Theories of therapeutic alliance

QUOTE:- “ The therapeutic alliance is a key concept and “ quintessential variable” whose importance is commonly accepted. It is seen as a multi-dimensional concept, emerging trends indicate four dimensions, namely: the patient’s affective relationship to the therapist; the patient’s capacity to purposefully work in therapy; the therapist’s empathic understanding and involvement; the client/therapist agreement on the goals and tasks of treatment.” B. JUST 1997

Essay

The concept of the Therapeutic Alliance has its roots in the seminal works of Freud when he began formulating his theories in respect of the various concepts relating to the phenomenon and dynamics of transference. (Freud S 1912). Freud began to refer to the concept in his early writings in different terms as a the therapeutic, working, or helping alliance which encapsulated the idea that a relationship between therapist and patient was important for therapeutic success. We note, in the context of this essay, that Freud’s opinion was that such a working arrangement was important but not essential for a therapeutic outcome. His early comments tended to refer to the “ positive feelings that develop between doctor and patient “ although, as his theories evolved, these concepts developed into more concrete forms.

As is the case with most evolving concepts it was developed and expanded by a number of other notable figures. Zetzel looked at a number of different types of alliance formation (Zetzel E R 1956) and Greenson conceptualised this in a fuller form drawing a distinction between the real and adaptive forms of this type of relationship and drawing attention to the transferential

properties and the possibility of the transference of fantasy in the adaptive elements of the alliance. (Greenson R R 1967)

Working at about the same time as Greenson in the USA, Rogers characterised the Therapeutic Alliance in the terminology of “ Client-centered therapy” and, for the first time in the literature, we find a reference to such an alliance being considered “ essential” rather than “ desirable” for the possibility of a positive outcome. (Rogers C R 1965). Rodgers referred to the Therapeutic Alliance as an “ empathetic bond” which had to be actively developed by both doctor and patient and was an essential precursor to any form of exploration of the patient’s problems.

Bordin expanded and generalised this concept further still and sought to increase its usefulness by adapting it to psychotherapy in all of its various forms. (Bordin E S 1979) and, in a seminal move towards Just’s analysis, proposed three elemental components of the Therapeutic Alliance, namely the identification of the goal, the identification of the task in hand and the formation of the doctor / patient bond of trust and empathy.

In consideration of the title of this essay we should consider this analysis more fully. Bordin conceived of the Therapeutic Alliance as a totally bipartisan construction which required an equal (but different) input from both therapist and patient. This construction required the mutual identification and recognition of the shared goals that were going to be achieved together with an agreed and accepted delineation and acknowledgement of the various tasks necessary to achieve these goals and the bond which he saw as and “ attachment bond generated primarily from

mutual respect and empathy“. (Bordin E S 1979). It follows from this analysis, that Bordin conceived the Therapeutic Alliance not as something which arose spontaneously form the efforts and interaction of therapist and patient, but as the actual vehicle and mechanism by which psychotherapy worked. His attempts to apply this concept to the various contemporary forms of psychotherapy culminated with the realisation and articulation that the different forms of psychotherapy focussed in on, and exploited different aspects of the Therapeutic Alliance at different stages of the treatment. This finding is echoed in other writings.

As we have outlined, the concept of the Therapeutic Alliance has its origins in the psychodynamic traditions of psychotherapy but has been embraced by the other traditions as well. Those theorists who are grounded in the cognitive school also acknowledge the establishment of a collaborative relationship between therapist and patient as an essential prerequisite to effective therapy. (Beck A T et al. 1979)

More recent work as sought to quantify the nature and depth of the Therapeutic Alliance in the various disciplines. Martin’s tour de force on the subject is an impressive meta-analysis which sought to quantify the relationship between the strength of the Therapeutic Alliance and the eventual outcome of treatment. (Martin D J et al. 2000). His findings suggest that it depends how one quantifies the Therapeutic Alliance as to how strong the relationship is found to be. This is an area that we shall return to shortly. Horvath takes this point further with a similar meta-analysis across various forms of psychotherapy and comes to the conclusion that the impact of the Therapeutic Alliance is roughly similar in the different forms and the efficacy

of outcome is directly related to the strength of the Therapeutic Alliance bond, irrespective of which particular mode of measurement is used. (Horvath A O et al. 1991).

These issues, and indeed the thrust behind Just's terminology of the Therapeutic Alliance as being the " quintessential variable" are all totally dependent on just how one defines or measures the concept. It is clear from the discussions presented already that it is a " multidimensional concept". One is certainly tempted to observe, from a brief overview of the literature, that it has at least as many dimensions as there are authorities writing on the issue. Although such a comment is superficially clearly bordering on the flippant, is can be taken at a much deeper level as a reflection of the fact that the Therapeutic Alliance is defined and measured by different authors in different ways.

