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

Pedro Campiao

Alliance issues confront therapists in their practices every day.
~LR Hatcher (2010: 7)

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 leveled 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 psychotherapy 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 divorced from relationship 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).

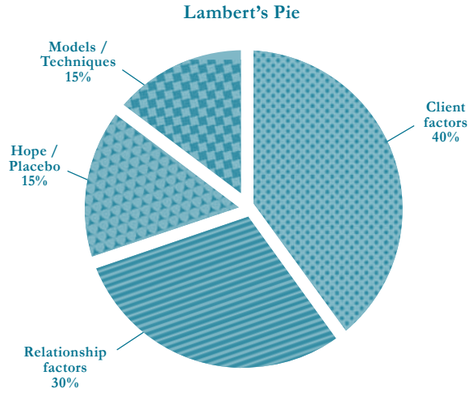
What is known as 'the great psychotherapy debate' (Wampold 2001) involves a dispute between research which claims that certain therapies are more efficacious than others and meta-analytic studies which claim the 'Dodo Bird verdict' (Wampold 2010). The Dodo Bird verdict in psychotherapy, named after the Dodo bird in *Alice in Wonderland* (1992) who claimed that "everyone has won and all must win prizes", is based on:

> one of the best-established findings in the … research field: that if one looks at the data on the *comparative* [italics original] efficacy of different therapies (either across studies or within the same study), rather than the data on which specific therapies have been shown to be efficacious with specific psychological problems, there is an overwhelming body of evidence to suggest that there is little difference in how efficacious different psychological therapies are … (even though it is evident that the therapists are doing quite different things) (Cooper 2008: 50).

Although the great psychotherapy debate continues, "with major implications for the practice, funding and development of therapeutic services" (Cooper, 2008: 58), the above comparative research findings have provided a strong impetus to uncover 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 where, as a research area, it "reigns supreme" (Cooper 2008: 102). In the last thirty years, over 4000 papers/dissertations have been written on it and 24 different scales have been developed to measure it (Cooper 2008). Yet the definition of the 'alliance' and how the 'alliance' is connected to the 'therapeutic relationship' is not at all clear or universally accepted.

Defining the Therapeutic Alliance

Difficulty defining the therapeutic alliance, also known as the working alliance, or simply the alliance, has led to a large amount of empirical research that is inconsistent and difficult to interpret (Messer & Wolitsky 2010). The reasons for this situation are:

> different conceptualisations of the alliance and what make up its components (eg, therapist empathy, bonds, tasks, goals); the use of different assessment tools … and who does the rating (patient, therapist or researcher); different results, depending on the phase of therapy studied (early, middle, late); the variety of therapy outcome measures to which the alliance is correlated (eg, symptom reduction, interpersonal changes, target complaints); the varied length of therapy; and variations reflecting the clinical group studied (Messer & Wolitsky 2010: 107).

Although many difficulties exist with regard to researching and defining the therapeutic alliance, by far the most popular understanding of the alliance is "the quality and strength of the collaborative relationship between client and therapist" (Norcross 2010: 120). 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—ie, outcomes of their work; (b) therapist and client consensus on the tasks of therapy—ie, the various behaviours which comprise the in- and out-of-session therapeutic 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: 166). Throughout this article I will use the terms alliance and therapeutic alliance synonymously.

The notion of the therapeutic alliance as a collaborative relationship—a conceptualisation that can be used to apply to all "interpersonal change processes" (Hatcher 2010: 10)—has helped to increase the status of the therapeutic relationship as an important common therapeutic factor across schools and models in the last 30 years (Safran & Muran 2006).

