The Alliance, the Relational Turn, and Rupture and Repair Processes in the Therapeutic Relationship

The term ‘therapeutic alliance’ has risen in status in the psychotherapy world in the last 30 years, especially through research into the factors common to various modalities of psychotherapy (Cooper 2008). In many ways it has strongly helped to increase the importance of the therapeutic relationship, especially as a counterpoint to a research focus solely on the techniques of therapy (Safran & Muran 2006, Wampold 2010). Yet, there is a lack of consensus in the usage and meaning of the term ‘therapeutic alliance’ and its relationship to the therapeutic relationship. This article presents a wide survey of how the therapeutic alliance concept is used in the literature. It specifically focuses on various criticisms levied against it from the relational psychotherapy tradition and explores how the therapeutic alliance concept looks from within the ‘relational turn’ (Mitchell 2000: xiii). In exploring the therapeutic alliance from a relational therapy perspective I will focus on how negotiating the therapeutic alliance through processes of alliance rupture and repair can be significantly therapeutic.

SECTION 1: THE THERAPEUTIC ALLIANCE AND THE THERAPEUTIC RELATIONSHIP

Locating the Therapeutic Alliance

After more than 100 years of psychotherapy, since the beginning of Freud’s project, it is estimated that “there are more than 500 distinct psychotherapy theories and that the number is growing” (Wampold 2010: 25). Two of the major impacts of this proliferation of psychotherapy theories are the divergence into ‘schoolism’ and the search for common factors. Schoolism denotes the allegiance of therapists to specific theories or schools of thought and to research programs focused primarily on the technical factors of therapy as divorced from relationships factors of therapy. These research programs attempt to show the model’s efficacy and superiority compared with other therapeutic models (Wampold 2010, Norcross 2002).

Attempts by other researchers aim to encourage integration between the various schools or theories of psychotherapy by identifying the common factors across and among these various models (Duncan, Hubble & Miller 2010). What is known as ‘the great psychotherapy debate’ (Wampold 2001) involves a dispute between research which claims that identifying the common factors across and among these various relationship factors of therapy. These research programs attempt theories or schools of thought and to research programs focused on the common factors across the different therapeutic models.

Common Factors, the Therapeutic Relationship and ‘Lambert’s Pie’

A well known synthesis of the common factors research is graphically portrayed as a pie chart, known as ‘Lambert’s Pie’ after leading figure in the psychotherapy research field Michael Lambert.

This chart expresses four fundamental factors common to therapy. In this chart, the therapeutic relationship accounts for 30% of variance in therapeutic outcomes, a figure which has inspired much research into the relational factors of therapy (Safran & Muran 2006). The research that has focused on the therapeutic relationship has primarily oriented itself around the concept of the therapeutic alliance as the collaborative relationship between client and therapist. The most widely used measure and conceptualisation of this collaborative relationship is Bordin’s (1979) widely accepted pan-theoretical notion of the working alliance (Wampold 2010), consisting of: (a) the therapist’s and client’s agreement on the goals of therapy, (b) outcomes of their work, and (c) the existence of a positive affective bond between therapist and client—namely, “the patient’s ability to trust, hope, and have faith in the therapist’s ability to help” (Safran & Muran 2001: 160).

Throughout this article I will use the terms alliance and therapeutic alliance synonymously.