Historically the evolution of the ability to measure the strength of the alliance has evolved in much the same was (and to some extent in parallel) as the actual formulation of the concepts of the Therapeutic Alliance itself. (Luborsky L et al. 1983). In essence, a judgement of the extent to which one considers the Therapeutic Alliance essential rather than simply desirable, is dependent on the way that one either quantifies or measures it. If we consider the implications of this statement further we can cite comments by two authorities that we have quoted earlier in a different context. In their critical analysis of the role of the Therapeutic Alliance in the field of general psychotherapy, Horvath and Luborsky suggest that research is unlikely to provide guidance to clinical practice unless the relations between clearly defined therapist actions in specific contexts and the effect of these

interventions on process or outcome can be demonstrated (Horvath A O, Luborsky L 1993 Pg. 568)

The effectiveness of the Therapeutic Alliance is also demonstrably effected by other factors. In his book the Heart and Soul of Change, Miller (et al. 1999) puts forward the suggestion that what is of fundamental importance in establishing the alliance is not the persuasion, or theoretical background of the therapist, nor even how empathetic the therapist actually is to the problems of the patient (even if the criteria that one uses is how empathetic the therapist believes that they are being) but is actually the degree to which the patient believe that the therapist understands their own perceptions of reality. To quote Miller " It the client's theory of change not the therapist's that is important."

This thread of argument is taken further with Gabbard's analysis (Gabbard G O et al. 1994) that the efficacy of the eventual therapeutic intervention, if measured in terms of transference interpretations, defence interpretations, and supportive interventions is ultimately dependent on factors that are therapist independent such as the strength of the patient's ego, the state of readiness that the patient has reached in terms of their own self-exploration or elaboration, the current phase of the therapeutic process and even the timing within any particular session. Which implies that it is both dynamic and variable.

If we consider the third of Just's four dimensions, that being that the therapist's empathic understanding and involvement is an essential prerequisite for the formation of the Therapeutic Alliance, then we can see

that Gabbard's analysis is clearly at odds with Just's. It is fair to observe that Gabbard is not alone in his assertions as Sexton's slightly later and incredibly detailed assessment of the status of the Therapeutic Alliance, came to essentially the same conclusions. (Sexton H C et al. 1996).

A rather more controversial view is expressed by Kernberg who was admittedly considering the phenomenon of Therapeutic Alliance in the specific context of severe personality disorder (Kernberg O F 1994) and came to the conclusion that the Therapeutic Alliance has to be initially very strong to allow the possibility of negative transference in order for the therapist to sometimes avoid the possibility of either premature termination of therapeutic stalemates. To an extent, he vicariously supports Miller's contentions by pointing out that the practical strength of the Therapeutic Alliance is largely independent of the therapist's wishes if one is dealing with a patient who is angrily attacking or even overtly manipulating the frame and goals of treatment. He adds the comment that in these circumstances the strength of the Therapeutic Alliance is largely determined by the level of the patient's intrinsic anxiety state. Perhaps this can be interpreted as an extension or perhaps a paraphrasing of Miller's later suggestion.

It therefore follows that if we are to agree or to disagree with Just's original statement, we need to consider just how we can quantify the strength of the various parameters of the Therapeutic Alliance. This is no easy topic and the literature on the subject is vast.

One of the first significant and serious attempts to produce some form of measuring tool came in the form of the Luborsky's Penn Helping Alliance

scales (Luborsky L et al. 1983). This had a number of serious shortcomings and was modified many times in the years immediately after its publication. The Penn Helping Alliance questionnaire was an offshoot of this collaboration and this evolved further into a 19 item scale. Many difficulties arose in the original tools because, to a degree they were dependent on the degree of benefit that the patient had already received from any previous attempts at therapy. A number of commentators made the suggestion that the tools, in order to maximise their applicability and usefulness, should be as independent as possible from the degree of benefit that the patient had already received. (Marmar C R et al. 1989).

If we return to our consideration of Bordin's tripartite assessment of the Therapeutic Alliance which can be considered a fundamental progenitor of Just's model, then we can cite Horvath and Greenberg's Working Alliance Inventory (Horvath H O et al. 1989) as a useful tool to measure the Therapeutic Alliance in terms of the three subsections of the Bordin definition mentioned earlier. This is perhaps the best direct justification and support of Just's hypothesis that we can find as Bordin's threefold thrust of assessment is essentially the same as three of the four elements of Just's and the fourth element that Just included of the therapist's empathetic understanding and involvement as being an " essential prerequisite" of the Therapeutic Alliance, is largely dismissed by authorities such as Gabbard and Sexton who we have cited earlier.