The Alliance and the Therapeutic Relationship

According to Safran and Muran (2006), "the alliance construct played an important role among psychotherapy researchers in bringing the therapeutic relationship back into focus at a time when the person-centered tradition with its emphasis on the core conditions had become marginalised by the mainstream, and the cognitive–behavioral tradition was in the ascendant" (2006: 289). Due to how the therapeutic alliance research has increased the status of the therapeutic relationship, it is important to understand how the therapeutic alliance concept is related to that of the therapeutic relationship. The literature provides us with three primary ways in which this 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. The understanding of the therapeutic alliance as a component of the therapeutic relationship is common. Using the latter understanding, the American Psychological Association conducted "the largest ever review of empirical evidence" (Cooper 2008: 101) in the area of the therapeutic relationship in an attempt to identify the relationship components of effective therapy (Norcross 2002). The following elements were found to be *demonstrably effective*: empathy, alliance, goal consensus and collaboration, positive regard and affirmation, congruence/genuineness, collecting client feedback, repair of alliance ruptures, management of counter-transference, and adapting the relationship to the individual client (Norcross 2010). In this study, the therapeutic alliance is defined as "the quality and strength of the collaborative relationship between client and therapist" (Norcross 2010: 120), and it is understood as one of the components of the therapeutic relationship.

Equivalence between the alliance and the therapeutic relationship. The idea that the therapeutic alliance and the therapeutic relationship are equivalent is expressed in the literature as a simple equation of the therapeutic alliance to the therapeutic relationship, as if these are two terms for the same thing/process. Here one finds such article titles as 'The Therapeutic Alliance: Cultivating and Negotiating the Therapeutic Relationship" (Safran, Muran & Rothman 2005) or phrases such as "the therapeutic relationship or alliance is a universal change factor" (Paivo & Pascual-Leone 2010: 103). In the above examples, the therapeutic relationship is equated to the therapeutic alliance, the latter being defined according to Bordin's (1979) working alliance concept, oriented to a positive bond between client and therapist and their agreement on the tasks and goals of therapy.

Alliance as one relationship among various relationships. In what has become an important research project, the alliance is understood within a tripartite model, originally stemming from the psychodynamic tradition (Greenson 1967), where the therapeutic relationship made is up of three different relationships, namely, (a) the working alliance, (b) the transference/counter-transference relationship and, (c) the real relationship (Gelso 2011, Gelso & Hayes 1998). Here, the working alliance is defined according to Bordin's (1979) working alliance model, as a positive bond between client and therapist and agreement on the tasks and goals of therapy.

History of a Concept

The therapeutic alliance concept has been found problematic throughout its history, and to understand some of these criticisms, some of its history needs to be understood. Freud "encountered alliance issues as soon as he began to use psychological methods to treat his patients" (Hatcher & Barber 2010: 8). Although he did not use the term alliance, Freud discussed a "pact" (cited in Gilbert & Orlans 2011: 132) between the client and therapist involving a positive bond, the "unobjectionable positive transference" (Freud cited in Messer & Wolitssky 2010: 97), between client and therapist. This transference 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 1930s (Hatcher 2010). An interest in rational processes led therapy to be articulated as supporting a split in the ego of the client between an observing, rational capacity and the irrational forces within the patient's transference (Sterba cited in Hatcher 2010). The term the therapeutic alliance was coined in the 1950s. It related to the conscious, rational and collaborative agreement between therapist and client about the nature of the therapeutic work and how to proceed with it (Zetzel cited in Gilbert & Orlans 2011).

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 transference-countertransference relationship, and the real relationship (Gelso & Hayes 1998, Gelso 2011, Greenson 1967). Within these psychoanalytic conceptualisations, the alliance provides the facilitative conditions for the curative work of therapy and is not in any way curative itself, that being the domain of the therapeutic techniques/interventions (Gelso 2011, Safran & Muran 2000). At the heart of much therapeutic alliance debate within psychodynamic circles is the relationship between the alliance and the transferential relationship. Is the alliance to be analysed? How? If so to what extent?