Currently known as Bordin’s (1979) working alliance concept, oriented to a positive “working alliance”, where the therapeutic relationship is understood as the collaborative relationship between client and therapist. The alliance as a component of the therapeutic relationship is conceptualised. In each of the following, the therapeutic alliance is understood as the collaborative relationship between client and therapist. The alliance as a component of the therapeutic relationship is conceptualised. In each of the following, the therapeutic alliance is understood as the collaborative relationship between client and therapist.
The therapeutic alliance concept has been found problematic throughout its history, and to understand some of these critiques, it needs to be understood. Freud “encountered alliance issues as soon as he began to use psychological methods to treat his patients” (Hatfield & Barber 2010: 8). Although he did not use the term alliance, Freud’s work emphasized the relationship between client and therapist. This relationship was not to be analysed as it provides the client with the motivation to continue with the work of therapy. Freud’s interest in the productive pact between client and therapist came into focus with the advent of ego-psychology, in the 1960s collaboration on the therapeutic work was elaborated in an important tripartite model which split the therapeutic relationship into three components: the working alliance, the bond aspect of the therapeutic relationship, and the real relationship (Gelso & Hayes 1998, Gelso 2011, Greenberg 1997). Within these psychoanalytic conceptualisations, the alliance provides the facilitative conditions for the curative work of therapy and is not merely a fact, but being a part of the domain of the therapeutic techniques/interventions (Gelso 2011, Safran & Muran 2000). At the heart of much therapeutic alliance debate within psychoanalytic circles is the relationship between the alliance and the transferential relationship. Within the relational movement, “the alliance receives less theoretical attention” (Safran & Muran, 2000: 12). I understand the relational psychotherapy tradition not as one school but as a field within which many relational voices and discourses “the alliance receives less theoretical attention” (Safran & Muran 2000: 10-11), and the reasons for this relate to a clash of paradigms underpinning the dichotomies above. The relational therapy perspective articulates a two-person psychology grounded in hermeneutics. However, the relational therapy perspective is typified, and meaning, truth and narrative are co-constructed by client and therapist. As the “meaning of any technical [task] factor can only be understood in the relational context in which it is applied” (Safran & Muran 1998: 166), some of the following criticisms arise from particular schools that are oriented towards constructivism and hermeneutics. These include contemporary constructivist therapy (Jacobs & Hyner 2008, Wheeler 2000), relational-cultural therapy (Jordan 2010), other feminist therapies, and some post-modernist therapies such as narrative therapy (Angus & Mcleod 2004).

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In the following inquiry, I argue that it is useful to understand the therapeutic alliance as being synonymous with the therapeutic relationship (Mitchell 1988, Safran & Muran 2000, Paivio & Pascual-Leone 2010). I thus use these two terms interchangeably.

**The Therapeutic Alliance as Bond and the Tasks and Goals of Therapy**

The definition of the therapeutic alliance as an affective and positive bond between client and therapist and collaboration and mutual agreement on tasks and goals of therapy (Bondy 1979) has been accepted and employed by many major therapeutic approaches. It is used in integrative therapy models (Dryden 1989, O’Brien & Houston 2007), cognitive-behavioural therapy (Nelson-Jones 2005, Ahlmont 2000), gestalt therapy (Joyce & Sills 2010, Mackewn 1997), process-experiential emotion-focused therapy (Elliott, et al. 2004, Watson & Greenberg 2000), psycho-dynamic models (Messer & Weiss 2004), narrative (Safran & Muran 2000). The agreement on the tasks and goals of therapy articulates the therapy as a collaborative and purposeful enterprise—namely, the ‘working alliance’. The tasks and goals agreed deemed therapeutic by the many therapeutic approaches, for example, free association (psychanalytical), behavioural homework assignments (cognitive-behavioural therapy), empty chair work (gestalt therapy), and rearrangement to somatic process (Gendlin’s focusing).

The goals of therapy are the objectives, “outcomes and priorities” (Bambling & King 2001: 38) which client and therapist agree on and work towards, for example: anxiety symptoms reduced, self-esteem increased, inner conflicts clarified.

The bond aspect of the therapeutic relationship is the affective quality of the therapeutic relationship between client and therapist and collaboration and mutual agreement on tasks and goals of therapy (Bondy 1979). The bond aspect of the therapeutic relationship is articulated as a “superficial negotiation towards consensus of goals and tasks” (Safran & Muran 2000: 15). Such an understanding of the process of alliance-building conceives it as facilitating the therapeutic work needed in therapy.

This conception overlooks important elements of alliance-building and -maintenance that persist, and require attending to, throughout the therapeutic work and that are, at critical junctures, therapeutic (Safran & Muran 2000). Although initial contracting and establishment of agreements around tasks and goals are vital processes for clients and therapists to undertake, the notion of alliance-building that is oriented to establishing initial contracts and focusing on clarifying the bond, tasks and goals throughout therapy.

The notion of negotiation, rather than collaboration, of the therapeutic alliance as an ongoing facet of therapy arises from the work of Safran & Muran (2000). To these authors the term collaboration is too loaded with idea of conscious/ rational agreement in the creation and contracting of a working alliance. Here “traditional conceptualizations of the

**Section 2: The Therapeutic Alliance and the Relational Turn**

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The notion that the therapeutic alliance is both facilitative of therapy and therapeutic in itself deconstructs the dichotomy between client and therapist and collaborates on tasks and goals.

