These measures are described at length below (see Data Analysis section).

6. Measures - Outcome

Psychotherapy outcome was assessed through measuring the changes in patients performance on several measures between the times of intake and treatment termination. Outcome was indicated by standardized residual gain scores derived from the difference between patients’ performance at intake and termination on the following measures:

Global Assessment Scale (GAS: Endicott, Spitzer, Fleiss & Cohen, 1976), is a clinician rated scale for evaluating the overall mental health of the patient. It involves a
single rating on a range from 1 to 100, based on clinical descriptions characterizing each 10-point interval in terms of social and occupational functioning and levels of subjective distress. This measure showed adequate psychometric properties and is widely used in clinical settings. Outcome is indicated by the change in GAS score from intake to termination.

**Target Complaints** (TC: Battle et al., 1966) is an idiographic self report instrument developed to assess patient’s presenting problems. The TC consists of two parts: 1) Patient Target Complaint (PTC) where patients are asked to described three of the problems that brought them to treatment and rate their degree of severity on a Lykert-type scale. 2) Therapist Target Complaint (TTC) Which consists of the therapist’s rating of the severity of these problems. Outcome is indicated by the change in the average degree of severity for the three target complaints between intake and termination.

**Inventory of Interpersonal Problems** (IIP: Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988) is a 127-item patient rated inventory of interpersonal functioning describing common interpersonal problems and the experiences often associated with them. Items are rated for degree of severity on a 5-point Lykert-type scale. They are divided into two sections, 78 concerning behaviors that are difficult for the patient to engage in, 49 concerning behavior that might be engaged in excessively. This study uses the overall mean score of the IIP to assess general interpersonal functioning. Outcome is indicated by change in this score.

7. Procedure

All the patients who participated in this study were treated with Brief Relational Therapy (BRT) (see description above.) BRT is one of three treatment modalities practiced at the Beth Israel Medical Center Brief Psychotherapy Research Project. In addition to
BRT, the project offers Brief Adaptive Psychotherapy (BAP), a modality influenced by traditional ego-psychological principles, and Cognitive Behavioral Therapy (CBT), a modality focusing on cognitive behavioral ideas and strategies. Patients are initially assigned to the different treatment modalities at random. However, they may be later switched from one modality to another based on clinical considerations.

All patients admitted to the project undergo an intake process that includes a clinical interview and completion of the Structural Clinical Interview for DSM-III-R, parts I and II (SCID-I: Spitzer et al., 1988; SCID-II: Spitzer et al., 1987), a semi-structural interview used to determine AXIS I and AXIS II DSM-III-R diagnoses. They also complete the PTC and IIP at intake, midphase, termination and 6 months follow-up. Therapists complete the TTC (Therapist Target Complaint) and GAS at intake, midphase and termination. Both patient and therapist complete a Post Session Questionnaire (PSQ) after each session.

The PSQ used in this study includes a 16-item version of the Interpersonal Adjective Scale (IAS-16) and a 12-item version of the Working Alliance Inventory (WAI-12), as described above. It also includes the Session Evaluation Questionnaire (SEQ: Stiles, 1980), two Lykert-type items assessing session helpfulness to the patient (Muram & Safran, 1990; Safran et al., 1987; Wexler & Elliot, 1988) and five questions targeting problems that might have emerged during the session, their temporal location, severity, and whether they have been resolved. The entire PSQ includes 52 items and requires around five minutes to complete. Out of these, 28 are used in this study. Patients’ forms are handed out following each session together with a stamped and addressed envelope. Patients are asked to complete and mail the PSQ back to the research project. Therapists complete parallel forms of the PSQ and deliver them to the research project offices as well. Neither patient nor therapist have access to the completed PSQs.
8. Data Analysis

As described above, the study reported aimed at examining the alliance as a process-oriented relational phenomenon. It attempted to do so based on 1) a definition of the therapeutic alliance as something that *occurs* in the therapeutic relationship rather than *exists* in the minds of its participants, 2) a method for measuring the alliance, so defined, in actual therapeutic relationships, and 3) an assessment of the strength of the alliance, so measured, in predicting psychotherapy outcome. An additional aim was to contrast the results obtained from a relational definition and measurement of the alliance with those obtained from self-report alliance measures and circumplex derived affiliation measures.

As also described above, psychotherapy outcome was measured using the GAS, TTC, PTC and IIP, and psychotherapy process using the WAI-12 and IAS-16. Both the WAI-12 and IAS-16 are content-oriented, self-report measures. As such, they provide accurate measurement of individuals' subjective perception of their relationships. However, their account of the independent reality of these relationships, so far as such an objective or intersubjective outlook on the phenomenon is assumed, is second hand, inferential, and does not entail the same immediacy or accuracy. The most crucial method problem faced here was therefore how to use the information yielded by the WAI-12 and IAS-16 as a basis for an intersubjective measure of the alliance. The following describes the proposed solution, addressing the WAI-12, then the IAS-16.

As a reminder: the WAI-12 includes 12, 7-point Lykert-type items, consisting of various statements designed to cover different aspects of the therapeutic alliance. These items can be used independently, or combined to yield an overall mean alliance score. For each session used in this study there are two completed parallel PSQs and therefore two completed parallel WAI-12 forms; one from the patient and one from the therapist. These forms detail the patient’s and therapist’s assessment of the same phenomenon through their ratings of parallel items. Traditionally, these forms are used separately, to study the
differences between patients' and therapists' assessment of the alliance and the relations between these assessments and outcome. This can establish the validity and clinical relevance of the alliance as a feeling, attitude and/or belief experienced by a particular subject (for example, it may establish that patient’s ratings of alliance are a stronger predictor of outcome). It cannot capture the alliance as an intersubjective phenomenon.

In the study reported, these parallel forms were used to create an intersubjective measurement of the alliance. This was done by calculating for each session a correlation between the patient’s and therapist' ratings on the WAI-12. The result is a single correlation coefficient per session. This correlation coefficient is a measurement of the congruence between the patient and therapist in their experiences of the alliance during that session. It is premised that the congruence between the patient and therapist can serve to indicate or approximate the level of actual in-tunement and agreement that transpired in that session, the alliance as it occurred. Such correlation coefficient was calculated for each session, for each dyad who participated in the study. The result is an intersubjective alliance index that could be examined, alongside the traditional patient and therapist subjective alliance indices in relation to outcome.

The same method was used to transform the participant reported raw IAS-16 scores into several intersubjective measurements. As a reminder, the IAS-16 consists of 16, 7-point Lykert-type items. These 16 items divide into two identical 8-item groups, in which each item contains a list of four adjectives representing one octant in Wiggins’ (1982) circumplex. One 8-item group is used by the subject to rate himself, the second, to rate the other in the interaction. The subject is asked to assess the degree in which these adjectives apply to the object of his rating. Specifically to this study, the patient’s IAS-16 form contained of two 8-item groups, the first used by the patient to assess himself, the second to assess the therapist. The converse is true for the therapist’s form.
For each session examined there are two IAS-16 forms, one form the patient and one form the therapist, each containing ratings of both self and other. That is, for each session there are four 8-item groups consisting of 1) patient rating of self, 2) patient rating of the therapist, 3) therapist rating of self, and 4) therapist rating of the patient. These ratings detail the patient’s and therapist’s judgment of the degree in which their experience of self and other is matched by the relevant IAS adjectives. As described above, the IAS yields eight interpersonal indices: friendliness and hostility on the dimension of affiliation, and dominance and submission on the dimension of control, each for both self and other. These indices are calculated based on weighting the relevant items according to their circumplex position (for a detailed explanation see above). For each session in this study there could therefore be calculated 16 indices, representing the ratings of both patient and therapist, of both self and other, on friendliness, hostility, dominance and submission.

This study concentrated on the dimension of affiliation, with its components of friendliness and hostility only. While both circumplex dimensions of affiliation and control are relevant to the therapeutic relationship and alliance, affiliation is much more readily interpretable as related to alliance. For example, indicating if they were friendly or hostile towards their therapists, patients in fact testify to their affective stance towards them. Judging how friendly or hostile their therapists were, they provide their perceptions of the therapists’ stance. In short, participants’ perception of friendliness and hostility in the session can be seen as closely approximating or summing up their perception of some components of the alliance, particularly those related to affect and affectively charged attitudes and beliefs.¹

¹ The case is different for dominance and submission. Although the allocation of power and struggle for control are an important aspect of the therapeutic relationship, and one that might be closely related to the therapeutic alliance, the relations between control and alliance are less immediate. Rather than the two constructs in essence tapping into the same experience or components thereof, as is the case with alliance and affiliation, control and alliance are more likely related in a much more complex way. Examining this relationship would require a separate set of assumptions about the nature of the phenomena and the proper ways for measuring it. Such venture is beyond the scope of this study.
A concentration on the dimension of affiliation only, enables the calculation of eight indices per session. These include: 1) patient rating of self friendliness, 2) patient rating of self hostility, 3) patient rating of the therapist's friendliness, 4) patient rating of the therapist's hostility, 5) therapist rating of self friendliness, 6) therapist rating of self hostility, 7) therapist rating of the patient's friendliness, and 8) therapist rating of the patient's hostility. These affiliation indices are the circumplex parallel of the mean scores yielded by the WAI-12. Both are simple weighted averages obtained from raw ratings. Both can serve as indices for a particular participant's perception of the phenomena. The WAI-12 mean scores provide a general measure of each participants perception of the therapeutic alliance. The IAS-16 affiliation indices provide a measure of their perception of self and other affiliative stance.

The method for transforming the IAS-16 content-oriented, self-report ratings into measurements of intersubjectivity was similar to that used for the WAI-12: calculating correlation coefficients for parallel patient and therapist forms. As is the case with the WAI-12, this can serve as means of capturing actual affective congruence between patient and therapist. Unlike the WAI-12, which requires subjects to assess some elements of their relationship and thus provides a measure, albeit indirect, of that relationship, the IAS-16 requires subjects to rate only individuals. Calculating a correlation coefficient based on these ratings is therefore the only statistical way to use the IAS-16 in studying the relationship between these individuals.