From the above brief exploration, it can be seen that the therapeutic alliance concept is articulated within three important dichotomies or conflicts, namely:

(a) a conflict between the rational/reasonable relationship and the irrational/transferential relationship where the therapeutic alliance involves "an alignment" (MacKewn 1997: 87) between the therapist's and the client's rational and reasonable side. This alliance creates an anchor to the work when it becomes difficult for the client, such as when analysing the transference or when difficult emotions arise;
(b) a conflict between relationship factors and technical factors, where work on the relationship is not understood as an intervention and, related to this;
(c) a conflict between facilitative and curative factors of therapy where establishing the alliance between client and therapist facilitates therapy, this being the application of techniques and interventions, but is not therapeutic in itself. (See Gelso 2011, Mitchell 1988, Safran & Muran 2000.)

Criticism of the Therapeutic Alliance Concept

Criticisms of these conflicts from the relational psychotherapy tradition have led some researchers to question whether the therapeutic alliance concept "has outlived its usefulness" (Safran & Muran 2006: 206). Within the relational psychotherapy 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 turn" (Mitchell, 2000: xiii) in psychotherapy is part of a wider post-modernist, social-constructivist and participatory paradigm shift across many disciplines (Gergen 2009). I understand the relational psychotherapy tradition not as one school but as a field within which many relational voices can dialogue (Wachtel 2007).

Although relational psychotherapy arose out of the psychodynamic tradition (Mitchell 1988, Stolorow, Brandschaft & Atwood 1987), because much within its theory involves a critique of the modernist paradigm—with its reliance on various presuppositions underlying a Cartesian worldview, such as the possibility of objectivity, individualism and its related subject-object/mind-body/rational-irrational split (Mitchell 1988, Safran & Muran 2000, Wheeler 2000)—I include within the relational psychotherapy tradition various other schools that are oriented towards constructivism and hermeneutics. These include contemporary gestalt therapy (Jacobs & Hycner 2008, Wheeler 2000), relational-cultural therapy (Jordan 2010), some other feminist therapies, and some post-modernist therapies such as narrative therapy (Angus & Mcleod 2004).

The relational psychotherapy tradition is grounded in a constructivist and dialogical epistemology, a shift from a one-person psychology to a two person-psychology, where the "therapist's reality is not more valid or objective or true than the patient's" (Yontef 2002: 17). At its heart is the concept of intersubjectivity, which "recognizes the constitutive role of relatedness in the making of all experience" (Stolorow 2002: 329) and involves a grappling with the "importance of the interactive in the creation of the intrapsychic" (Boston Change Process Study Group, 2010: 143).

What follows are criticisms of the three dichotomies inherent within the therapeutic alliance concept. Although some of the following criticisms arise from particular relational psychotherapy traditions, I believe they apply, in one way or another, to all constructivist therapies.

The real relationship versus the transferential relationship. Within a constructivist and hermeneutic orientation to therapy, the dichotomy between the therapeutic alliance and the transferential relationship is problematised through the concept of intersubjectivity (Mitchell 2000, Safran & Muran 2000, Boston Change Process Study Group 2010). Intersubjectivity, a concept "central to the entire evolution of the relational movement" (Wachtel 2000: 151), "opposes the rigid demarcation between subject and object" (Safran & Muran 2000: 10) and thus the possibility of ascertaining what is the real relationship and what is the transferential relationship in psychotherapy. Within the relational psychotherapy tradition, "what is real or unreal, true or untrue, is replaced by the recognition that there are multiple truths and that these truths are socially constructed. The distinction between transference and real aspects of the relationship thus becomes meaningless" (Safran & Muran, 2000: 10. See also Jacobs 2011 working in the gestalt therapy tradition.)

Relational factors versus technical factors. A social constructivist epistemology involves the affirmation that there is no objective reality, where the "therapist's reality is not more valid or objective or true than the patient's" (Yontef 2002: 17). Without an objective reality and the unsullied authority of the therapist to fall back on, relational therapy perspectives articulate a two-person psychology grounded in hermeneutics. Here epistemic processes are dialogical, 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 2001: 166), technical interventions thus become "relational acts" (Boston Change Process Study Group 2010: 196). Here the dichotomy and conflict between relational and technical factors, at the heart of the therapeutic alliance conceptualisation, is seen as problematic.