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### Criticism of the Therapeutic Alliance Concept

Criticisms of these conflicts from the relational psychotherapy tradition have to question whether the therapeutic alliance concept “has outlived its usefulness” (Safran & Muran 2006: 206). Within the relational psychotherapy tradition, the tasks and goals of therapy are seen instead as the very fabric of therapy. It becomes meaningless” (Safran & Muran, 2000: 10). See also Jacobs 2011 working in the gestalt therapy tradition.

**Facilitative versus therapeutic factors.** One of the important dichotomies within which the therapeutic alliance is articulated is whether it is “a precondition of change … [or] a by-product of change” (Norton 1989: 111-114)—that is, whether it facilitates therapy or is therapeutic in itself. Within relational perspectives, negotiating the therapeutic alliance seems both to “establish the necessary conditions for change to take place and [is] an intrinsic part of the change process” (Safran & Muran 2000: 15, Jacobs & Hyner 2011, Jordan 2011 ). This intrinsic part of the change process often comes under the rubric of the corrective emotional experience or “new relational experience” (Wachtel 2007: 257). This therapeutic alliance is both facilitative of therapy and therapeutic in itself deconstructs the dichotomy between client and therapist and collaborates on tasks and goals.

### Initial Contracting Versus Ongoing Negotiation

Although collaboration on tasks and goals is widely stressed in the literature as an integral part of the alliance, there is also a “superficial negotiation towards consensus of goals and tasks” (Safran & Muran 2000: 15). Such an understanding of the process of alliance-building conceives it as facilitating the therapeutic work needed in therapy.

This conception overlooks important elements of alliance-building and -maintenance that persist, and require attending to, throughout the therapeutic work and that are, at critical junctures, therapeutic (Safran & Muran 2000). Although initial contracting and establishment of agreements around tasks and goals are vital processes for clients and therapists to undertake, the notion of alliance-building that is oriented to establishing initial contracts and focusing on clarifying the bond, tasks and goals throughout therapy.

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**Tasks and Goals of Therapy**

Agreement on the tasks and goals of therapy is often articulated as a “fourth wall” of therapy manuals as the importance of creating a counselling contract at the start of therapy that is mutually agreed upon by client and therapist (e.g., Feltham & Dryden 2005, O’Brien & Houston 2007).

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**Related factors versus technical factors.** A social constructivist epistemology would be that there is no objective reality, where “the therapist’s reality is not more valid or objective than the patient’s” (Yontef 2002: 17). The bond aspect of the therapeutic relationship consists of the bond between client and therapist, and collaboration and mutual agreement on tasks and goals of therapy (Bondy 1979). The bond aspect of the therapeutic relationship is articulated as a “superficial negotiation towards consensus of goals and tasks” (Safran & Muran 2000: 15). Such an understanding of the process of alliance-building conceives it as facilitating the therapeutic work needed in therapy.

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Alliance ruptures are inevitable facets of therapeutic work. Alliance ruptures are between the therapist’s and client’s relational patterns that arise through ruptures in the bond between client and therapist. This could be due to mis-attunements or empathic failures on the part of the therapist or to interpersonal patterns the client brings. Either way the rupture will open a door to an exploration of the client’s interpersonal patterns.

B.1a. Changing the task or goal. Rather than directly focusing on disagreements underlying tasks and goals, the therapist works with tasks and goals that are meaningful to the client. Doing so may strengthen the bond, thus motivating the client to engage in tasks that are meaningful to him or her.

B.1b. Reframing the meaning of the tasks or goals. Reframing the meaning of the tasks and goals in terms acceptable to the client is an important repair technique.

B.2a. Exploring core-interpersonal themes. Here the therapist focuses on helping the client explore the content of core-interpersonal schemas, the therapist’s relationship to them, and the repair process can provide the client with an experiential sense of the reason for the rupture and how it relates to the goals of therapy.

B.2b. Corrective emotional experience. The provision of a corrective emotional experience may heal a rupture in the bond component. An indirect way of addressing such ruptures involves taking a certain interpersonal stance that the therapist assesses the client needing, rather than addressing the rupture directly.

