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Therapeutic alliance: a conceptual review

Abstract

Therapeutic alliance (TA) is the reciprocal one-to-one relationship that evolves during the patient and therapist experiences and during a variety of interpersonal mechanisms involved in psychotherapy. But very minimal recent literature discussing conceptualisation of TA is available. Literature review and qualitative comparison of information were carried out to conceptualise the development of the concept of TA using Pubmed, Medline, Google Scholar, and PsychINFO databases. The results showed that good alliance helps in the successful outcome of therapy. Therapist characteristics and behaviours like warmth, flexibility, and accurate interpretation are positively associated with alliances formation while rigidity, criticalness, inappropriate self-disclosure affect alliance negatively. Alliance literature reveals a significant lack of unanimity about how the alliance operates. But, the good alliance itself is therapeutic for clients regardless of the psychological interventions.

Keywords: Psychotherapy, therapist factors, therapeutic process, empathy

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INTRODUCTION

Therapeutic alliance (TA) is a patient-centred care approach that helps in various medical fields apart from being the main component of psychotherapy. But very minimal recent literature discussing conceptualisation of TA is available. This paper traces the development of the concept of TA, and its application in psychotherapy and other therapeutic relationships. Authors have also tried in this paper to look into variables affecting the strength of the alliance, confounding factors affecting alliance, and methods to improve alliance. For this paper, literature review and qualitative comparison of information were carried out to conceptualise the development of the concept of TA. Pubmed, Medline, Google Scholar, and PsychINFO databases were searched for the terms like psychotherapy, working alliance, therapeutic alliance. The initial search identified around 473 articles of which the abstracts were screened for around 300 articles and full texts were searched for 83 potentially relevant articles.

RESULTS

TA is described as the interactivity between the therapist and their patients. It refers to a variety of interpersonal mechanisms involved in psychotherapy that are complementary to each other.[1] With the help of establishing this alliance, the therapist facilitates goal achievement of the patient with a patient-centred care rather than being an authoritative figure. Patients are encouraged to become more active in their treatment. It is thus a collaborative, active approach to recovery. TA is the reciprocal one-to-one relationship that evolves during the patient and therapist experiences. Patient and therapist engage in the positive and constructive dialogue using TA to achieve effective results in therapy. Similar outcomes in all aiding treatments, irrespective of the procedure used, have prompted the hunt for a common factor; the therapeutic partnership has emerged as the most important common factor.[2]

Development of the concept

Various theories have been proposed to explain the origin of the concept of TA with a few dating back to the times of Sigmund Freud. These theories have been explained in the coming section.

Psychodynamic origins of therapeutic alliance

Several concepts have been extended in the early era to conceptualise and understand the definition TA. In 1912, Freud's initial theorisation of transference was regarded as purely negative but was seen as the key process of therapy and progress.[3] However, later it was considered as a development of advantageous attachment between the patients and the therapist grounded in the reality that helps in the therapeutic process. In 1956, Zetzel first used the term 'therapeutic alliance' to refer to a relational component between the patient and therapist which is defined as non-neurotic and non-transferential.[4] In 1961, Greenson's model suggested three components, namely the real relationship, transference, and working alliance to define this concept. He said that the client oscillates between the three during therapeutic

interventions.[5] In 1976, Luborsky called the alliance a dynamic entity and divided it into two types: [6]

Type 1: It is evident at the beginning of the therapy with patient experiencing the perception of receiving role for themselves and the therapist fulfils the supporting and helping roles.

Type 2: It emerges in later phases and is characterised by a sense of 'we-ness'. It represents a shared responsibility between the patient and the therapist to achieve objective of the therapy and a collaborative relationship is maintained in order to overcome the problems faced by the patient.

Different conceptualisations

Object relationists, Bibring (1937), Gitelson (1962), Horwitz (1974), and Bowlby (1988), proposed that the attachment between the therapist and the patient is represented by new object relation and therefore, it differs from transference. Behaviour therapists gave increased importance to the role of "techniques" rather than emphasising on the relationship component in therapy. Effectiveness of the therapy was dependent on therapist's expertise to promote the therapeutic relationship to achieve their patients' goals. They emphasised that clients appreciate efficacious therapists. Others (e.g., Goldfried, Lazarus) considered the value of TA more readily while extending techniques adopted by the behaviour therapists. They suggested that a dynamic environment of interpersonal therapy is needed to promote the systematic restructuring of thoughts and behaviour along with skills development which help clients achieve positive outcomes.[7]

Client-centered concept

Rogers[8] raised three initial theories. Firstly, he said that the relationship requirements that the therapist provide such as empathy, congruence, and unconditional positive concern, sufficiently activate the natural healing mechanism of the client. Secondly, he added that these expectations provided by therapists results into improvement and overall development of efforts to help the clients, irrespective of the therapist's theoretical context. Thirdly, he proposed that there was a distinctive client-centered position. He suggested that it is the therapist who is responsible for these aspects of the partnership. This was for the first time that theoretical argument placed more importance on relationship provided by the therapist for effectiveness of therapy instead of techniques applied by them. However, these propositions do not take into account the possibility of varying ability and motivation of the clients to respond to the offer of such a relationship.