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] … the central mechanism of change" (Norcross 2010: 114);—that is, whether it facilitates therapy or is therapeutic in itself. Within relational perspectives, negotiating the therapeutic alliance is seen *both* to "establish the necessary conditions for change to take place and [a]s an intrinsic part of the change process" (Safran & Muran 2000: 15, Jacobs & Hycner 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: 237). This idea affirms therapeutic change as the client having a new relational experience with the therapist (DeYoung 2003). The notion that the therapeutic alliance is both facilitative of therapy and therapeutic in itself deconstructs the dichotomy between facilitative and curative factors at the heart of the alliance discourse (Boston Change Process Study Group 2010, Mitchell 1988, Safran & Muran 2000).

Section 1 located the therapeutic alliance in current research discourses, defined it and articulated various complexities and differences within its definition and use, especially in how it is related to the therapeutic relationship, expressed some of its history while also provided various criticisms of how the therapeutic alliance is articulated. Section 2 outlines one way to understand the therapeutic alliance from a relational perspective. The criticisms of the above three dichotomies, inherent in the therapeutic alliance concept, will allow an understanding of the maintenance of the therapeutic alliance as a highly therapeutic intervention that can be seen to lie at the heart of therapy.

Section 2: The Therapeutic Alliance and the Relational Turn

In the following inquiry, I argue that it is useful to understand the therapeutic alliance as being synonymous with the therapeutic relationship (Dryden 1989, Safran & Muran 2000, Paivo & 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 agreement on the tasks and goals of therapy (Bordin 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, Arnkoff 2000), Gestalt therapy (Joyce & Sills 2010, Mackewn 1997), process-experiential/emotion-focused therapy (Elliott, et al. 2004, Watson & Greenberg 2000), psycho-dynamic models (Messer & Wolitsky 2010), and relational models (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 of therapy are the various activities deemed therapeutic by the many therapeutic approaches, for example, free association (psychoanalysis), behavioural homework assignments (cognitive-behavioural therapy), empty chair work (gestalt therapy), and attunement 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, needs and life-direction clarified.

The bond aspect of the therapeutic alliance consists of the affective quality of the therapeutic relationship between client and therapist such as "the extent to which the patient feels understood, respected, valued" (Safran & Muran 2000: 12).

In this model there is an interdependence between bond, task and goals. Collaborating on the tasks and goals may strengthen the bond, whereas failure to establish the bond may stress the alliance through inability to agree on tasks and goals (Bambling & King 2001).

This integrative model provides a flexible way to negotiate the construction of different alliances, depending on different client needs or presenting issues. Some clients may need more structuring at the start of therapy, more focus on explaining tasks or clarifying goals; other clients may need a lot of work on establishing a safe and trusting bond, and much less work on clarifying goals or tasks.

Agreement on the tasks and goals of therapy is often articulated in therapy manuals as the importance of creating a counselling contract at the start of therapy that is mutually agreed upon by client and therapist (eg, Feltham & Dryden 2005, O'Brien & Houston 2007).

Initial Contracting Versus Ongoing Negotiation

Although collaboration on tasks and goals is widely stressed in the literature, this notion is often applied at the start of therapy 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 and not therapeutic in itself.*

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 needs to be expanded by focusing on the ongoing negotiation of 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

alliance may overemphasize the role of conscious or rational collaboration between therapist and patient and underestimate the pervasive role of unconscious factors in both patients' and therapists' participation in the relationship" (Safran & Muran 2006: 287-288). From an intersubjective and relational perspective the unconscious participation of the therapist in alliance negotiation is unavoidable.

The term negotiation affirms that the therapeutic alliance is negotiated both consciously and unconsciously, involving emotional and 'transferential' aspects, thus problematising the notion of the alliance as rational agreement. Ongoing negotiation also "puts an emphasis on the process by which the tasks and goals of therapy develop and transform in the course of the therapeutic endeavour" (Rozmarin, et al. 2008).

