J. Christopher Muran and Jeremy D. Safran

Negotiating the Therapeutic Alliance in Brief Psychotherapy: An Introduction

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Like many aspects of the psychotherapeutic process, the importance of the therapeutic relationship was originally discussed by Freud in his early theoretical papers on transference. Although he first spoke of the importance of making a so-called collaborator of the patient in *Studies of Hysteria* (1885/1955), Freud (1912/1958) was primarily concerned with the transferential aspects of the relationship and the importance of transference analysis. For Freud, *transference* involved the displacement of affects from one object or person to another, traditionally the transference of attitudes formerly associated with a parent. He distinguished between positive and negative tranferences (i.e., the transference of positive vs. negative attitudes). Freud also spoke of the "unobjectionable positive transference"—the aspect of the transference that should not be analyzed because it provides the patient with the motivation necessary to collaborate effectively with the analyst. To a limited extent, he acknowledged the role of friendliness and affection as "the vehicle of success in psychoanalysis" (S. Freud, 1912/1958) and described the analyst and patient banding together against the patient's symptoms in a "pact" based on free exploration by the patient and competent understanding by the analyst (S. Freud, 1940/1964).

From Freud, one can trace the development of psychoanalytic perspectives on the therapeutic relationship to two emergent lines. The first develops through the influence of Ferenczi (see Aron & Harris, 1991). As analyst to Balint, Jones, Klein, and Rickman, he had great impact on British

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object relations. As analyst to Thompson, Roheim, and Rado, Ferenczi likewise influenced interpersonal and cultural psychoanalysis in America. Ferenczi (1932) was the first to suggest that it was essential for patients to not merely remember but to actually relive the problematic past in the therapeutic relationship. Thus he sowed ideas later cultivated by Balint (1968), Winnicott (1965), and Alexander (with his notion of the corrective emotional experience: Alexander & French, 1946). (Alexander was influenced by Ferenczi when both were associated with the Hungarian Psychoanalytic Society.) Ferenczi was also first to consider the role of the analyst's personality and experience in the treatment process. He highlighted the analyst as a real person and recognized the real impact of the analyst on the transference–countertransference enactment (Ferenczi, 1932). Thus he suggested ideas, such as participant observation, developed further by the interpersonalists (Thompson, 1944).

The second line can be identified as the ego-psychological tradition, which emphasized the reality-oriented adaptation of the ego to its environment (A. Freud, 1936; Hartmann, 1958). Largely in response to the exclusive view held particularly by Kleinians (e.g., Bion, 1970) that all meaningful reactions of the patient to the person of the analyst are transference manifestations and the only important interventions are transference interpretations, the ego psychologists refocused attention on the real aspects of the therapeutic relationship and developed the notion of the therapeutic alliance (Greenson, 1971). The concept of the therapeutic alliance was the ego-psychological attempt to bring the interaction between analyst and patient to the fore. In addition, it permitted modifications in the traditional analytic stance and the use of noninterpretive measures.

Sterba (1934, 1940) was the first to explicate the role of positive identification with the therapist in leading the patient to work toward the accomplishment of common therapeutic tasks. Specifically, he spoke about the importance of helping the patient to form a "therapeutic split in the ego" so that the reality-focused elements of the ego could become allied with the therapist in the task of self-observation. It was Zetzel (1956, 1966) who first introduced the therapeutic alliance as essential to the effectiveness of any therapeutic intervention. She argued that the alliance is dependent on the patient's fundamental capacity to form a stable trusting relationship, which in turn is rooted in his or her early developmental experiences. Zetzel believed that when this capacity does not exist at the outset, it is critical for the therapist to provide a supportive relationship which facilitates the development of an alliance, in the same way that a mother needs to provide the appropriate maternal environment to facilitate the development of a fundamental sense of trust.

Greenson (1967, 1971) extended this tradition with a seminal formulation of the therapeutic relationship. He described the relationship as consisting of a transference configuration and a real relationship (although he recognized that the boundary is somewhat artificial). The real relationship refers to the mutual human response of the patient and therapist to each other, including undistorted perceptions and authentic liking, trust, and respect for each other, which exist along with the inequalities inherent in the therapy situation. Greenson introduced the working alliance as the ability of the dyadic partners to work purposefully together in the treatment they have undertaken. Although the patient's transference reactions may support the working alliance, the essential core of the alliance is the real relationship. Thus, like Sterba (1934, 1940), Greenson emphasized the importance of rationality and objectivity in therapy with this concept.