However, unlike the WAI-12, which provides one set of scores per participant and can therefore yield only one general correlation index per session, the IAS provides four sets of scores (two per participant) and offers therefore a much wider range of possibilities. The correlation indices calculated for this study are as follows: 1) between the patient rating of self and the therapist rating of the patient (PS/TP), 2) between the patient rating of the therapist and the therapist rating of self (TS/PT), 3) between the patient rating of self and the therapist rating of self (PS/TS), 4) between the patient rating of the therapist and the
therapist rating of the patient (PT/TP), 5) between the patient rating of self and his rating of the therapist (PS/PT), and 6) between the therapist rating of self and his rating of the patient (TS/TP).²

The information provided by the IAS-16 can be used to create more than these six indices. It could be used to create a smaller number of more conclusive indices such as, for example, a correlation index for the patient’s ratings of both self and other and the therapist’s ratings of both self and other. It could be used to create a greater number of more specific indices by, for example, breaking up the general dimension of affiliation into its two components of friendliness and hostility, and thus providing double the number of more accurate indices. The choice to create six correlation indices capturing the entire range of possibilities for correlating the four IAS item sets on the level of affiliation was guided by a wish to use the full potential lying in the data while avoiding over generalization and ambiguity on the one hand, and excessive detail on the other. A smaller number of more inclusive indices might have been easier to process but more difficult to interpret. A greater number of more specific indices could have increased specificity, but at the cost of debilitating complexity and problems in statistical validity.

The six affiliation correlation indices have the potential of offering a unique range of perspectives into the intersubjective reality of the therapeutic relationships studied here. The correlation between the patient’s rating of himself and the therapist rating of the patient (PS/TP) provides a measure of the congruence between patient and therapist about the patient’s affiliation. Based on the patient’s report of his feelings and the therapist’s assessment of those feelings, this correlation can serve as an indication for how attuned the therapist was in any given session to his patient’s affiliative stance. The converse: the

² These six indices represent all the possible variations of correlating the four IAS rating sets obtained for each session in this study, when these sets are used in their entirety to yield a general affiliation measure. As explained above, this study concentrated exclusively on the dimension of affiliation. Affiliation is the circumplex dimension ranging between friendliness and hostility. A general affiliation measure would therefore consist of the three IAS items related to friendliness and the three related to hostility (for more details see above).
correlation between the patient’s rating of therapist and the therapist’s rating of himself (TS/PT) provides a measure of their congruence about the therapist’s affiliative experience. This can serve as an indication for how sensitive or accurate the patient was in assessing his therapist’s affiliative stance.

The correlation between the patient’s and therapist’s ratings of themselves, that is, between the patient rating of himself and the therapist rating of himself (PS/TS), provides a measure of the congruence between them in their respective subjective experiences in that session. Capturing the degree in which these individuals’ experiences of self reflect and complement each other, this correlation can serve as an indication for their affiliative complementarity. Its counterpart, the correlation between the patient’s and therapist’s rating of each other, that is the patient’s rating of therapist and the therapist’s rating of the patient (PT/TP), provides an additional yet more sophisticated measure of complementarity. Based on each participant’s assessment of the other’s affiliative stance rather than report of his own experience, this correlation captures the congruence between patient and therapist in their awareness and judgment of each other’s feelings. It provides therefore an indication for a more relationally embedded and conscious complementarity.

The correlation between the patient’s rating of himself and his rating of the therapist captures the level of concordance or discord among the patient’s own affiliative perceptions. Unlike the four affiliation correlation indices just described, this correlation is inherently subjective since it measures the congruence within rather than between individuals. However, it is different than most traditional subjective measures since it does not conclude with the individual’s self report. Most subjective measures, including those derived from the WAI-12 and IAS-16, are based on individuals’ responses to direct questions about their perceptions, thoughts and feelings in a given situation. As such, they target and therefore capture individuals’ consciously articulated perceptions. A correlation between the patient’s report of his affiliative stance and his rating of the therapist’s, while based on such consciously articulated perceptions, does not involve conscious assessment.
of the congruence between them. Rather, it captures the patient’s unmediated - that is, free of conscious articulation - registration of his affiliative congruence with the therapist. Although subjectively based, this correlation therefore provides a more direct representation of the intersubjective field from the patient’s perspective. It can augment the view obtained from the traditionally derived assessment. The correlation among the therapist’s perceptions of himself and of the patient provides a similarly unmediated representation of the intersubjective field from the therapist’s perspective.

To sum up, the process or suboutcome data analyzed in this study consists of the following: 1) two raw alliance indices, representing the patient’s and therapist’s subjective perception of the alliance, 2) one alliance correlation index representing the congruence between patient and therapist in their perception of the alliance, 3) eight raw interpersonal indices detailing the patient’s and therapist’s subjective perception of friendliness and hostility in self and other, and 4) six correlation indices capturing various elements of the affiliative congruence between patients and therapists. All obtained per session. The raw indices represent traditional, content-oriented, subjective relationship measures. The correlation indices are proposed, as detailed above, as process-oriented, intersubjective measures.

Having defined and developed a measure of the alliance as a relational phenomenon and having developed a set of associated relational measures based on the interpersonal circumplex, the suggestion that such construct and measures of the alliance are not only useful, but superior to traditional definitions and measures could be tested. Since the historic variations of the construct of alliance gained validation and popularity through demonstrating strength in predicting psychotherapy outcome, this study put the relational alternative to the same test.

The method used for analyzing the predictive relationship of all suboutcome and outcome measures is regression analysis based on a generalized estimating equations
approach developed by Liang and Zeger (1986; Zeger & Liang, 1986). This approach was
developed for analyzing measurements that are obtained at multiple time points for each
participant within a group of participants. It allows for repeated measures, as well as
possible dependence between them. It also allows for missing data. On the other hand it
requires independence between the participants. This approach offers an excellent match for
the structure of the data in this study, where 22 independent dyads yield 30 to 40 repeated
instances of the measures described above. It is implemented by using a FORTRAN
program titled RMGEE (Davis, 1993) based on Liang and Zeger's approach.

Because of the specific statistical procedure used by the RMGEE, each process
variable was evaluated independently. The regression equation used for evaluating the
predictive power of each measure included all available instances where this measure was
obtained (up to 40 per case, for all 22 cases) as predictor variable. An outcome measure
(one per case) served as criterion variable. Each such analysis provided an estimate for the
predictive power of one process variable over one outcome measure. This estimate was
then contrasted with those yielded by the analyses of others to evaluate their comparative
strengths. As described above, outcome was assessed using several individual as well as
combinations of measures. These include the GAS, PTC, TTC and IIIP. The patterns in
which these measures are influence by the different process measures is of interest as well.
Chapter III

RESULTS

1. Psychometric Properties of Suboutcome and Outcome Measures

Table 1 (below) presents the frequency of per session ratings obtained in this study on the WAI-12 and IAS-16.

<table>
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<tr>
<th>Session</th>
<th>Patient WAI-12</th>
<th>Therapist WAI-12</th>
<th>Patient IAS-16</th>
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<td>30</td>
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<td>18</td>
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<td>16</td>
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</tbody>
</table>

| Average | 19             | 19               | 19             | 19               |

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Table 2 (below) presents the internal consistency obtained for patients’ and therapists’ ratings on these measures. Internal consistency was calculated for 3 sessions (nos. 6, 16 and 26), representing the three thirds of the psychotherapy protocols studied here. It was found adequate for patients’ and therapists’ WAI-12 but poor for their IAS-16 ratings.

<table>
<thead>
<tr>
<th>Item Alpha for</th>
<th>WAI - 12</th>
<th>IAS - 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Number</td>
<td>Patient</td>
<td>Therapist</td>
</tr>
<tr>
<td>6</td>
<td>0.89</td>
<td>0.83</td>
</tr>
<tr>
<td>16</td>
<td>0.83</td>
<td>0.86</td>
</tr>
<tr>
<td>26</td>
<td>0.85</td>
<td>0.86</td>
</tr>
</tbody>
</table>

WAI-12 = Working Alliance Inventory (Tracey & Kokotovic, 1989); IAS-16 = Interpersonal Adjective Scale (Muran et al., 1991). Standardized Item Alpha 1, 2, 3 = standardized item alpha for sessions nos. 6, 16 and 26, respectively.

Test/Retest reliability of the various indices derived from the WAI-12 and IAS-16 is presented in Table 3 (below). Both WAI-12 alliance indices (Patient Working Alliance and Therapist Working Alliance) and all but one IAS-16 affiliation indices show adequate levels of test/retest reliability.

Table 3
Test - Retest Reliability of Suboutcome indices.

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>TA</th>
<th>PSF</th>
<th>PSE</th>
<th>POF</th>
<th>POH</th>
<th>TSF</th>
<th>TSH</th>
<th>TOF</th>
<th>TOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>0.88</td>
<td>0.89</td>
<td>0.83</td>
<td>0.6</td>
<td>0.89</td>
<td>0.42</td>
<td>0.96</td>
<td>0.88</td>
<td>0.9</td>
<td>0.86</td>
</tr>
</tbody>
</table>

PA = patient alliance; TA = therapist alliance; PSF = patient self friendliness; PSH = patient self hostility; POF = patient other friendliness; POH = patient other hostility; TSF = therapist self friendliness; TSH = therapist self hostility; TOF = therapist other friendliness; TOH = therapist other hostility.

All outcome measures used in this study demonstrate significant change in the direction of higher functionality between the times of intake and termination, as detailed in Table 4 (below).
Table 4
Outcome Measures: Means, Standard Deviations and Statistical Significance.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (and Standard Deviation)</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretreatment</td>
<td>Posttreatment</td>
</tr>
<tr>
<td>GAS</td>
<td>62.10 (4.97)</td>
<td>68.15 (6.63)</td>
</tr>
<tr>
<td>TTC</td>
<td>10.10 (1.12)</td>
<td>6.71 (2.14)</td>
</tr>
<tr>
<td>PTC</td>
<td>9.56 (1.80)</td>
<td>6.64 (2.15)</td>
</tr>
<tr>
<td>IIP</td>
<td>1.29 (.43)</td>
<td>1.02 (.51)</td>
</tr>
</tbody>
</table>

GAS = Global Assessment Scale; TTC = Therapist Target Complaints (overall mean); PTC = Patient Target Complaints (overall mean); IIP = Inventory of Interpersonal Problems (overall mean).

2. Intercorrelations Among Suboutcome Measures

In order to assess and establish the relations between the various suboutcome indices used in this study, the intercorrelations between them were calculated for 3 sessions (nos. 6, 16 and 26) representing the three psychotherapy thirds. Tables 5, 6, 7, 8 and 9 (below) present these intercorrelations. Highlighted in these tables and discussed are those intercorrelations found significant in either two or three out of three representative sessions.

As evident in Table 5, all alliance indices are significantly intercorrelated in at least two of three sessions. The correlation between Patient Alliance (PA) and Therapist Alliance (TA) is predictably high, ranging from 0.52 to 0.65. The correlations between the two subjective alliance indices and the Alliance Correlation Index (PA/TA) are also high, ranging from 0.49 to 0.72 for the correlation between Patient Working Alliance and the Alliance Correlation Index, 0.55 to 0.59 for the correlation between Patient Working Alliance and the Alliance Correlation Index. This pattern of correlations suggests that the two subjective alliance indices and the intersubjective alliance index used in this study overlap considerably and to a significant extent capture the same construct. However, it also suggests that each of these indices capture either a somewhat different construct or different aspects of the same construct.