Clearly we do not presume to make a judgement as to which authority is essentially correct as we have to observe that the evidence base to support either view is not particularly strong.

To return to the original thrust of the concept of measurement, we can state that authorities have regarded Horvath and Greenberg's Working Alliance Inventory as being highly reproducible and as having high levels of interrater reliability in both the 36 item and the shorter 12 item version. (Horvath H O et al. 1989)

A degree of vindication for Just's analysis of the Therapeutic Alliance can be found in the California Psychotherapy Alliance Scales (CALPAS) , which essentially measures the strength of the therapist / patient alliance as a multidimensional construct. It uses four subscales to assess the strength of the bond namely:

(i) the patient's capacity to work purposefully in therapy,

(ii) the affective bond with the therapist,

(iii) the therapist's empathic understanding and involvement

(iv) the agreement between patient and therapist on the goals and tasks of treatment.

Which, in essence, cover the four basic premises of Just's hypothesis. Like the other scales already referred to, the CALPAS scale utilises a 6 point Likert scale for each item.

This particular scale has achieved wide acceptance in research literature with a good predictive ability which appears to be valid across the majority of psychotherapeutic disciplines including cognitive behavioural therapy (Fenton L R et al. 2001), psychodynamic psychotherapy (Barber J P et al.

2000) and across several other different treatment areas (Gaston L et al. 1991). It has been found to be especially useful among neurotic patients, but it does appear to be only a weak predictor of outcome with cocaine-dependent patients (Barber J P et al. 1999).

In terms of the arguments set out earlier, we note that all of the scales that we have already cited have both a therapist rated and patient rated version as well as an independent observer version. If one considers the literature we can see that the patient self-reported versions tend to give better predictions of outcome than those reports that are therapist based (particularly when assessed early in treatment trajectory). This gives credence to Miller's view that it is the patient ' s perception of the Therapeutic Alliance which is the single most important prediction measure of outcome in the psychotherapeutic field.

Thus far in this essay we have largely considered the presence of the Therapeutic Alliance as being a comparatively static modality which is either present or not. Although we have acknowledged some views that refer to its dynamic state, we should perhaps examine this in more detail. We have referred to the evolution of the strength of the Therapeutic Alliance as therapy progresses, but we should point to the fact that a number of authorities refer to the relationship of either the variability of the fundamental stability of the Therapeutic Alliance to a number of both clinical and empirical implications. (Hatcher R L et al. 1996).

As long as three decades ago Luborsky wrote about the dynamic nature of the Therapeutic Alliance which was actively responsive to the dynamic and

changing demands of the evolution of the various phases of therapy. (Luborsky L 1976). A further aspect of this dynamism is to be found in the writings of Bordin who, while acknowledging that the role of the therapist is generally one of support, noted that the role of the therapist tends to be the dominant factor at the beginning of the therapeutic relationship and this evolves into a more shared responsibility as goals and treatment plans are both articulated and defined. He writes that it is the inevitable cycle of the Therapeutic Alliance bond being strained, ruptured and then repaired that is central to the therapeutic process. (Bordin E 1980)

Writers such as Gelso and Carter (Gelso C J et al. 1994) formalised (some would say stylised) the evolution of the alliance over the therapeutic interaction as involving “ a weakening after an initial development, followed in successful therapy by an increase to earlier, high levels.” Other authorities have taken a more idiosyncratic view, which may reflect their own personal experience rather than necessarily an informed overview. Horvath characterises the typical trajectory as “ an initial phase of development for the alliance, held to occur within the first five therapy sessions (and probably peaking during the third session), followed by a second, more critical phase, during which the therapist challenges maladaptive patterns, the effect of which is a weakening or rupturing of the alliance that must be repaired if therapy is to continue successfully”. (Horvath A O et al. 1994). In order to provide a balanced picture of the literature, one could also cite the opinion of Greenberg who appears to have a more philanthropic outlook when he describes the process of evolution of the Therapeutic Alliance in successful

therapies as “ either rising or holding a steady value over time”. (Greenberg L S 1994)

In consideration of the evidence that we have assembled thus far we can state that the Therapeutic Alliance, in Just’s words, is clearly a key concept. We would suggest that the evidence points to the fact that not only is it a key concept but that it is both crucial and fundamental to the whole discipline of psychotherapeutic intervention.

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