Social influence concept

Strong[9] and LaCrosse[10] in their hypothesis stated that if the client perceives their therapist to be an expert, trustworthy figure, and attractive then this impression allows power to the helper to strengthen the change promotion.

So, by the 1970s, there had been increasing awareness related to employing a diverse number of therapies for alleviation of psychological issues. There was little evidence, however, to suggest that a particular method dominated or condescended the field. Thus, by the middle of the decade, many clinicians and scholars had a widely felt need for a systematic, pan-theoretical conceptualisation of therapeutic relationship.

Transtheoretical concept of the alliance

According to Bordin,[11] in this theory, the original psychodynamic concept was remodelled by proposing that the alliance is fundamentally a "here-and-now' relation of consciousness. It has been said that the relationship is similar to all assisting processes and includes understanding and cooperation between the client and the therapist; therefore, this has been described as a "real" bidirectional connection. It is considered both a facilitative condition and an advantageous therapeutic agent in its own right. TA is consensus between therapist and client concerning "what is to be done" in therapy and conduction of variety of activities to contribute towards solving client's problems; agreement on the short-term and long-term outcome expectations from therapy between the client and therapist. According to this model, no particular type of therapy is essential for achieving positive client change and therefore, it has been widely embraced as a pan-theoretical model.

Bordin further described phases of alliance evolution during the process of therapy. He told that the first phase is characterised by growing strong alliance, the second phase is characterised by client resistance and dissatisfaction, and the third phase is characterised by a return to a stable and strong alliance. In each phase, the alliance may be damaged for different reasons:

In the first phase, the alliance may be damaged due to the challenges faced during the development of a supportive relationship and difficulties with the collaborative agreement related to the procedures of therapy.

In the second phase, alliance ruptures might not heal due to critical nature of the challenges along with not catering to it properly.

The failure of experiencing interruptions in the alliance might be due to poor confrontation with client's dysfunctional affects, behaviour patterns or thoughts. Other reason owes to client's unreasonable and idealised response towards the therapist.

Variables affecting the strength of the alliance

The effectiveness of the alliance between client and therapist can be affected due to client factors, therapist factors, and therapy factors.

Client factors

Problem severity: Research has shown a negative link between the nature of the problem and the therapeutic partnership. A part of this association may be that clients with more serious issues appear to drop out early.

Type of impairment: Relationship is difficult to establish in some patients as with personality disorders.

Nature of attachment or object relationship: The quality of attachment types, particularly afraid, dismissive, anxious,

and worried types, are associated with low outcomes from the alliance.[12-14]

Therapist factors

Communication skills: The ability of the therapist to communicate effectively about understanding their client's perspective and appreciating it aid TA.

Exploration, empathy, and openness: These traits of a therapist lead to beneficial results in therapy. The alliance predicts the variance elucidated by empathy as well as results of the therapy.

Experience and training: It is seen that more the experience, better is the alliance. The possible reason for the same can be the ability of an experienced therapist to better detect ruptures in the alliance and repair them.

Therapist's personality and interpersonal process: Positive correlation with characteristics such as understanding, confidence, acceptability, flexibility, trustworthy, interested, alert, and relaxed attitude is seen with TA. While the therapist's disaffiliating-hostile, challenging, or controlling nature negatively impacts the alliance.[15,16]

Therapy factors

Theoretically psychodynamic therapy should pertain to more emotional investment and comparatively increased uncomfortable session whereas, cognitive behavioural therapy (CBT) is considered to have less strained sessions. Studies which inspected characteristics of alliance in these two therapies produced mixed evidence. To overcome the difficulty of illustrating remarkable differences between behavioural, psychodynamic, and cognitive therapies,[17] the California Therapeutic Alliance Rating System was used to find significant differences between these therapies.[18] The results demonstrated that observers gave notably high rating to the cognitive behavioural group on the Working Alliance Inventory (WAI), indicating better alliance.[19]

Measures of therapeutic alliance

Scales/groups of scales used to determine TA are the California scales, the Toronto scales, the Vanderbilt scales, the Pennsylvania scales, WAI, the Therapeutic Bond Scales (TBS). There are difficulties in measuring and studying alliance because of different conceptual definitions of TA since it is an entity rather than a measure. As there is no common reference as to what these scales are measuring, the measurement may be affected by the type of scale used, if the alliance is rated by the client, therapist, or observer (known as Rashomon effect), time of assessment (early/middle/late in therapy) and type of treatment: CBT/interpersonal psychotherapy (IPT)/dynamic, etc. Halo effect also results in difficulty in measuring alliance. Halo effect is because of acquiring information about process (alliance) and outcome data from one individual which exaggerates the magnitude of the connection of alliance with the outcome.