From a relational, constructivist and hermeneutic perspective, what is being negotiated is the meaning of the work, specifically the meaning of the various tasks in which client and therapist are engaging (Safran & Muran 2000). Although the greater majority of psychotherapy research, including research into the therapeutic alliance, involves splitting relational and technical factors (Cooper 2008), within a social constructivist worldview, the "meaning of any technical [task] factor can only be understood in the relational context in which it is applied" (Safran & Muran 2001: 166). The "usefulness of an intervention is always mediated by its relational meaning and ... any attempt to disentangle technical and relational dimensions [is] conceptually problematic, even if it is possible to do so statistically (Safran & Muran 2006: 288). Here, a particular hermeneutic trajectory needs to be embodied, ie, the ongoing exploration of the meaning the client is making of the various interventions made by the therapist.

Development of the Alliance Through Time

The concept of negotiation of the therapeutic alliance implies a process that extends through time. Much therapeutic alliance research has focused on the development of the alliance throughout therapy (Stiles, Glick, Hardy, Shapiro, Agnew-Davies, Rees & Barkham 2004; Stevens, Muran, Safran, Gorman & Winston 2007), while looking for patterns in this development. Four patterns have been researched, and found, although research data are not conclusive:

1. a stable alliance pattern (little change in alliance strength across sessions)
2. a linear growth pattern (increasing alliance strength across sessions)
3. a U-shaped alliance pattern, involving a high-low-high development (alliance strength is relatively strong at the start of the therapy, weakens in the middle and increases in strength at the end)
4. a V-shaped pattern, (where therapy is characterised, especially in the middle sessions, by a series of brief ruptures and repairs in which the alliance is strained and then repaired) (Stiles et al 2004, Stevens et al 2007).

Some of the thinking that motivates this research is based on the idea that "although the alliance is initially in the forefront of the relationship, it subsequently fades into the background, returning to the foreground only when needed" (Gelso & Carter 1994 in Stiles et al 2004). It often arises into the foreground due to strains in the alliance (Safran & Muran 2000). The field of research into V-shaped alliance patterns, where therapy is characterised by processes of rupture and repair, through negotiation of the tasks, goals and bonds of therapy, is "one of the most innovative and exciting areas of development" (Cooper 2008: 119). It is to V-shaped alliance patterns and the important concept of alliance ruptures that I now turn.

Alliance Ruptures

Alliance ruptures are inevitable facets of therapeutic work.

> Alliance ruptures are breaches in relatedness and negative fluctuations in the quality of the relationship between the therapist and client. They vary in intensity, duration, and frequency, depending on the particular therapist–client dyad. In more extreme cases, the client may overtly indicate negative sentiments to the therapist or even terminate therapy prematurely. At the other end of the continuum are minor fluctuations in the quality of therapeutic alliance that may be extremely difficult for the outside observer, or even the skilled therapist, to detect (Safran & Muran 2000a: 159–160).

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 was shown, the therapeutic alliance is negotiated both consciously and unconsciously by client and therapist. A relational perspective affirms that alliance ruptures are co-created and therapists need to inquire into their part in the rupture.

Synthesising ideas about resolving alliance ruptures from a variety of therapeutic schools, including cognitive-behavioural, psycho-dynamic, relational and process-experiential, Safran & Muran (2000a) provide a useful schematic. This schematic allows us to understand different sorts 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.).

Repairing Alliance Rupture Guidelines

When involved in alliance ruptures, it may be helpful for therapists to keep these guidelines in mind:

1. Clients often have negative feelings about therapy that they are reluctant to express. The more the therapist is attuned to subtle indications of ruptures and takes the initiative to explore with the client what is happening in the therapeutic relationship, the more the client is free to bring him- or herself into relationship with the therapist.
2. Research shows that it is important for clients to express negative feelings about therapy and perspectives which differs from the therapist's. Supporting the client to express these negative feelings can be deeply therapeutic for the client, especially the more therapists are able to respond in a non-defensive manner while accepting responsibility for their contribution to the rupture.