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The intercorrelations between all alliance indices and the subjective affiliation indices are presented in Table 5 as well. For the therapeutic relationships studied here, Patients’ Working Alliance is highly correlated \([0.44 - 0.81]\) with most subjective patient affiliation indices (PSF, PSH, POF), except for Patient Other Hostility (POH). Therapists’ Working Alliance is highly correlated \([0.61 - 0.77]\) with all subjective therapist affiliation indices (TSF, TSH, TOF, TOH). For all these intercorrelations, subjective alliance is positively correlated with those subjective affiliation indices measuring positive affiliation and negatively correlated with those measuring negative affiliation. This pattern of intercorrelations indicates that in this sample, individuals are more likely to report alliance when they experience themselves and others as friendly than when the prominent experience is of hostility.

There are no significant intercorrelations between any of the subjective affiliation indices and the Alliance Correlation Index. In addition, while many subjective affiliation indices are intercorrelated within subject, there are virtually no significant correlations of subjective affiliation indices across subjects (Table 6). In other words, different elements of patients’ affiliative experience are intercorrelated, for example, patients’ reporting of experiencing themselves as friendly is, as expected, negatively correlated with their experiencing themselves as hostile. Most elements of therapists’ affiliation are predictably intercorrelated as well. However, in this sample, patients’ and therapists’ affiliative experiences were not found to be related to each other.

Taken together, these intercorrelations suggest three distinct yet partially overlapping constructs, tapped into by the various alliance and affiliation indices. These are subjective affiliation, subjective alliance and intersubjective alliance. Subjective affiliation, as measured by the IAS-16 derived subjective indices, is a subject based construct representing the way in which patients and therapists perceive and report their affective and affiliative experiences. Subjective alliance, as measured by the WAI-12 derived patient and therapist alliance indices, is a construct involving the way in which these individuals
perceive and report their experience of the alliance. Intersubjective alliance, as measured by the WAI-12 based Alliance Correlation Index, is a construct pertaining to the degree of actual congruence or agreement between patients and therapists about their alliance.

Table 5
Intercorrelations Among Suboutcome Indices: Alliance Indices, the Alliance Correlation Index and Affiliation Indices.

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>TA</th>
<th>PA/TA</th>
<th>PSF</th>
<th>PSH</th>
<th>POF</th>
<th>POH</th>
<th>TSF</th>
<th>TSH</th>
<th>TOF</th>
<th>TOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWA</td>
<td>.52*</td>
<td>.49*</td>
<td>.25</td>
<td>.58**</td>
<td>.44*</td>
<td>-.018</td>
<td>0.32</td>
<td>-0.45</td>
<td>0.36</td>
<td>-.54*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.65**</td>
<td>0.44</td>
<td>.81**</td>
<td>.64**</td>
<td>.80**</td>
<td>-.24</td>
<td>0.19</td>
<td>-.55*</td>
<td>0.48</td>
<td>-.45</td>
<td></td>
</tr>
<tr>
<td>TWA</td>
<td>.59*</td>
<td>.72**</td>
<td>.47*</td>
<td>.67**</td>
<td>0.27</td>
<td>-0.4</td>
<td>0</td>
<td>0.22</td>
<td>0.35</td>
<td>-0.48</td>
<td></td>
</tr>
<tr>
<td></td>
<td>.55*</td>
<td>-.04</td>
<td>-0.28</td>
<td>.13</td>
<td>-0.15</td>
<td>.68**</td>
<td>.70**</td>
<td>.76**</td>
<td>.65**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.31</td>
<td>0.48</td>
<td>-0.39</td>
<td>0.52</td>
<td>0.3</td>
<td>.62**</td>
<td>.70**</td>
<td>.72**</td>
<td>.77**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA/TA</td>
<td>.59**</td>
<td>.42</td>
<td>-.69**</td>
<td>0</td>
<td>-.36</td>
<td>0.45</td>
<td>0</td>
<td>-.61**</td>
<td>-.75**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PA = patient alliance; TA = therapist alliance; PA/TA = alliance correlation index; PSF = patient self friendliness; PSH = patient self hostility; POF = patient other friendliness; POH = patient other hostility; TSF = therapist self friendliness; TSH = therapist self hostility; TOF = therapist other friendliness; TOH = therapist other hostility. * p <.05. ** p <.01.

The partial overlap between patients’ and therapists’ subjective affiliation and their subjective experiences of the alliance (respectively) can be explained if it is considered that both constructs involve these individuals’ affective experience. That, in addition to the apparent heuristic relationship between affiliation and alliance, indicated by the direction of the intercorrelation between the subjective indices. The overlap between patients’ and therapists’ subjective view of the alliance and between these and the alliance as indicated by the congruence between these views is likely due to the fact that all these perspectives on the alliance are anchored, albeit from different epistemological angles, in the patient’s and therapist’s intersubjective field. This field is tapped into from each individual’s point of view by the subjective alliance indices and as a pattern of de-facto agreement between individuals by the alliance correlation index. The subjective component captured by these indices results in their differences. The shared intersubjective field is likely the cause of
their overlap.³

**Table 6**
Intercorrelations Among Suboutcome Indices: Affiliation Indices.

<table>
<thead>
<tr>
<th></th>
<th>PSF</th>
<th>POF</th>
<th>POH</th>
<th>TSF</th>
<th>TSH</th>
<th>TOF</th>
<th>TOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSF</td>
<td>-0.27</td>
<td>0.36</td>
<td>-0.08</td>
<td>-0.1</td>
<td>0.05</td>
<td>-0.19</td>
<td>0.09</td>
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<tr>
<td></td>
<td>-0.49*</td>
<td>0.49*</td>
<td>0.05</td>
<td>-0.15</td>
<td>0.12</td>
<td>-0.37</td>
<td>0.14</td>
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<tr>
<td></td>
<td>-0.41</td>
<td>0.74**</td>
<td>-0.36</td>
<td>0.08</td>
<td>-0.8**</td>
<td>-0.2</td>
<td>0.39</td>
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<tr>
<td>POF</td>
<td>-0.37</td>
<td>0.09</td>
<td>-0.31</td>
<td>0.03</td>
<td>-0.25</td>
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<tr>
<td></td>
<td>-0.56**</td>
<td>0.09</td>
<td>-0.33</td>
<td>0.32</td>
<td>-0.39</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>-0.62**</td>
<td>0.45</td>
<td>0.07</td>
<td>0.27</td>
<td>0.24</td>
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<td>POH</td>
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<td>0.38</td>
<td>-0.22</td>
<td>0.36</td>
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<td>0.22</td>
<td>-0.28</td>
<td>0.04</td>
<td>-0.14</td>
<td>-0.21</td>
<td>0.51</td>
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<tr>
<td>TSF</td>
<td>-0.75**</td>
<td>-0.48*</td>
<td>0.68**</td>
<td>-0.37</td>
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<td></td>
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<tr>
<td></td>
<td>-0.66**</td>
<td>0.49*</td>
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</tr>
<tr>
<td>TSH</td>
<td>-0.42</td>
<td>0.58*</td>
<td>-0.17</td>
<td>0.36</td>
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<td></td>
<td></td>
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<tr>
<td>TOF</td>
<td>-0.69**</td>
<td>-0.53*</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

PSF = patient self friendliness; PSH = patient self hostility; POF = patient other friendliness; POH = patient other hostility; TSF = therapist self friendliness; TSH = therapist self hostility; TOF = therapist other friendliness; TOH = therapist other hostility. * p < .05. ** p < .01.

³ It is important to note in this context a particular characteristic of the WAI-12 and its derived indices. Unlike the IAS-16, which is given to patient and therapist in exactly parallel forms, WAI-12 forms are not parallel and are to an extent patient centered. Half of the WAI-12 items are concerned with either patient and therapist assessing their levels of mutual agreement and collaboration; the other half require both to assess the patient’s attitudes and beliefs. Consequently, the patient’s alliance index captures an alliance that is a relational and personal experience, while the therapist’s alliance index captures an alliance that is an experience of the relationship as well as an assessment of the patient. This raises a question as to the meaning of comparing and contrasting these two indices as representing the constructs of patient and therapist subjective alliance. The two constructs represented by these indices are comparable so far as they both involve the alliance as an individual’s subjective experience. They are also comparable to the extent that they both involve these individuals’ assessment of their relationships. They are not similarly comparable to the extent that the experiencing agent or object of the alliance they measure is not in both cases the self, but the patient. However, while this consideration remains, the pattern of intercorrelations obtained for this sample, and particularly the strong correlations between the therapist subjective alliance and subjective affiliation indices suggest that the therapist subjective alliance index can be justifiably regarded as representing the therapist’s subjective experience.
Table 7
Intercorrelations Among Suboutcome Indices: Affiliation Correlation Indices.

<table>
<thead>
<tr>
<th></th>
<th>PS/TP</th>
<th>TS/PT</th>
<th>PS/TS</th>
<th>PT/TP</th>
<th>PS/PT</th>
<th>TS/TP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS/TP</td>
<td>.65**</td>
<td>.89***</td>
<td>.69**</td>
<td>.60**</td>
<td>0.30</td>
<td></td>
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<tr>
<td></td>
<td>.69**</td>
<td>.77**</td>
<td>.70**</td>
<td>0.41</td>
<td>.77**</td>
<td></td>
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<tr>
<td></td>
<td>.64*</td>
<td>.69**</td>
<td>.94**</td>
<td>0.06</td>
<td>.26</td>
<td></td>
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<tr>
<td>TS/PT</td>
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<td>.87**</td>
<td>.11</td>
<td>.06</td>
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<td>.85**</td>
<td>.47</td>
<td>.047</td>
<td>.49</td>
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<td></td>
<td>0.43</td>
<td>.70**</td>
<td>-0.15</td>
<td>-0.16</td>
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<td></td>
</tr>
<tr>
<td>PS/TS</td>
<td>.57**</td>
<td>.69**</td>
<td>.59*</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.24</td>
<td>.73**</td>
<td>.59*</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.58*</td>
<td></td>
<td>.69**</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PS/PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.07</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.25</td>
<td>0.14</td>
</tr>
</tbody>
</table>

PS/TP = the correlation between patient rating of self and therapist rating of patient; TS/PT = the correlation between therapist rating of self and patient rating of therapist; PS/TS = the correlation between patient rating of self and therapist rating of self; PT/TP = the correlation between patient rating of therapist and therapist rating of patient; PS/PT = the correlation between patient rating of self and patient rating of therapist; TS/TP = the correlation between therapist rating of self and therapist rating of patient. * p <.05. ** p <.01.