Confounders in studying alliance

Various confounding factors that lead to difficulty in the formation/measuring TA are listed below and has been divided into client and therapist factors:

Client characters

Alliance is difficult to develop in patients with personality disorders such as patients with borderline personality disorder. Nature of attachment affects the quality of alliance between client and therapist. At the initial stage, if the client has fearful, anxious, dismissive, and preoccupied styles of attachment then it could lead to poor alliance.[20,21]

Moderating variables of therapists

Therapist factors include empathy, openness, communication abilities, exploration, experience, and training. Clients who find it challenging to form intimate relationship form more secured alliance with expert counsellor as they are better at identifying deteriorating relationship as compared to less experienced colleagues. Therapist's hostility, disaffiliating, disputing, or restraining the clients are negatively correlated with the alliance.[22-24]

Therapeutic alliance in special therapies

Therapeutic alliance in adolescents

Alliance forming in adolescents is not a one-time phenomenon but a recurring one. The formation of an alliance involves not only the client but also their carers. Moreover, due to their limited cognitive abilities, clients are to be treated differently. Clients usually enter the treatment process unconscious of their problems, in conflict with their parents, and initially face high resistance. To solve these issues, the therapist demands that he be not only amusing or encouraging with the clients, but also supportive with the parents. Therefore, in the therapy phase, several alliances need to be created.[25,26]

Couple/family therapy

A family has different persons each with a different set of cognitive patterns and influenced by others at the same time. The success of the therapy depends on how the unit as a whole is responding to the treatment. The couple/family therapy involves the formation of multiple alliances, with therapist requiring to keep monitoring the personal bonds with each member, the goals and tasks given along with remaining aware of what is going in the family. Members of a family should feel secure and warm with each other during the therapy. The therapist should be able to provide a safe, collaborative, and supportive environment. The family should feel that they can connect with the therapist. He should acknowledge the strengths of the family and validate their struggles. An important aspect of the success of therapy is the retention of members in the treatment process.[27] Various factors that help in the success of couple/family therapy are listed below.

Therapist factors: Therapist providing information and education, and addressed resistance, exploring feelings/experiences, family member(s) into the discussion, clarified process and roles, authoritative.

Family factors: Expressed belief in therapy, shared sense of purpose within the family, shared contributions to problem.[27]

Therapeutic alliance in group therapy: Similarly, group therapy involves multiple alliances. The success of group therapy has been predicted by fewer symptoms at baseline, higher client self-esteem, and stronger group cohesion.[28,29]

Methods to improve the therapeutic alliance

As TA is a critical component of psychotherapy, resulting in good therapy outcomes, it becomes important to learn about a few of the techniques to improve TA. Various methods to improve TA include expressing respect, positive regard and empathy towards the client, taking a collaborative approach towards treatment with client and therapist both working towards common goals, and being respectful towards each other. Therapist beliefs, feelings, and behaviour which are essential to developing these core elements involve non-judgemental observation, warmth, good listening skills, including reflective listening, praising client's courage, effort, and behavioural change, discussing, negotiating, and reaching a joint understanding of the goal, exploring the client's expectations of treatment, describing common experiences people have during treatment and how to handle them.

DISCUSSION

Good alliance helps in the successful outcome of therapy. Characteristics and behaviours of the therapist like warmth, flexibility, and precise interpretation are associated positively with formation of alliance while rigidity, criticalness, and inappropriate self-disclosure affect alliance negatively. Thus, the therapists should endeavour establishing, monitoring, and maintaining a positive relationship and a secure alliance with the clients irrespective of the clinical problem or the treatment modality. Therapists should resolve the challenges faced during alliance formation for the successful outcome of the therapy.

Conclusion

Alliance literature demonstrated a significantly high absence of unanimity concerning operating of the alliance and exact contributions by participants for development of a strong alliance in the therapy. Meta-analytic techniques are inadequate in determining the effect of patient's diagnosis on alliance outcomes. But, the good alliance itself is therapeutic for clients regardless of the psychological interventions. So future research should be focused in such a way that therapists can deal with different clients with personality disorders and other difficult patients. Research should focus on developmental patterns of the alliance, and the same should be incorporated in training for successful outcomes of therapy.

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