Therapeutic Value of Repairing Rupture Alliances

In the literature, the therapeutic alliance has most commonly been articulated as a framework that facilitates the work of therapy but is not therapeutic in itself (Gelso 2011, Safran & Muran 2000). Research into alliance ruptures shows that they are an inevitable facet of therapy and that repairing them leads to positive therapeutic outcomes through the strengthening of the alliance. It was argued that the progress of the therapy involves a development of the therapeutic alliance that is marked by a series of rupture and repair sequences which, if engaged in, will strengthen the therapeutic alliance.

It is theorised that this rupture-repair sequence is therapeutic for two reasons. Firstly, the therapist is bound to empathically fail and mis-attune to the client, just as she was failed in a similar way by her caregivers. Repairing these ruptures in attunement provides the client with a "gradually increasing ability to regulate negative affect states" while becoming more aware of the other (Dales & Jerry 2008: 283). Secondly, alliance ruptures allow the client to "reconcile their needs for agency versus relatedness" (Safran & Muran 2000a: 238), which are often in conflict. The process of negotiating alliance ruptures "involves helping clients to learn that they can express their needs in an individuated fashion and assert themselves without destroying the therapeutic relationship" (Safran & Muran 2000a: 238), supporting them to feel, paradoxically, more individuated and more relational.

In short, negotiating the therapeutic alliance is not simply facilitative of therapy but therapeutic in and of itself through the provision of a corrective emotional or corrective relational experience for the client.

	1. Task & Goal		*2. Bond*	
A. DIRECT	a. Providing rationale for micro-processing tasks	b. Exploring core interpersonal themes	a. Clarifying misunderstandings	b. Exploring core interpersonal themes
B. INDIRECT	a. Changing task or goal	b. Reframing meaning of task or goal	a. Empathy attunement	b. Corrective emotional experience

After Safran & Muran (2000a).

A1a. ***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 such as a mindfulness task or a focus on somatic process can provide the client with an experiential sense of the reason for the task and how it relates to the goals.

A1b. ***Understanding tasks and goal disagreements in terms of core-interpersonal schemes.*** Often, alliance ruptures due to disagreements or mis-attunements on the tasks and goals of therapy will lead to the exploration of client core-interpersonal schemes. For example, a client may struggle with opening herself up to the therapist, leading to a rupture. When this is explored, themes of not trusting authority may be apparent. The brief relational treatment of Safran & Muran (2000) understands alliance ruptures as a royal road into how clients structure their relationships and sees this exploration as central to the healing work of therapy.

A2a. ***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.

A2b. ***Exploring core-interpersonal themes.*** Here the therapist focuses directly on exploring the core-interpersonal themes and 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.

B1a. ***Changing the task or goal.*** 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 about which they may reticent .

B1b. ***Reframing the meaning of the tasks or goal.*** Reframing the meaning of the tasks and goals in terms acceptable to the client is an indirect way to strengthen the alliance and to motivate the client.

B2a. ***Empathic attunement.*** An indirect way to heal a rupture in the alliance bond is through empathic attunement to the client's rupture experience. Here the client feels understood and the bond is repaired. Core-interpersonal themes that may arise are not explored.

B2b. ***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.

References

Angus, L and Mcleod, J (Eds) 2004, *The Handbook of Narrative and Psychotherapy*, London: Sage

Arnkoff, DB 2000, 'Two examples of strains in the therapeutic alliance in an integrative cognitive therapy', JCLP/*In Session: Psychotherapy in Practice* 56(2): 187-200

Asay, T and Lambert M 1999, 'The Empirical Case for the Common Factors in Therapy: Quantitative Findings, in Hubble, M, Duncan, B & Miller, S (Eds), *The Heart & Soul of Change: What Works in Therapy Washington*: American Psychological Association

Bachelor, A & Horvath, A 1999, 'The Therapeutic Relationship' in Hubble, M, Duncan, B & Miller, S (Eds) *The Heart and Soul of Change: What Works in Therapy*, Washington: American Psychological Association

Bambling, M and King, R 2001, 'Therapeutic alliance and clinical practice', *Psychotherapy in Australia* 8(1): 38-43 November