Table 7 presents the intercorrelation among the six IAS-16 derived affiliation correlation indices. The intercorrelations between the PS/TP index, the TS/PT index, the PS/TS index and the PT/TP index are all high, ranging from 0.64 to 0.94. This suggests that all measure similar aspects of the same construct. With one exception, these four correlation indices are not significantly intercorrelated with either the PS/PT index or the TS/TP index. These latter indices are also independent of each other. This pattern of intercorrelations suggests that PS/PT and TS/TP are different from the other four affiliation correlation indices. Taken together with the fact that PS/PT and TS/TP are highly correlated with the subjective alliance indices within category but not across category (table 9), this pattern of intercorrelation confirms that measuring the congruence of affiliative experiences within individuals, these indices are to a significant extent measures of

4 the correlation between the patient rating of himself and the therapist's rating of the patient.

5 the correlation between the patient's ratings of the therapist and the therapist's rating of himself.

6 the correlation between the patient's rating of himself and the therapist's rating of himself.

7 the correlation between the patient's rating of the therapist and the therapist's rating of the patient.

8 the correlation between the patient's rating of self and his or her rating of the therapist.

9 a correlation between the therapist's rating of self and his or her rating of the patient.
subjective phenomena. This, as opposed to PS/TP, TS/PT, PS/TS and PT/TP; all measuring the congruence of affiliation experiences between individuals and therefore interpretable as capturing intersubjective phenomena.

**Table 8**
Intercorrelations Among Suboutcome Indices: Affiliation Indices and Affiliation Correlation Indices.

<table>
<thead>
<tr>
<th></th>
<th>PS/TP</th>
<th>TS/PT</th>
<th>PS/TS</th>
<th>PT/TP</th>
<th>PS/PT</th>
<th>TS/TP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSF</td>
<td>0.36</td>
<td>0.17</td>
<td>.62**</td>
<td>-0.04</td>
<td>.72**</td>
<td>-0.45</td>
</tr>
<tr>
<td></td>
<td>.66*</td>
<td>.59*</td>
<td>.64*</td>
<td>0.31</td>
<td>.64**</td>
<td>.54*</td>
</tr>
<tr>
<td></td>
<td>0.34</td>
<td>0.33</td>
<td>.69**</td>
<td>0.21</td>
<td>0.43</td>
<td>-0.04</td>
</tr>
<tr>
<td>PSH</td>
<td>-.67**</td>
<td>-0.36</td>
<td>-.80***</td>
<td>-0.12</td>
<td>-.86**</td>
<td>-0.01</td>
</tr>
<tr>
<td></td>
<td>-.61**</td>
<td>-0.59*</td>
<td>-.82**</td>
<td>-0.02</td>
<td>-.71**</td>
<td>-.62*</td>
</tr>
<tr>
<td></td>
<td>-0.25</td>
<td>-0.11</td>
<td>-0.28</td>
<td>-0.38</td>
<td>-0.49*</td>
<td>-0.44</td>
</tr>
<tr>
<td>POF</td>
<td>.55*</td>
<td>.50*</td>
<td>.59**</td>
<td>0.34</td>
<td>0.39</td>
<td>-0.03</td>
</tr>
<tr>
<td></td>
<td>.55*</td>
<td>.61*</td>
<td>0.47</td>
<td>0.41</td>
<td>0.44</td>
<td>.55*</td>
</tr>
<tr>
<td></td>
<td>0.24</td>
<td>.71**</td>
<td>0.15</td>
<td>0.37</td>
<td>0.39</td>
<td>-0.38</td>
</tr>
<tr>
<td>POH</td>
<td>-0.42</td>
<td>-.64**</td>
<td>-0.34</td>
<td>-0.39</td>
<td>-0.31</td>
<td>0.09</td>
</tr>
<tr>
<td></td>
<td>0.07</td>
<td>-0.33</td>
<td>-0.04</td>
<td>-0.05</td>
<td>-0.18</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>0.04</td>
<td>0.19</td>
<td>0.18</td>
<td>-0.05</td>
<td>-0.52*</td>
<td>-0.21</td>
</tr>
<tr>
<td>TSF</td>
<td>0.43</td>
<td>.60**</td>
<td>0.34</td>
<td>0.55*</td>
<td>0.00</td>
<td>.45*</td>
</tr>
<tr>
<td></td>
<td>0.48</td>
<td>.58*</td>
<td>.55*</td>
<td>0.34</td>
<td>0.13</td>
<td>.59*</td>
</tr>
<tr>
<td></td>
<td>0.42</td>
<td>.62*</td>
<td>0.36</td>
<td>.54*</td>
<td>0.00</td>
<td>.53*</td>
</tr>
<tr>
<td>TSH</td>
<td>-.67**</td>
<td>.82**</td>
<td>-.64**</td>
<td>-.79**</td>
<td>-0.08</td>
<td>-0.34</td>
</tr>
<tr>
<td></td>
<td>-.64**</td>
<td>-.55*</td>
<td>-.52*</td>
<td>-.62*</td>
<td>-0.08</td>
<td>-.66**</td>
</tr>
<tr>
<td></td>
<td>-0.14</td>
<td>-0.12</td>
<td>0.17</td>
<td>.0.18</td>
<td>0.25</td>
<td>-0.40</td>
</tr>
<tr>
<td>TOF</td>
<td>0.44</td>
<td>.48*</td>
<td>0.35</td>
<td>.73**</td>
<td>0.01</td>
<td>.63**</td>
</tr>
<tr>
<td></td>
<td>.61*</td>
<td>0.36</td>
<td>0.29</td>
<td>.73**</td>
<td>0.04</td>
<td>.67**</td>
</tr>
<tr>
<td></td>
<td>.57*</td>
<td>0.49</td>
<td>0.40</td>
<td>.67**</td>
<td>0.16</td>
<td>.48*</td>
</tr>
<tr>
<td>TOH</td>
<td>-.77**</td>
<td>-.65**</td>
<td>-.62**</td>
<td>-.75**</td>
<td>-0.19</td>
<td>-.60**</td>
</tr>
<tr>
<td></td>
<td>-.56*</td>
<td>-.22</td>
<td>-0.09</td>
<td>-.82**</td>
<td>0.26</td>
<td>-.59**</td>
</tr>
<tr>
<td></td>
<td>-0.11</td>
<td>0.21</td>
<td>-0.02</td>
<td>-.19</td>
<td>-0.20</td>
<td>-.79**</td>
</tr>
</tbody>
</table>

PSF = patient self friendliness; PSH = patient self hostility; POF = patient other friendliness; POH = patient other hostility; TSF = therapist self friendliness; TSH = therapist self hostility; TOF = therapist other friendliness; TOH = therapist other hostility. PS/TP = the correlation between patient rating of self and therapist rating of patient; TS/PT = the correlation between therapist rating of self and patient rating of therapist; PS/TS = the correlation between patient rating of self and therapist rating of self; PT/TP = the correlation between patient rating of therapist and therapist rating of patient; PS/PT = the correlation between patient rating of self and patient rating of therapist; TS/TP = the correlation between therapist rating of self and therapist rating of patient. * p <.05. ** p <.01.

The intercorrelations between the affiliation correlation indices (PS/TP, TS/PT, PS/TS, PT/TP, PS/PT, TS/TP) and the subjective affiliation indices (PSF, PSH, POF, POH, TSF, TSH, TOF, TOH) are presented in Table 8. Notable in this table is that for all
significant intercorrelations obtained in this sample, those between the affiliation correlation indices and subjective indices measuring positive affect were positive, and those between the affiliation correlation indices and subjective indices measuring negative affect were negative. In other words, overall, the level of congruence between patient’s and therapists’ affiliative experiences moves together with positive subjective experience and against negative subjective experience. Affiliative congruence flourishes on the background of friendliness and falters when hostility is prominent. As described above, the same is true for the subjective experience of alliance: in the relationships studied here, alliance was more likely to be experienced by individuals on the background of friendliness than on the background of hostility.

The relations between all alliance indices and affiliative congruence are presented in Table 9. As indicated by the significant intercorrelation between the patients’ alliance and the PS/TP index, patients’ experience of their own alliance is in this sample closely related to the congruence between patient and therapist on their assessment of the patient’s affiliative experience. The same cannot be said about therapists’ experience of the alliance. Therapists’ subjective alliance was not related in this sample to congruence regarding either patient (PS/TP) or therapist (TS/PT). A symmetry does exist in the relations between patients’ and therapists’ alliance and the PS/TS and PT/TP indices, respectively. That is, patients’ subjective experience of the alliance was in this sample related to the congruence between patient and therapist on their own affiliation, therapists’ subjective experience of the alliance was in this sample related to the congruence between patient and therapist on each other’s affiliation. This pattern of relations could be explained if it is assumed that in most psychotherapies the patient’s orientation it toward the self whereas that of the therapist is toward the other.

Most interesting is perhaps the finding that at the current level of intercorrelation analysis there was no significant persistent correlation indicated between any of the affiliation correlation indices and the alliance correlation index. This suggests that while
both (with the exception of PS/PT and TS/TP) measure the congruence between patients and therapists on their ratings of various experiences and are, in that sense, measures of intersubjective phenomena, they do not measure the same phenomena. Based on the present intercorrelations, the congruence between patients and therapist about their level of agreement, mutual understanding and collaboration, and their congruence in the realm of affiliative or affective experience represent separate and independent constructs.

Overall, the intercorrelations among suboutcome measures in this sample suggest the existence of four distinct yet partially overlapping constructs: subjective alliance, subjective affiliation, intersubjective alliance and intersubjective affiliation. All four display significant patterns of intercorrelation, indicating the close relations between subjective and intersubjective phenomena in terms of both alliance and affiliation, as well as the close relations between the constructs of affiliation and alliance. However, they also indicate that while affiliation and alliance are related on the subjective level, they are independent of each other when measured as intersubjective constructs.

Table 9
Intercorrelations Among Suboutcome Indices: Alliance Indices, Alliance Correlation Index and Affiliation Correlation Indices.