Synthesising ideas about resolving alliance ruptures from a variety of therapeutic schools, including cognitive-behavioural, psycho-dynamic, relational and process-experiential, Safian & Muran (2000a) provide a useful schematic. This schematic allows us to understand different kinds of alliance ruptures and how to intervene in them in order to repair them through strengthening the alliance. Alliance ruptures can occur in the tasks, the goals, and the therapeutic bond. A therapist can intervene in a direct or indirect way.

Alliance Ruptures
Alliance ruptures are inevitable facets of therapeutic work. Alliance ruptures are between the therapist’s and client’s relational patterns that arise through ruptures in the bond between client and therapist. They vary in intensity, duration, and frequency, depending on the particular therapist–client dyad. In more extreme cases, alliance ruptures lead to the therapist, detected (Safian & Muran 2000a: 190–160).

Alliance ruptures arise due to the relationship factors and thus cannot simply be attributed to what the client brings, which can often happen when therapists struggle with clients. As shown, the therapeutic alliance is negotiated both consciously and unconsciously by client and therapist. A relational perspective shows that the ruptures are co-created and therapists need to inquire into their part in the rupture.

Therapeutic rationale and micro-processing tasks
A.1a. Therapeutic rationale and micro-processing tasks. When a rupture arises through lack of clarity of the goals and tasks of therapy, the therapist may offer the treatment rationale, ie, explaining the reason for unpacking irrational thoughts. Rather than explaining the treatment rationale, the provision of micro-processing tasks across a spectrum of techniques can focus on somatic processes that provide the client with an experiential sense of the reason for the rupture and how it relates to the goals of therapy.

A.1b. Understanding tasks and goal disagreements in terms of core-interpersonal schemas. One alliance disruption is the client’s failure to see the therapeutic bond. A therapist can intervene in a direct or indirect way. Here, rather than directly focusing on disagreements underlying tasks and goals, the therapist works with tasks and goals that are meaningful to the client. Doing so may strengthen the bond, thus motivating the client to engage in tasks that are meaningful to him or her.

A.2b. Exploring core-interpersonal themes. Here the therapist focuses on helping the client explore the content of core-interpersonal schemas, the therapist’s relationship to them, and the repair process can provide the client with an experiential sense of the reason for the rupture and how it relates to the goals of therapy.

A.2b.1. Providing rationale for micro-processing tasks. When a rupture arises through lack of clarity of the goals and tasks of therapy, the therapist may offer the treatment rationale, ie, explaining the reason for unpacking irrational thoughts. Rather than explaining the treatment rationale, the provision of micro-processing tasks across a spectrum of techniques can focus on somatic processes that provide the client with an experiential sense of the reason for the rupture and how it relates to the goals of therapy.

A.2b.2. Clarifying misunderstandings. Rather than focusing on relational patterns that may be arising, the therapist directly explores what is transpiring in the dynamics of the here-and-now bond between client and therapist in an attempt to clarify any misunderstandings. This would focus on both attunement to the client’s process and on disclosing the therapist’s process.

A.3a. Re-framing the meaning of the tasks or goals. Reframing the meaning of the tasks and goals in terms acceptable to the client is an important repair technique.

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would be really draining.” On whether she knows counsellors have to be so reliant on myself, and I think after some time that If I were on my own, I think I would feel very isolated. I would such as this committee some way have peer support and, hopefully, be provided with professional paid or unpaid, to get up your hours, feel connected to others, well as professional development.

idea of weekend PDs for the value for money in regard to time low price of $50 was “unbelievable” and said that she likes the effect on people.”

what I thought on certain things. I think that had a flow-on people. People would ask me questions about my therapy and meal together on the Saturday night; you got to know some went on to say, “I think that interaction with other therapists, breakthrough. Plus the speakers were excellent as well.” He their local area so to meet like that and share stories was a big things with therapists is their self-evaluation: they might be the same things I’m going through.’ I think one of the felt, ‘Oh, there are people like me, probably going through well run. The venue was great. The area was great. And you getting together on Saturday night, and ‘time out’—a mini break from our usual lives.

in feeling less isolated and in learning from other attendees.

content itself—information provided and keeping up to (continued from Page 17)


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