Bordin, ES 1979, 'The generalizability of the psychoanalytic concept of the working alliance', *Psychotherapy: Theory, Research and Practice*, 16(3): 252-260

Boston Change Process Study Group 2010, *Change in Psychotherapy: A Unifying Paradigm*, New York: W.W. Norton & Company

Caroll, L. 1992, *Alice in Wonderland*, London: W.W. Norton & Company

Cooper , M 2008, *Essential research findings: The facts are friendly*. London: Sage

Dale, S & Jerry, P 2008, 'Attachment, affect regulation and mutual synchrony in adult psychotherapy', *American Journal of Psychotherapy*, 62(3); 283-312

DeYoung, P 2003, *Relational Psychotherapy: a primer*, New York: Routledge

Dryden, W 1989, 'The Therapeutic Alliance as an Integrating Framework, in Dryden, W (Ed), *Key Issues for Counselling in Action*, London: Sage Publications

Duncan, B, Miller, S, Wampold, B, Hubble, M (Eds) 2009, *The Heart and Soul of Change: Delivering What Works in Therapy* (2nd Ed), Washington: American Psychological Association

Elliott, R, Watson, JC, Goldman, RN & Greenberg, LS 2004, *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change*, Washington: American Psychological Association

Feltham, C & Dryden, W 2006, *Brief Counselling: A Practical Integrative Approach*, (2nd Ed), London: Open University Press

Gelso CJ & Hayes, JA 1998, *The Psychotherapy Relationship: Theory, Research and Practice*, New York: John Wiley & Sons

Gelso, CJ 2010, *The Real Relationship in Psychotherapy: The Hidden Foundation of Change*, Washington: American Psychological Association

Gergen, K 2009, *Relational Being: Beyond Self and Community*. Oxford: Oxford University Press

Gilbert, M & Orlans, V 2011, *Integrative Therapy: 100 Key Points and Techniques*. London: Routledge

(*continued on Page 35*)

(*continued from Page 17*)

Greenson, R 1967, *The Technique and Practice of Psychoanalysis* (Vol. 1), New York: International University Press

Hatcher, LR 2010, 'Alliance theory and measurement', in Muran, JC & Barber, JP (Eds), *The Therapeutic Alliance: An Evidence-Based Guide to Practice*, New York: Guildford Press

Horvarth, A, 2006, 'The alliance in context: Accomplishments, challenges and future directions', *Psychotherapy: Theory, Research, Practice, Training*, 43(3): 258-263

Jacobs, L 2011, Critiquing Projection: Supporting Dialogue in a Post-Cartesian world. In Talia Bar-Yoseph Levine (Ed.) *Gestalt Therapy: Advances in Theory and Practice*, London: Routledge

Jacobs L. & Hycner R (Eds) 2008, *Relational approaches in gestalt therapy*, New York: Gestalt Journal Press

Joyce, P & Sills, C 2009, *Skills in Gestalt Counselling and Psychotherapy* (2nd Ed), London: Sage

Mackewn, J 1997, *Developing Gestalt Counselling*, London: Sage

Messer, SB & Wolitsky, DL 2010, 'A Psychodynamic Perspective on the Therapeutic Alliance: Theory, Research, and Practice', in Muran, JC & Barber, JP (Eds), *The Therapeutic Alliance: An Evidence-Based Guide to Practice*, New York: Guildford Press

Mitchell, SA 2000, *Relationality: From Attachment to Intersubjectivity*, New York: Routledge

Nelson-Jones, R 2005, *practical counselling and helping skills* (5th Ed), London: Sage Publications

Norcross, J (Ed), 2002, *Psychotherapy Relationships That Work*, Oxford: Oxford University Press

Norcross, J 2010, 'The Therapeutic Relationship', in Hubble, MA, Duncan, BL, & Miller, SD (Eds) *The Heart and Soul of Change: What Works in Therapy*, Washington: American Psychological Association

O'Brien, M & Houston, G 2007, *Integrative Therapy: A Practitioner's Guide*, London: Sage Publications