<table>
<thead>
<tr>
<th></th>
<th>PS/TP</th>
<th>TS/PT</th>
<th>PS/TS</th>
<th>PT/TP</th>
<th>PS/PT</th>
<th>TS/TP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PA</strong></td>
<td>.61**</td>
<td>0.34</td>
<td>.67**</td>
<td>0.29</td>
<td>.46*</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>.71**</td>
<td>.63*</td>
<td>.64**</td>
<td>.53*</td>
<td>.61**</td>
<td>.71**</td>
</tr>
<tr>
<td></td>
<td>-0.08</td>
<td>-0.03</td>
<td>0.09</td>
<td>0.04</td>
<td>0.25</td>
<td>0.16</td>
</tr>
<tr>
<td><strong>TA</strong></td>
<td>0.41</td>
<td>.57*</td>
<td>0.42</td>
<td>.58**</td>
<td>0.03</td>
<td>.53*</td>
</tr>
<tr>
<td></td>
<td>.7**</td>
<td>0.47</td>
<td>0.46</td>
<td>.69**</td>
<td>0.13</td>
<td>.87**</td>
</tr>
<tr>
<td></td>
<td>-0.03</td>
<td>-0.07</td>
<td>0.36</td>
<td>.05</td>
<td>.64**</td>
<td>.62**</td>
</tr>
<tr>
<td><strong>PA/TA</strong></td>
<td>.53*</td>
<td>0.22</td>
<td>.54*</td>
<td>0.20</td>
<td>.53*</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>0.15</td>
<td>0.08</td>
<td>-0.09</td>
<td>0.17</td>
<td>0.29</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td>-0.23</td>
<td>-0.27</td>
<td>0.14</td>
<td>-0.17</td>
<td>0.47</td>
<td>0.27</td>
</tr>
</tbody>
</table>

PA = patient alliance; TA = therapist alliance; PA/TA = alliance correlation index; PS/TP = the correlation between patient rating of self and therapist rating of patient; TS/PT = the correlation between therapist rating of self and patient rating of therapist; PS/TS = the correlation between patient rating of self and therapist rating of self; PT/TP = the correlation between patient rating of therapist and therapist rating of patient; PS/PT = the correlation between therapist rating of self and therapist rating of therapist; TS/TP = the correlation between therapist rating of self and therapist rating of patient. * p < .05. ** p < .01.
3. The Relations between Suboutcome and Outcome Measures

As indicated above, one of the purposes for this study was to establish the possibility of defining and measuring the therapeutic alliance as an intersubjective construct. The previous section included a detailed description of the intercorrelations between all suboutcome measures used in this study including the correlation indices created for that purpose, and suggestions as to some of their implications to the characteristics and relations of the constructs they were designed to measure. It concluded that these intercorrelations support the proposition that the alliance, when represented through an index measuring the congruence between patients' and therapists' subjective perceptions, is a construct both related and distinguishable from these subjective experiences. Having established that, the next stage is to determine the predictive power of that construct.

Table 10 presents the overall treatment relations between the two subjective alliance indices, the alliance correlation index and two outcome measures. For outcome as indicated by a composite of standardized residualized gain scores on the IIP, TTC and PTC, both subjective indices predict outcome significantly but moderately. The alliance correlation index is a significantly\(^8\) and considerably more powerful outcome predictor.

The same pattern of results is obtained albeit in reduced volume when outcome is measured by a residualized gain scores on the Inventory of Interpersonal Problems only. It is also generally repeated when tested on treatment thirds (Table 11).

---

\(^8\) The estimates of the power and significance of the differences between \(B\) coefficients presented here are based on Fischer's Z Test and calculated using a software program titled POWCOR developed by David A. Allison and Bernard S. Gorman. In the absence of a model for estimating the power of differences between correlation coefficients when these coefficients are based on a sample containing a number of independent cases each consisting a number of potentially dependent repeated measures, the estimates presented here are calculated using for sample size the geometric mean between the number of independent cases (22) and the total number of observations available in this sample (660) (Method suggested by Bernard S. Gorman in a personal communication). This solution represents a conservative assumption as to the power of the present sample. Based on this assumption, the difference between the \(B\) coefficients of both subjective alliance indices and the alliance correlation index is significant (in a 2-tailed solution) at \(p = 0.003\).
Table 10
Overall Treatment Relations Between Three Alliance Indices and Two Outcome Measures: β Coefficients, t Values and Significance Levels From Regression Analyses Using Generalized Estimating Equations.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Alliance Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Alliance</td>
</tr>
<tr>
<td>Composite β</td>
<td>0.31</td>
</tr>
<tr>
<td>t</td>
<td>2.78</td>
</tr>
<tr>
<td>p</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>IIPrgs  β</td>
<td>0.14</td>
</tr>
<tr>
<td>t</td>
<td>1.97</td>
</tr>
<tr>
<td>p</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

Composite = Mean of standardized pretreatment to posttreatment residualized gain scores on the IIP, PTC and TTC (IIP = Inventory of Interpersonal Problems; PTC = Patient Target Complaints; TTC = Therapist target complaints; IIPrgs = Pretreatment to posttreatment residualized gain on overall mean score on the IIP.

Table 11
Relations Between Three Alliance Indices and a Composite Outcome measure by Treatment Thirds: β Coefficients, t Values and Significance Levels From Regression Analyses Using Generalized Estimating Equations.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Alliance Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Alliance</td>
</tr>
<tr>
<td>1st third β</td>
<td>0.32</td>
</tr>
<tr>
<td>t</td>
<td>2.76</td>
</tr>
<tr>
<td>p</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>2nd third β</td>
<td>0.39</td>
</tr>
<tr>
<td>t</td>
<td>2.85</td>
</tr>
<tr>
<td>p</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>3rd third β</td>
<td>0.31</td>
</tr>
<tr>
<td>t</td>
<td>2.78</td>
</tr>
<tr>
<td>p</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

Composite = Mean of standardized pretreatment to posttreatment residualized gain scores on the IIP, PTC and TTC (IIP = Inventory of Interpersonal Problems; PTC = Patient Target Complaints; TTC = Therapist target complaints)
In addition to the notion that subjective and intersubjective alliance are interdependent yet distinguishable constructs, the intercorrelations presented in the previous section support the notion that a similar relationship also exists between the constructs of subjective and intersubjective affiliation. This similarity is, however, limited to the relations between the affiliation as a subjective versus intersubjective construct. It does not persist within the level of the subjective, that is, in the relations between individuals’ subjective experiences. Specifically, with the construct of intersubjective affiliation represented consistently by the various affiliation correlation indices\(^{11}\) and that of subjective affiliation measured by the patient and therapist subjective affiliation indices, there is a pattern of intercorrelation and therefore an indication for some interdependence between the construct of affiliation as subjective experience and that of affiliation as intersubjective phenomena (Table 8). There are, however, no significant intercorrelations and therefore no indication of interdependence between patients’ and therapists’ subjective affiliative experiences (Table 6). This, in contrast to patients’ and therapists subjective experiences of the alliance which are in this sample interdependent (Table 5).

The difference between alliance and affiliation in this regard is likely a consequence of the difference in focus between the measures used to assess them in this study. As described above, the WAI-12 requires both patient and therapist to evaluate the components of their alliance explicitly. That is, it requires them to evaluate their relationship. As also suggested above, this intersubjective feature of the WAI-12 and of the construct of alliance in general is likely a cause for the intercorrelation between the two subjective alliance indices as well between these and the alliance correlation index. The IAS-16, on the other hand, targets explicitly only the subject's isolated experiences of self and other. It does not require any assessment of the relationship. The subjective affiliation indices derived from the IAS-16 are therefore more distinctly subjective and consequently independent of each other.

\(^{11}\) As detailed above, this is true for the four correlation indices measuring the congruence between subjects (PS/TP, TS/PT, PS/TS, PT/TP), all highly intercorrelated, and not for the two correlations indices measuring congruence within subjects (PS/PT, TS/TP) which are not correlated with the above.
Because of this more fully subjective focus of the IAS-16 as opposed to the WAI-12, and because of the consequent differences between the indices derived from them, the contrast between subjective and intersubjective affiliation is in this context somewhat more pronounced than that between subjective and intersubjective alliance. This makes affiliation a particular interesting arena for assessing and comparing the predictive powers of subjective versus intersubjective relationship constructs.

**Table 12**

Overall Treatment Relations Between Eight Affiliation Indices and Two Outcome measures: $\beta$ Coefficients, $t$ Values and Significance Levels From Regression Analyses Using Generalized Estimating Equations.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Affiliation Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSF</td>
</tr>
<tr>
<td>Composite $\beta$</td>
<td>0.06</td>
</tr>
<tr>
<td>$t$</td>
<td>1.11</td>
</tr>
<tr>
<td>$p$</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

| IIP | $\beta$ | 0.02 | -0.02 | 0.02 | 0.02 | 0.05 | -0.07 | 0.07 | -0.08 |
|     | $t$ | 0.54 | -0.81 | 0.8 | 0.79 | 1.55 | -1.61 | 2.33 | -2.38 |
|     | $p$ | >.05 | >.05 | >.05 | >.05 | >.05 | >.05 | <.05 | <.05 |

PSF = patient self friendliness; PSH = patient self hostility; POF = patient other friendliness; POH = patient other hostility; TSF = therapist self friendliness; TSH = therapist self hostility; TOF = therapist other friendliness; TOH = therapist other hostility.

Tables 12 and 13 present the relations between all affiliation indices and two outcome measures. As evident in Table 12, subjective affiliation indices do not predict psychotherapy outcome. The $\beta$ coefficients obtained in this sample are mostly close to zero and insignificant. Those significant are all very low. The four intersubjective correlation affiliation indices (PS/TP, TS/PT, PS/TS, PT/TP) are significant predictors of outcome, with two of them (PS/TP, PT/TP) significant predictors of outcome as indicated by a composite of standardized residualized gain scores on the IIP, TTC and PTC, and all four significant predictors of outcome as measured by residualized gain scores on the Inventory of Interpersonal Problems. From the two subjective affiliation correlation indices, PS/PT does not predict outcome. However, TS/TP is a particularly strong predictor of outcome.
Table 13
Overall Treatment Relations Between Six Affiliation Correlation Indices and Two Outcome measures: β Coefficients, t Values and Significance Levels From Regression Analyses Using Generalized Estimating Equations.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Affiliation Correlation Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PS/TP</td>
</tr>
<tr>
<td>Composite</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>2.13</td>
</tr>
<tr>
<td></td>
<td>&lt;.05</td>
</tr>
<tr>
<td>IIP</td>
<td>0.33</td>
</tr>
<tr>
<td></td>
<td>2.38</td>
</tr>
<tr>
<td></td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

PS/TP = the correlation between patient rating of self and therapist rating of patient; TS/PT = the correlation between therapist rating of self and patient rating of therapist; PS/TS = the correlation between patient rating of self and therapist rating of self; PT/TP = the correlation between patient rating of therapist and therapist rating of patient; PS/PT = the correlation between patient rating of self and patient rating of therapist; TS/TP = the correlation between therapist rating of self and therapist rating of patient.