Over the years, there has been much controversy in analytic circles over what is meant by the alliance concept (see Langs, 1976). In fact, there are those within the ego-psychological tradition, such as Brenner (1979), who find the distinction between alliance and transference neither meaningful nor useful, and still others, such as Meissner (1996), who find the distinction at least conceptually (if not practically) useful. Nevertheless, the ego psychologists have at least reminded many of the analytic community that it is meaningful to recognize that the psychotherapeutic process does involve a real and personal relationship (Lipton, 1983).

In contrast, among interpersonalists (e.g., Lionells, Fiscalini, Mann, & Stern, 1995), the alliance concept has not been the focus of much attention, given that their perspective is primarily one of interaction. The principle of participant observation fundamental to their field theory places the real relationship between patient and therapist prominently in the theoretical foreground and thereby has permitted greater technical flexibility. Recent developments in contemporary psychoanalytic theory toward a relational perspective (Mitchell, 1988) have extended the interpersonal emphasis on therapist participation and subjectivity. These include perspectives influenced by feminist theory, social constructivist discourse, and the notion of intersubjectivity (see Aron, 1996); these perspectives collectively oppose the rigid demarcation between subject and object, between observer and observed, with its emphasis on reason and rationality. 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. Thus, the therapeutic relationship can be understood as comprised of plural, perspectival, ever-changing truths co-created by patient and therapist.

The recognition that the psychotherapeutic process involves a real and personal relationship between patient and therapist is one

not missed by other traditions. This is a perspective that has always been central to the humanistic–experiential tradition in which Rogers (1951) advocated for empathy, congruence, and unconditional positive regard as necessary and sufficient conditions for therapeutic change. It has also received increasing attention by behavioral therapists, who have come to recognize not only the value of therapist warmth and empathy but also the therapeutic relationship as a sample of behavior (e.g., Goldfried & Davison, 1976).

The psychotherapy research community represents another forum where the therapeutic alliance has been most topical. Interest in this concept among researchers can be partly attributed to the search for understanding change across treatments, given that no particular treatment has been shown to be consistently better than any other in effecting change (Smith, Glass, & Miller, 1980). It can also be attributed to Bordin (1979), who stirred the psychotherapy research community with his transtheoretical reformulation of the alliance concept. He suggested that a good alliance is a prerequisite for change in all forms of psychotherapy and defined the concept as consisting of three interdependent components: agreement on tasks, agreement on goals, and the bond. According to him, different types of therapy focus on different types of tasks and goals and thus require different types of bonds. The strength of the alliance is, therefore, a function of the degree of agreement between patient and therapist about the tasks and goals of psychotherapy and the quality of the affective bond between them. In other words, the quality of the bond mediates the extent to which the patient and therapist are able to negotiate an agreement about the tasks and goals of therapy, and the ability to negotiate an agreement about the tasks and goals in therapy in turn mediates the quality of the bond.

The tasks of therapy consist of the specific activities (either overt or covert) that the patient must engage in to benefit from the treatment. For example, classical psychoanalysis requires the patient to free associate by attempting to say whatever comes to mind without censoring it. An important task in cognitive therapy may consist of completing a behavioral assignment between sessions. The goals of therapy are the general objectives toward which the treatment is directed. For example, classical psychoanalysis assumes that the problems that bring people into therapy result from a maladaptive way of negotiating the conflict between instincts and defense, and the goal consists of developing a more adaptive way of negotiating that conflict. A behavior therapist, in contrast, may see as the goal of treatment the removal of a specific symptom. The bond component of the alliance consists of the affective quality of the relationship between patient and therapist (e.g., the extent to which the patient feels understood, valued, and so

on). Bordin's (1979) seminal contribution was a significant impetus to the proliferation of measures and research, which demonstrated that the most robust predictor of outcome in psychotherapy is the quality of the therapeutic alliance (Gaston, 1990; Hartley, 1985; Horvath & Symonds, 1991).

A Reconceptualization of the Therapeutic Alliance

Historically, the concept of the therapeutic alliance has played an important role in the evolution of the classical psychoanalytic tradition, insofar as it has provided a theoretical justification for greater technical flexibility. By highlighting the critical importance of the real, human aspects of the therapeutic relationship, it provided grounds for departing from the idealized therapist stance of abstinence and neutrality. An interpersonal or relational perspective does not adhere to classical notions of therapist abstinence and neutrality and provides considerably more scope for technical flexibility. Moreover, from such a perspective, the experience of a new, constructive interpersonal experience with the therapist is viewed as a critical component of change. In fact, one might say that the processes of developing and resolving problems in alliance are not simply prerequisite to change but rather the essence of the change process. The question thus arises as to whether the concept of the therapeutic alliance is still valuable or whether it is superfluous.