Paivo, S & Pascual-Leone, A 2010, *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach*, Washington: American Psychological Association

Rosmarin, E, Muran, C, Safran, J, Gorman, B, Nagy, J & Winston, M 2008, 'Subjective and intersubjective analyses of the therapeutic alliance in a brief relational therapy', *American Journal of Psychotherapy*, 62(3): 313-328

Safran JD and Muran JC 2000, *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*, New York: The Guildford Press

Safran, JD and Muran JC 2001, 'The Therapeutic Alliance as a Process of Intersubjective Negotiation', in Muran JC (Ed) *Self-Relations in the Psychotherapy Process*, Washington DC: American Psychological Association Books

Safran, JD and Muran JC 2006, 'Has the Concept of the Therapeutic Alliance Outlived Its Usefulness?', *Psychotherapy: Theory, Research, Practice, Training*. 43(3): 286–291

Safran, JD, Muran, JC and Rothman M 2006, 'The Therapeutic Alliance: Cultivating and Negotiating the Therapeutic Relationship', in O'Donohue, W, Cummings, N & Cummings, J (Eds) *Clinical Strategies for Becoming a Master Psychotherapist*, London: Elsevier

Safran J, and Muran C 2000a, 'Resolving therapeutic alliance ruptures: Diversity and integration' JCLP/*In Session: Psychotherapy in Practice*, 56(2): 159–161

Stevens, C, Muran, C, Safran, J, Gorman, B and Winston, A 2007, Levels and patterns of the therapeutic alliance in brief psychotherapy, *American Journal of Psychotherapy*, Vol. 61, No. 2, 2007

Stiles, W, Glick, M, Osatuke, K, Hardy, G, Shapiro, D Agnew-Davies, R, Rees, A and Barkham, M 2004, 'Patterns of alliance development and the rupture-repair hypotheses: Are productive relationships U-shaped or V-shaped?', *Journal of Counselling Psychology*, 2004, 51(1): 81-92

Stolorow, R 2002, 'Impasse, Affectivity and Intersubjective Systems', *Psychoanalytic Review* 89(3): 329 337

Stolorow, RD, Brandchaft, B and Atwood, GE 1987, *Psychoanalytic Treatment: An Intersubjective Approach*, Hillsdale, NJ: The Analytic Press

Wachtel, PL 2007, *Relational Theory and the Practice of Psychotherapy*, New York: The Guildford Press

Wampold, BE 2001, *The Great Psychotherapy Debate: Models, Methods, and Findings*, New York: Routledge

Wampold, BE 2010, *The Basics of Psychotherapy: An Introduction to Theory and Practice*, Washington: American Psychological Association

Wheeler, G 2000, *Beyond Individualism: Toward a New Understanding of Self, Relationship & Experience*, Hillsdale, NJ: The Analytic Press

Wolitsky, D 2010, 'Psychoanalytic Theories of Psychotherapy', in Norcross, J, Vandenboss, J & Fredheim, D (Eds) *History of Psychotherapy: Continuity and Change* (2nd Ed), New York: American Psychological Association

Yontef, G 2002, 'The Relational Attitude in Gestalt Theory and Practice', *International Gestalt Journal* 25(1): 15-34

I would like to acknowledge the influence on this article of Jeremy Safran and Christopher Muran's work, and to thank Laura Daniel for her invaluable editing support.

Pedro Campiao, *BA, Grad Dip Edu, Grad Dip Couns, MA Gestalt. Clin CAPA, GANZ, PACFA Reg., divides his time equally between part-time work as a counsellor for NSW Health, in the area of chronic illness, and private practice, where he sees individuals and couples and facilitates Gestalt/Yalom relationally oriented therapeutic groups. In 2012 he will be undertaking research for NSW Health in transformational learning experiences during Hepatitis C treatment. He is based in the Northern Rivers area of NSW where he directs a therapy centre in Mullumbimby, the Stuart St Practice Rooms. www.pcampiao.com.*