The results in the area of affiliation repeat therefore to a large extent, and with an even greater distinction those obtained in the area of alliance: measures representing the congruence between individuals on given elements of their experience in the context of their relationships and therefore capturing an intersubjective component of these relationships are superior in predicting outcome to those concentrating on individuals' subjective experience of their relationships. However, the subjective correlation index representing the congruence between patient and therapist within the therapist's perspective is also a superior predictor of outcome.
Chapter IV

DISCUSSION

The study presented here has been motivated by two major concerns, the first theoretical. As described above, the concept of alliance was originally conceived in order to draw theoretical and clinical attention to the significance of the therapeutic relationship in the therapeutic process. Such concept was missing in early psychoanalysis where with only marginal dissent the therapeutic relationship was considered primarily under the term of "transference" that is, as fantasy, while the significance of regarding it as "real" as well was becoming increasingly apparent. The concept of alliance has served its purpose well for decades. However, with clinical thinking infiltrated if not fully reorganized around interpersonal and relational ideas, there is at present much consideration given to the therapeutic relationship from various perspectives, and in a wide range of psychological schools. It could therefore be argued that in this new environment the concept of alliance is no longer valuable. This study was conceived partly in an effort to address this concern.

The second concern behind this study is empirical. As described above at length, the alliance was heavily studied in the past two decades, mostly in the context of the search for the "common factor." The body of research on the alliance could be summed up as yielding two major conclusions. First, that the alliance is a robust and useful construct, repeatedly demonstrated to be valid and reliable, as well as to have considerable predictive power. Second, that all existing conceptualizations and measures of the alliance capture the construct only partially, leaving untapped an underlying component of the alliance referred to in terms of "mutuality and collaboration" (Horvath & Symonds, 1991). In addition to addressing the general question of alliance, this study attempted an empirical clarification
and examination of this specific proposition.

The strategy offered for addressing both of these concerns was based first and foremost on a distinction between the notions of "subjective" and "intersubjective." The term "subjective" was defined here as referring to what happens inside individuals' minds, to what individuals perceive, register, represent and/or report of their experience. The term "intersubjective" was defined as referring to what occurs between individuals, to a register of interpersonal process where the interaction itself, not its participants is the focus of attention. With this distinction in mind, it was argued that the alliance was traditionally conceptualized and measured as a subjective phenomenon, a subject's (usually the patient's) attitude or capacity to think, feel or behave in certain ways. It was suggested that both theory and research indicate that there could be considerable benefit to regarding the alliance as intersubjective phenomena as well.

Related to the distinction between subjective and intersubjective as two possible registers of interpersonal phenomena, as well as perspectives from which it can be viewed, was another - pertaining to the assumed nature of this phenomena - between the notions of content and process. Using these terms, it was suggested that the alliance could be seen as a content variable, something that develops and resides inside an individual's mind. It could also be seen as a process variable, something that unfolds between individuals over time. It was argued that the therapeutic alliance has traditionally been regarded as a content variable. This, while alliance and circumplex research indicate that the alliance could not be described satisfactorily as either content or process, but as a balance of both.

The distinction between the subjective and intersubjective served as a framework for formulating and examining the concerns described above. Empirically, if these two facets of interpersonal phenomena are operationalized, they could provide means of capturing and evaluating different aspects of the alliance, especially those alluded to by Horvath and Symonds, more fully and accurately. Theoretically, if the concept of alliance could be
enhanced or reframed to imply not only subjective tendencies but also intersubjective process, a stronger argument could be made that it remains meaningful within the context of current relational thinking.

The notions of subjective and intersubjective were applied to the constructs of alliance and affiliation and operationalized using the WAI-12 and IAS-16. When used traditionally, both of these measures yield self-report based, subjective assessments of interpersonal phenomena; the WAI-12 regarding patients’ and therapists’ alliance related experiences, the IAS-16 their experience of self and other affiliation. However, as argued, the information obtained by these measures could also be used to capture or approximate an intersubjective facet of the phenomena. This was achieved through creating correlation indices measuring the congruence between patients’ and therapists’ assessments of the various alliance and affiliation related phenomena. Within the group of correlation indices, the index created from the WAI-12 (PA/TA)\textsuperscript{12} and four out of the six indices created from the IAS-16 (PS/TP, TS/PT, PS/TS, PT/TP)\textsuperscript{13}, targetted the congruence between patients and therapists and are therefore interpretable as intersubjective. The other two (PS/PT, TS/TP)\textsuperscript{14} focused on affiliative congruence within either patient or therapist and should be considered subjective. However, as argued above, they are different than traditional self-report based subjective measures in that they provide an unarticulated and unmediated subjective view of the intersubjective process.

The findings obtained using the WAI-12 and IAS-16 based indices provide significant support to the distinction between subjective and intersubjective as well as to the proposition that these notions can be empirically represented and evaluated. First in this

\textsuperscript{12} the correlation between the patient’s subjective alliance ratings and the therapist’s subjective alliance ratings.

\textsuperscript{13} PS/TP is the correlation between the patient’s rating of himself and the therapist’s rating of the patient; TS/PT is the correlation between the therapist’s rating of himself and the patient’s rating of the therapist; PS/TS is the correlation between the patient’s rating of himself and the therapist’s rating of himself; PT/TP is the correlation between the patient’s rating of the therapist and therapist’s rating of the patient.

\textsuperscript{14} PS/PT is the correlation between the patient’s rating of himself and his or her rating of the therapist; TS/TP is the correlation between the therapist’s rating of himself and his or her rating of the patient.
context is the pattern of intercorrelations between the various suboutcome indices. As detailed above, this pattern establishes the related yet distinct constructs of subjective and intersubjective for both alliance and affiliation. The pattern of relations between these constructs and outcome, demonstrating clear and consistent differences in predictive power between the subjective and intersubjectively oriented suboutcome measures, provides this distinction with additional support. Finally, significant are the differences between alliance and affiliation in both intercorrelation and predictive power. These differences demonstrate that for the most part, the more purely representative is the measure of either register, and consequently the greater is the contrast between subjective and intersubjective in that case, the stronger are the differences between them in both intercorrelation and predictive power.

The notion that alliance and affiliation were measured and represented in varying degrees of subjectivity and that the indices used to measure subjective affiliation were more purely subjective than those used for subjective alliance is based, as described above, on the differences between the WAI-12 and IAS-16. While the IAS-16 requires subjects to report only their own experience (of either self or other), the WAI-12 requires them to provide an assessment of the relationship as well. This results in a subjective measure that could be considered intersubjectively biased and a lesser contrast between subjective and intersubjective in the case of alliance.

The findings reflect a possible association between the greater conceptual and measurement contrast in the case of affiliation and the greater independence between the patients’ and therapists’ subjective affiliation indices, as well as greater differences between the subjective and intersubjective affiliation indices in predictive power. As detailed above, unlike in the case of alliance, patients’ and therapists’ subjective affiliation indices were independent of each other. In addition, while in the case of alliance the subjective indices are mild predictors of outcome and the intersubjective measure is a stronger predictor, in affiliation the contrast is between no predictive power for the traditional subjective indices and strong predictive power for several of the intersubjective indices.
An important exception to this pattern is the case of the affiliation correlation index TS/TP. This index is in essence subjective since it targets the congruence among the therapist’s own affiliative perceptions. It was also found to be mostly unrelated to the four intersubjective affiliation indices. However, it is also both conceptually and empirically different than all other subjective indices used here. TS/TP is a correlational rather than simple self-report based index. While drawing information from a single subject it targets an unmediated, unarticulated registration of intersubjective congruence. Its pattern of intercorrelation with the subjective affiliation indices and its predictive power are similar to those of the intersubjective indices.

The finding that TS/TP demonstrates a similar capacity to the intersubjective affiliation indices in predicting outcome may be due to the special characteristics of the treatment modality provided in the psychotherapy cases studied here. Labeled BRT (Brief Relational Therapy), this modality focuses heavily on the therapeutic relationship and suggests that therapeutic success is to a large extent related to the therapist’s ability to sense, process and attend to relational dynamics. That the congruence among the therapist’s own perceptions of himself and the patient is strongly predictive of outcome may reflect the possibility that BRT therapists have successfully been trained to develop and fine-tune such abilities and that these abilities are indeed important in achieving good outcome. In that case, TS/TP (and for that matter PS/PT) is a measure of how well did the individual’s subjective representation of the intersubjective field match intersubjective reality. This suggestion is supported by the pattern of intercorrelations between TS/TP and the subjective affiliation indices. It is not indicated by the pattern of intercorrelation between TS/TP and the intersubjective affiliation indices.

The findings regarding TS/TP may also raise some general questions regarding the distinction between the subjective and intersubjective registers. Is the essence of what makes a certain perspective on an interpersonal event “subjective” in the source of that
perspective, that is, in the fact that it is obtained from one person. Or is it, rather, in the nature of the process of its construction, in this case, in the extent to which it was consciously perceived, formulated and articulated by that person. A similar question can be raised regarding the notion of “intersubjective.” Is the essence of what makes a certain perspective on an interpersonal event “intersubjective” in the location from which it originates, that is, in the fact that it originates from a place between persons. Or is it again, in the process of its construction, in this case, in the extent to which it was filtered through subjective perception, formulation and articulation, or was its object. The findings regarding the affiliation correlation index TS/TP presents a case where while technically subjective, a measure based on a correlational technique, targeting intersubjective congruence and assessing it through capturing an unarticulated subjective state, behaves both in terms of some intercorrelations and predictive power as an intersubjective measure.

Taking under consideration the complexity of both notions of subjective and intersubjective, the findings strongly suggest that for the most part, in the case of the therapeutic relationships examined in this study, measures designed to capture the intersubjective register or component of interpersonal phenomena are superior to those designed to measure subjective experience in predicting psychotherapy outcome. This implies that so far as these measures succeed in capturing intersubjective versus subjective realities, the congruence between patients and therapists on the aspects of their relationships tapped into by the constructs of affiliation and alliance is more important to the outcome of their relationships than what each of them experiences on his or her own.

Further, “more important” is a statement describing mostly the findings in the case of alliance, where patients’ and therapists’ subjective experiences were still predictive, although less so, of outcome. In the case of affiliation, subjective experience was not important at all. Taking into account only the findings regarding prediction, it did not matter whether patients or therapists thought themselves or each other to be friendly or hostile. It only mattered if they thought so together. Considering this aspect of the findings together
with the notion discussed above, that in the case of affiliation the subjective indices were purely subjective whereas in the case of alliance they were biased in the direction of intersubjectivity, it might be possible to conclude that it is mostly if not only the intersubjective register that predicts outcome. If this is the case, subjective alliance predicts outcome only so far as it incorporates or reflects intersubjective congruence.