A broadened conceptualization of the therapeutic alliance along the lines that Bordin suggested still seems useful for several reasons (Safran & Muran, in press). First, it highlights the fact that at a fundamental level, the patient's ability to trust, hope, and have faith in the therapist's ability to help always plays a central role in the change process. Some aspects of this type of alliance may involve conscious, rational deliberation, but other aspects are unconscious and affectively based. This type of perspective on the alliance is closer in nature to Zetzel's conceptualization than it is to Sterba's or Greenson's. Second, Bordin's conceptualization of the alliance highlights the fact that different types of alliance are necessary depending on the relevant therapeutic tasks and goals. The type of alliance focused on by Greenson and Sterba, which emphasizes the patient's rational collaboration with the therapist in the task of self-observation, is only one such type. There is a wide range of other therapeutic tasks and goals both within psychoanalysis and within other forms of psychotherapy; for exam-

ple, accessing painful feelings or reconstructing historical memories (psychoanalysis), monitoring and recording one's internal dialogue between sessions (cognitive therapy), and engaging in a dialogue between different parts of the self (Gestalt therapy). The process of relating to the therapist in an authentic and organismically grounded fashion (common to both existential and relational psychoanalytic approaches) can be thought of as another therapeutic task.

Each of these tasks places different demands on the patient and will tend to be experienced as more or less helpful depending upon the patients' capacities and characteristic ways of relating to themselves and others. A patient prone to self-criticism may experience the task of self-observation as difficult. Another patient may be easily susceptible to self-consciousness and shame before another and may find lying on a couch and sharing innermost thoughts easier than than facing the analyst. Of course, such experiences may shift from time to time within a given case; for example, a benign question in one moment can be a provocative one in another. This point has a number of important implications.

First, it highlights the interdependence of relational and technical factors in psychotherapy. It suggests that the meaning of any technical factor can only be understood in the interpersonal context in which it is applied. Any intervention may have a positive or negative impact on the quality of the bond between the patient and therapist depending on its idiosyncratic meaning to the patient, and conversely, any intevention may be experienced as more or less facilitative depending on the preexisting bond.

Second, our point provides a rational framework for guiding the therapist's interventions in a flexible fashion. Rather than basing one's approach on the basis of some inflexible and idealized criterion, such as therapeutic neutrality, one can be guided by an understanding of what a particular therapeutic task means to a particular patient in a given moment. For example, how is an exploratory question being experienced by a patient? Does it facilitate greater understanding of an issue? Does it close off an exploration because it feels intrusive to the patient or because it evokes too much anxiety to tolerate? And how is a given interpretation experienced? Does it communicate empathy by the therapist or is it experienced as criticism? Could it be that the therapist is using the interpretation to defend against the patient?

Third, as Stolorow and colleagues (Stolorow, Brandchaft, & Atwood, 1994) have highlighted, ruptures in the therapeutic alliance are the royal road to understanding the patient's representational world. As contemporary Kleinians such as Joseph (1989) point out, the therapist should continually attend to the way in which patients respond to their interventions. Exploring the factors underlying the

patient's construal of an intervention as hindering can provide a rich understanding of the patient's idiosyncratic construal process and internal object relations.

Fourth, understanding patients (not to mention therapists) as diverse in capacity and variable in experiencing highlights the importance of the negotiation between patient and therapist about the tasks and goal of therapy. Conceptualizations of the alliance such as Sterba's and Greenson's assume that there is only one therapeutic task (i.e., rational collaboration with the therapist in the task of self-observation). Although they emphasize the importance of the therapist acting in a supportive fashion to facilitate the development of the alliance, ultimately, they assume that the patient will identify with the therapist and adapt to the therapist's conceptualization of the tasks and goals of therapy or accept the therapist's understanding of the tasks and goals of therapy. In contrast, Bordin's conceptualization of the alliance is more dynamic and mutual or reciprocal. It assumes that there will be an ongoing negotiation between therapist and patient at both the conscious and unconscious levels about the tasks and goals of therapy, and that this process of negotiation establishes the necessary conditions for change to take place and is an intrinsic part of the change process as well.