However, the picture is more complex. For one, the pattern of intercorrelations between the subjective and intersubjective indices indicates that while outcome is not directly predicted by subjective affiliation, the level of congruence between patients' and therapists' affiliative experiences - a strong predictor of outcome - increases with positive subjective affiliation. The subjective experience of alliance also increases with positive subjective affiliation and while intersubjective alliance is not related to subjective affiliation, it is related to subjective alliance. Considering the entire body of findings, it does seem to matter where patients and therapists stand in terms of friendliness and hostility. Intersubjective congruence on both affiliation and alliance is in general closely related to patients' and therapists' subjective views.

The relations between the subjective experience and intersubjective congruence could be regarded in several ways. It could be hypothesized that intersubjective congruence depends on positive subjective experience, that is, that patients and therapist are much more likely to think and feel alike when they feel good about each other. It could also be hypothesized that positive subjective feelings and experiences are the result of intersubjective congruence, that is, that when patients and therapists see eye to eye they tend to feel good about each other. Finally, it could be argued that the subjective and intersubjective are two facets of the same phenomenon and are therefore not causally linked. While the findings indicate certain patterns of co-occurrence and covariance of certain subjective and intersubjective aspects of the relationships studied, they do not indicate any particular causal link between them. What they do suggest strongly, taken in their entirety, is that while subjective experience is highly relevant to the process and
outcome of psychotherapy, the intersubjective congruence between patients and therapists is a more direct and superior predictor of therapeutic success.

The findings obtained raise several important questions. Perhaps first is what is the therapeutic success being predicted? Psychotherapy outcome is perhaps the most elusive construct in psychotherapy research, largely because there is little agreement in general psychology about what the outcome of psychotherapy consists of and what it should be. In this study, outcome was defined as change in 1) the patient's perception of the severity of the problems he said brought him to treatment (PTC), 2) the therapist's perception of the severity of these problems (TTC), and 3) the overall level of interpersonal trouble reported by the patient (IIP). It was, in other words, derived from the patient's and therapist's subjective assessments of the change that occurred in the patient, a change in conditions formulated in the patient's own terms, as well as specifically targeted interpersonal problems. Outcome was measured using a composite of all the above. Because of the relational focus of this study as well as the therapy it examines, it was also measured using only the patient's rated change in interpersonal problems.

The results regarding prediction achieved for both of these outcome measures reveal a difference in scope but similarity in pattern. Outcome measured only through change in patient rated interpersonal problems was more weakly predicted than that measured by a composite of all three measures described above. However in both cases, outcome was more strongly predicted by intersubjective indices and less so, or not at all, by subjective ones. The difference in scope may be a result of the likelihood that while some patients formulate their complaints in terms of interpersonal problems, some do not, and that patients' complaints cover a wider range of problems. Those patients who formulate their problems in non-interpersonal terms may report substantial change in the severity of their problems as they have formulated them, but not in interpersonal terms. An outcome measure sensitive to this possibility is likely to capture more change. That a wider range of possible outcomes is more strongly predicted suggests that one important factor in the
context of outcome is not what the problem is, but how and by whom it is formulated. In
the findings presented here, when patients not only assessed change but also formulated in
their own words the conditions to be changed, outcome was more strongly predictable.15
In either case, whether conditions were formulated in predetermined interpersonal terms or
in the patient's own words, it is the patient's and therapist's subjective assessment of the
change in these conditions that were predicted by the various measures of alliance and
affiliation.

Another question raised by the findings is about the relations between affiliation and
alliance. Affiliation was included in this study as means of introducing into it an element of
the circumplex model that is particularly relevant to the study of alliance. It was argued that
an individual assessing his own or another's friendliness and hostility is assessing the
affect transpiring in his interpersonal surroundings. Such assessment, when obtained from
the participants of a therapeutic relationship, can be interpretable as akin to the affective
component of the alliance. The construct of affiliation can therefore be used to provide an
additional, affect-focused perspective on the alliance.

The findings support this assumption so far as both affiliation and alliance are seen as
subjective phenomena. Patients' subjective affiliation is highly correlated with their
subjective alliance. Therapists' subjective affiliation is also highly correlated with their
subjective alliance. In both cases, as expected, alliance is positively correlated with
friendliness and negatively correlated with hostility. An individual's subjective experience
of being allied with another is closely related to how he experiences his own and the other's
interpersonal feelings. But as closely related as affiliation and alliance are on the subjective
level, they are completely unrelated on the intersubjective. While intersubjective alliance

15 In addition to the patient's formulation contribution, it is also possible that the stronger effect
demonstrated by the composite outcome measure is a result of the added therapist's assessment. While
rating change in conditions formulated by the patient, the therapist may do so with more precision,
enhancing the predictability of the composite measure not through expanded range of coverage, but through
increased accuracy and sensitivity. This, however, requires an assumption that there is a 'real' outcome that
could be assessed with less or more accuracy. Such assumption, however, cannot be supported.
and affiliation predict outcome strongly, they do not do so in concert.

This surprising finding may be understood using the distinction between content and process. On the level of the individual, both alliance and affiliation are in a sense subjective contents, they are feelings, attitudes and beliefs that individuals hold in their minds in relation to the interpersonal situation. It is not surprising, although it is also not trivial, that for example, on that level, one’s feeling that the other is friendly is closely related to feeling that he empathizes and understands. It is not surprising in general that feeling good about someone is followed by feeling good about one’s relationship with him. All the same, this does not necessarily happen simultaneously to the other.

The findings, however, suggest that it is this happening simultaneously that counts. More so in the case of alliance and only so in the case of affiliation, it is the coming together of thoughts and feelings between individuals\textsuperscript{16} in the unfolding intersubjective process that seem to affect outcome. The co-occurrence of affiliation and alliance related feelings and thoughts inside the individual may be a prerequisite or consequence of a process involving intersubjective congruence, but it implicates outcome mostly indirectly. While feelings of affiliation and alliance tend to co-occur in individuals’ subjective experience, they do not on the level of intersubjective process. So far as it is indicated by the current findings, affiliation is a component of alliance only on the subjective level. Intersubjective affiliative congruence is, if anything, complementary to intersubjective congruence on alliance.

This, finally, raises again the central question motivating this study, the question of alliance. It was previously concluded that based on both past theory and research the alliance should be conceptualized as a dynamic balance of subjective content and intersubjective process elements. This conclusion was based in part on the relative weakness of specific subjective alliance measures in capturing the construct fully,

\textsuperscript{16} And in the case of the therapist within individual as well.
suggesting that an underlying intersubjective component is yet to be formulated, and in part on the complex patterns of affiliative complementarity shown to predict outcome in circumplex research.

The findings obtained here provide this conclusion with further support. First, having contrasted a well researched and validated subjective alliance measure with a measure of the alliance as intersubjective congruence resulted in these subjective measures’ failing to capture as much of what the alliance is, or at least the aspect of it that predicts outcome. The intersubjective measure on the other hand demonstrated considerable predictive power. Since much of the interest in alliance is motivated by its usefulness in predicting psychotherapy outcome and therefore potential as the “common factor,” this finding is of particular significance. It suggests that the common factor is to be found largely on the level of intersubjectivity. The findings regarding affiliation point in this context in the same direction. Subjective affiliation, despite it being readily interpretable as a component of the alliance was not directly predictive of outcome whereas measures of affiliative congruence were strongly so.

However, while all this points to the superiority of the intersubjective, other findings underlie the role of the subjective. A considerable number of subjective affiliation indices are closely related to intersubjective indices in a pattern indicating that intersubjective congruence increases with positive subjective affiliation. Intersubjective alliance increases with subjective alliance. And while according to the findings, intersubjective alliance does not depend on subjective affiliation, intersubjective affiliation increases with subjective alliance. In short, it appears that subjective experiences participate intimately in the processes resulting in intersubjective congruence.

Further, the findings related to the affiliation index measuring affiliative congruence within the therapist’s experience indicate that a certain type of subjective measure, one that targets subjective congruence rather than content, can be a strong outcome predictor as
well. While this finding could be, as discussed above, specific to the currently studied treatment modality, it also suggests that a subjective congruence index can under certain conditions demonstrate similar characteristics to those of intersubjective indices. Subjective congruence, at least in the case of the therapist, either approximates intersubjective congruence or contributes independently to therapeutic success.

These complex characteristics and relations between the subjective and intersubjective both as components of interpersonal phenomena and as phenomenological perspective on it, and the varying behavior of the constructs of alliance and affiliation in relation to them, all offer support to the model of the therapeutic alliance as dynamic balance. As previously described, this model suggests that at different points in time, some elements of the alliance are stable while others are in flux and under negotiation. For example, using Bordin's (1979) terms, at one point in time, a solid affective bond can facilitate reevaluation and change in the patterns of agreement on the goals of therapy. At another point in time, a strong agreement can help the relationship withstand considerable affective turmoil. That affiliation and alliance are intimately related on the subjective level means that most individuals cannot tolerate much discord or dissonance in their inner worlds. They tend to experience positive affect and a sense of being allied with others together, rather than apart.

This, however, might not be true in an interpersonal situation designed to foster, contain and work out such discord. In psychotherapy, as many since Freud have noticed, what cannot be experienced subjectively is recreated in the interpersonal process. Thus, for example, at some points in time patient and therapist can be affiliatively congruent while not at all feeling that they are working together towards a mutually agreed upon goal. At others they might be on the same wavelength regarding their work together while quite discordant in how they feel about it. Their alliance is at different point a different thing. At one point it is a mutual sense of working together, at another it is mutual appreciation and liking, at yet another it is a sum of discordant personal experiences that all the same fuel the relationship with enough interest and intensity to proceed.
While the findings obtained are strong in their support of the initial hypotheses regarding the value of conceptualizing and measuring the alliance as an intersubjective, process oriented construct, they should be regarded with some reservations. Perhaps first in significance is related to the inherent difficulty in defining and achieving concise operationalization for the highly complex concepts of subjectivity and intersubjectivity. As described above, the notions of “subjective” and “intersubjective” can be defined as pertaining to the location of experience or the perspective taken on it. They can be defined as based on the status of experience in terms of consciousness or awareness. They can also be defined in terms of its focus. Subjective can be anything that happens inside an individual, only what that individual formulates and articulates, or the subject matter of experience. Intersubjective can be anything that happens between individuals or anything that involves an experience or representation of intersubjective phenomena. A person can only have subjective experiences. There is no such thing as intersubjective experience, only a subjective registration of intersubjective reality or an intersubjective phenomenological perspective.

All these considerations result in considerable challenge to any operationalization of these notions. The strategy developed here centered around a conceptualization of “subjective” as the articulated content of one’s mind and “intersubjective” as congruence between subjects. It defined intersubjective congruence as congruence about such articulated subjective contents and premised that it could be captured empirically through the statistical procedure of correlating them in various ways. The findings obtained are therefore indicative only of the relations between subjective, intersubjective and outcome so defined. They do no implicate any other possible understanding of subjectivity and intersubjectivity.

The limitations in operationalizing the notions of subjective and intersubjective impact, in turn, the extent to which the findings implicate the notions of alliance and affiliation as defined in terms of subjective or intersubjective phenomena. When affiliation
and alliance are regarded as subjective phenomena, affiliation could be viewed as representing an aspect of the alliance. The findings support this assertion. However, when defined in terms of intersubjective congruence, alliance and affiliation varied independently. There were several possible explanations given to this finding as indicating various characteristics of these constructs and their relations. These included a suggestion that this finding should in fact be expected under a model of the alliance as a dynamic intersubjective process.

However, this finding also points to the limitations of the current definitions and measures of both alliance and affiliation. As indeed was one of the rationales behind this study, alliance and affiliation are inherently relational constructs that have been traditionally defined and measured as subjective ones. The effort presented here to reframe and develop means of measuring these constructs as relational has succeeded in demonstrating their potential. It also succeeded in elucidating the need for further evaluation and reframing of alliance and affiliation as dynamic process variables.

Some more specific reasons for regarding the findings with some reservation involve the nature of the actual measures used to study the constructs of alliance and affiliation. As described above, the alliance measure used (WAI-12) is of a dual nature. It requires respondents to make assessments of individuals as well as of their relationships. This results in an overall alliance measure that is midway between subjective and intersubjective. It is subjective in the sense that it is based on a single subject’s assessment but it is both subjective and intersubjective in its focus. So far as it is a subjective measure, The WAI-12 is also biased in that those of its items involving the assessment of an individual are in both the patient’s and therapist’s forms about the patient. While the patient’s WAI-12 provides information about their subjective experience of the alliance, the therapist’s in fact does not provide such information. Some previous research (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) suggests that all elements of the alliance measured by the WAI-12 are highly intercorrelated and can therefore be justifiably used together. This suggestion is
partly supported by the intercorrelations obtained here. However, this is not entirely the case. As indicated by the complex pattern of intercorrelation between other related variables, some of the components tossed together by the WAI-12 can be quite divergent.

The definition and means used to measure affiliation also entail some complications. Affiliation is the circumplex dimension extending from friendliness to hostility. While these two extremes are in principle pure opposites, both previous research and the findings presented here suggest that they do not always behave so. For one, while they often co-vary to a large extent together, they are never fully intercorrelated. Their relation to outcome is also not always as predicted. Because of the non-trivial relations between friendliness and hostility, affiliation is a somewhat vague and not as easily interpretable construct. However, both heuristic and statistical considerations contributed to friendliness and hostility being combined in this study into a single affiliation measure. This served to simplify the execution of the study but might have necessitated regarding the interpretation of its results more tentatively. It is possible that studying friendliness and hostility separately would have resulted in a clearer picture of the relations of affiliative experience to the therapeutic alliance and its place in the process and outcome of psychotherapy.

Some limitations of the affiliation and alliance measures used here could be addressed by further research. Regarding measurement of the alliance, it is suggested that the WAI-12 be split and its subjective and intersubjectively oriented items be used independently to derive two separate alliance indices. The constructs measured by such split indices would be more easily defined and interpreted. The index derived from the six subject focused items could be interpreted as the subjective experience (in the case of the patient) or assessment (in the case of the therapist) of the alliance as an attitude, state of mind or tendency of the patient. The index derived from the six relationship focused items could be interpreted as measuring how patient and therapist view the alliance as a relational state. It would be of interest how these two alliance indices and related constructs intercorrelate among themselves as well as with other relationship measures, and how predictive of
outcome they are. It would be of particular interest whether the subjective item based index demonstrates characteristics similar to subjective affiliation measures and the intersubjective item based index resemble more the intersubjective congruence indices.

Such two separate alliance indices could also be combined through correlation into two additional congruence indices, one representing the congruence within the patient of his perception of his alliance feelings with his perception of the actual alliance, the other representing the congruence within the therapist of his perception of the patient’s alliance feelings and the actual alliance. These subjective congruence indices could serve to further the understanding of the construct of alliance in general, as well as expand the view and range of possible interpretations of the elements and perspectives of intersubjective phenomena tapped into by the findings obtained for the two subjective affiliation congruence (PS/PT, TS/TP). All this could be done using the same data base.

A similar benefit of increasing clarity and enabling further understanding through refining definition and measurement could be achieved by splitting the construct of affiliation into its components of friendliness and hostility. This option was rejected in the present study on the grounds that the correlation yielded be statistically unstable since with the way the IAS-16 is structured, it would have relied on only there data points per session. Calculating correlations combining several sessions into single units for analysis would have prohibited any comparative analysis of affiliation with alliance. However, the findings obtained suggest that separating affiliation into its components might be of value in clarifying the relationship between affiliation and alliance. One possible route for studying friendliness and hostility separately is calculating correlations and testing the significance of the results obtained from only three data points. Another is using a larger than one session unit for calculating both affiliation and alliance correlation indices. A comparison of such larger units can still be of value to the understanding of the process and outcome of psychotherapy and roles of alliance and affiliation in them. Both these routes can be applied to the current data base as well.
Another route for further investigation could focus on examining whether the findings obtained for the cases and treatment modality studied here remain across other cases and treatment modalities. The theoretical popularity and value of the construct of alliance are commonly regarded as deriving precisely from its stable performance across treatment circumstances and modalities. This stability is generally attributed to the notion that this construct captures a factor that is shared by all treatment modalities: some type of collaborative therapeutically oriented relationship. This study attempted to expand on existing definitions and methods of measurement of the alliance in order to establish it further as an intersubjective, relationship based construct. However, it tested the expanded definitions and methods of measurement in only one treatment modality. It is essential for these conceptualizations and measurements to be of general theoretical and clinical value that their performance be evaluated in others.

Finally, while much can be learned from further elucidation, fine tuning and expanding of the application of the definitions and measurement methods used here, the findings obtained in the present study seem to raise more questions than answers. To sum up, this study aimed to establish the theoretical and empirical usefulness of formulating and considering the therapeutic alliance as a relational phenomenon. More specifically, it formulated the alliance as consisting of subjective and intersubjective components, examined some of these components, their characteristics and relations, and established their predictive powers.

Perhaps its most significant findings is that when the intersubjective component of the alliance is defined as congruence between patients and therapists on their experience of the alliance, it is a distinct construct with superior predictive power. Another significant finding is that intersubjective congruence on affiliative experiences is also a strong predictor of outcome although it proceeds and varies independently of intersubjective congruence on alliance. Also, subjective affiliative congruence seems in certain cases capable of
approximating the characteristics and predictive power of intersubjective congruence. These and other findings underline the value of regarding the alliance as consisting of a significant intersubjective component. They also support a conceptualization of the alliance that expanding on Muran and Safran (1998), regards it as a process of ongoing dynamic balancing between various intersubjective and subjective elements.

Both these results are, however, preliminary. The findings obtained here provide only partial information about the characteristics of the various suggested subjective and intersubjective components of the alliance. They provide even less insight as to the relations between them and the processes by which they are co-impacted and balanced. Achieving further understanding of these notions and processes is likely dependent on expanding the methods of studying them. The research presented here examines the therapeutic relationship and alliance from a macro-aggregate perspective. It assesses the phenomenon from a cumulative and longitudinal point of view, focusing by nature on common, large scale patterns. This type of research may provide a general view of the factors interacting in creating the phenomenon, but it is at a disadvantage in providing insight into how the smaller pieces come together. Those are, however, often the smaller pieces and interactions that constitute the common patterns.

Understanding the therapeutic relationship and the alliance therefore requires the development an application of research methods designed to study the smaller pieces. Such methods may entail focusing on smaller time units, observing the unfolding process in addition to requesting its participants to report on it in hind sight, or asking them to do so with much greater detail. Last, but not least, they may also include old fashion clinical experience and observation. All this with the purpose of mapping and understanding more closely what are the components of subjective experience in the process of therapy, what particular types of congruences, both subjective and intersubjective, occur and matter, and what other types of intersubjective processes unfold and impact the therapeutic venture.
The alliance can be viewed (as it was originally) as a sister concept to the observing ego. It could mean that the patient is able to step out of his transference into a place where he knows that the therapist is his therapist, not his mother, and that he does not really hate her but works with her to somehow get better. From a different perspective it can be referred to as a kind of mutual respect and camaraderie that allows both patient and therapist to immerse themselves in the difficult and painful work of therapy. From another perspective still, the alliance can be defined as formulated agreement between patient and therapist on their mutual goals. It could also be seen as a sort of unformulated in-tunement that at different times both reflects and facilitates the ways in which these elements and others develop and change.

Although this study emerges and its findings are consistent with the view that the alliance is an intricate and complex interaction of all these elements, its emphasis is on the latter. The method and findings presented here target and validate that component of the alliance which can be approximated by measuring the patient’s and therapist’s intersubjective congruence and loosely defined as mutuality or unformulated in-tunement. Having established some of the theoretical and empirical benefits of examining this component of the alliance as well as some related questions left to be answered, what remains to be touched is its possible clinical value.

As perhaps described most succinctly in Safran (1993; Safran & Muran, 1996), the alliance is to a large extent unnoticed until it is disturbed. What could be defined as ruptures in the alliance or shifts in the balance and prominence of different aspects of it, can offer golden opportunities for growth and change. But what might be the secret to keeping the alliance unnoticed and intact? What are the patient and even more so the therapist to do in order to facilitate and maintain the unformulated in-tunement that seems so beneficial to the prospects of their work together?
Psychotherapy, particularly psychoanalytic psychotherapy, has often been likened to the relationship between a parent and an infant. The answer to the question just posed is perhaps akin to what Winnicott (1961) concludes when he attempts to describe what it is that makes that relationship work:

It is by minute to minute that the parent is laying down the basis of the future mental health of the infant. And this is the tremendous parental task. Its size is reflected in the length of a psychoanalytic treatment, and in the duration of mental illness, even when the patient is given the best possible mental nursing. And on the whole, parents always tended to succeed in this, their essential, tremendous task, the reason being that for this purpose what they need to be is themselves, and to be and to do exactly what they like being and doing; and by doing just this they save their children from jerky reorganizations of defenses, and from the clinical distress that lies behind each of these reorganizations. ... We cannot tell parents how to behave as parents if all goes well. If all goes well it just happens. What we can do then is to study what is happening, and properly to evaluate this parental function, and so to recognize and support it, and to see that it is not interfered with when it exists (p. 75).
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