This conceptualization of the alliance as both dynamic and mutual is consistent with a view of the essence of therapy as entailing an ongoing negotiation between two subjectivities, between the patient and therapist (Mitchell, 1993). Pizer (1992) has described therapeutic action as constituted by the engagement of two persons in a process of negotiation. He suggests that therapists in their interventions and patients in their responses are recurrently saying to each other, "No, you can't make this of me. But you can make that of me" (p. 218). Pizer includes in this process all aspects of therapy, the agreement on fees, the arrangement about scheduling, and so forth. He summarizes that "the very substances and nature of truth and reality . . . are being negotiated toward consensus" (p. 218) in the therapeutic relationship. This view fits nicely with Bordin's emphasis on the negotiation of tasks and goals in his conceptualization of alliance.

The Therapeutic Alliance in Brief Psychotherapy

The history of short-term psychotherapy can likewise be traced back to Freud, whose clinical efforts were typically short term (Messer &

Warren, 1995). Other significant early contributions include Rank's (1929) setting of a specific time for termination to mobilize the patient's will and accentuate dependency and separation issues; Ferenczi's (Ferenczi & Rank, 1925) experiments with active, directive interventions to promote a more rapid and effective therapy; Deutsche's (Deutsche & Murphy, 1955) emphasis on focality and confining one's efforts to an exploration of a limited area in a patient's psychic world; and Alexander's (Alexander & French, 1946) focus on the need to formulate a comprehensive understanding of the patient in the first few interviews and to use that understanding to plan treatment. These contributions became central to the development of the short-term models that followed (see Flegenheimer, 1982; Messer & Warren, 1995).

Although therapeutic practice has a long-standing tradition of short-term treatment models fueled by both theory and research, the surge in interest in brief psychotherapies can be attributed to current changes in the social, political, and economic environment. Recent surveys indicate that short-term psychotherapy now constitutes a substantial component of the psychotherapy that is practiced (Messer & Warren, 1995), and it is likely that this trend will continue to increase as the shift toward managed care and greater accountability in the health care sector continues. When it comes to understanding the therapeutic alliance in short-term psychotherapy, there has been little in the way of a systematic attempt to explore the alliance concept specific to the short-term context (although most of the research demonstrating the importance of the alliance has been based on short-term psychotherapy).

A number of obvious factors need to be entered into the negotiation of the therapeutic alliance in short-term psychotherapy. To begin with, there is the establishment of the time limit. Short-term treatments also invariably involve a greater degree of focality and a high level of therapist activity, as the therapist intervenes constantly to maintain the focus in the given time frame, on a circumscribed area of difficulty. In addition, issues regarding separation and termination are much more salient throughout the treatment process because of the time limit. All these factors greatly shape the process toward agreement on tasks and goals, and they impact upon the affective experience between patient and therapist. How or when does the therapist intervene to limit the focus? How is this experienced by the patient? What effect does it have on their bond in a given moment?

This book is designed to acquaint the reader with how the therapeutic alliance is understood in short-term treatment from the perspective of various contemporary theoretical orientations and treatment modalities. Specifically, Harold Been and Arnold Winston

present from a drive–structural model (influenced by Malan, Davanloo, and Sifneos); Jeffrey L. Binder presents from a relational perspective (including contributions by Luborsky, Horowitz, Weiss, and Sampson); Barbara S. Kohlenberg and colleagues present from a radical–behavioral perspective; Cory F. Newman presents from a cognitive therapy model; Jeanne C. Watson and Leslie S. Greenberg present from a humanistic–experiential perspective; James C. Coyne and Carolyn M. Pepper present from a strategic perspective; Douglas S. Rait presents from a structural family and couples therapy perspective; and K. Roy MacKenzie presents with respect to group psychotherapy.

To organize these chapters in a thematically consistent fashion, we have asked all the contributors to address the following questions in their chapters:

1. How do you conceptualize the therapeutic alliance? In other words, is there a specific conceptualization that you find particularly helpful in your work, or do you find some combination of conceptualizations (or some adaptation of a concept) to be useful?
2. In what way do the special demands of your short-term approach influence the way in which you conceptualize the alliance?
3. What implications do the specific demands of your short-term approach have for the initial establishment of the alliance?
4. What implications do the specific demands of your short-term approach have for the maintenance of the alliance?
5. What specific types of ruptures in the alliance are likely to be most common in short-term approach, and why?
6. What type of interventions are likely to be most useful for resolving ruptures in the alliance.

The therapeutic alliance has been described as the "quintessential integrative variable" because its importance does not seem to lie within one school of thought (Wolfe & Goldfried, 1988). We hope this volume will contribute to the dialogue necessary for diverse schools to see if there is common ground.

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