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A brief overview of the therapeutic alliance: historical, theoretical and contemporary debates

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ABSTRACT

The therapeutic alliance has a historical importance in psychiatry, especially in the effectiveness of psychotherapies. The therapeutic alliance is a critical concept that reflects the quality of the relationship between the patient and the therapist in the psychotherapy process and for many clinicians it is the main factor in the patient's recovery. While a strong alliance increases the success of the therapy, in cases of weak alliance, it is difficult to achieve therapeutic goals. Although different psychotherapy approaches position the concept of therapeutic alliance differently, in the future, in-depth exploration of the therapeutic alliance in different contexts and populations will contribute to the scientific knowledge in this field. The therapeutic alliance is a valuable concept not only in psychotherapy, but also in every field of psychiatry, and even wherever there is a physician-patient relationship. In this article, the therapeutic alliance is examined in the historical process, its importance in psychotherapy is discussed, and the prevention of rupture or what to do in case of rupture is explained.

Keywords: Therapeutic alliance, psychotherapy, therapist-patient relationship

INTRODUCTION

The therapeutic alliance is a fundamental concept that refers to the relationship between patient and therapist based on cooperation, trust and common goals. This concept, which plays a critical role in determining the effectiveness of psychotherapy, has a central importance in different therapy approaches. The therapeutic relationship, which Freud first associated with the concept of "transference" in 1912/1913, has been one of the cornerstones of psychoanalytic therapies. While Freud emphasized the healing potential of positive transference, he stated that negative transference and countertransference could negatively affect the treatment process. Ferenczi (1949), on the other hand, considered countertransference as a part of the therapeutic relationship, arguing that the emotional responses of the therapist to the patient are a natural and understandable process (Ferenczi, 1949).

Since the 1950s, the therapeutic alliance has emerged as a focal point in various psychotherapy approaches. In 1952, Eysenck conducted a review of 24 psychotherapy studies, questioning the effectiveness of psychotherapy and concluding that it was largely ineffective (Eysenck, 1952). This controversial conclusion sparked extensive debates and critiques, including those by Auerbach et al. (1963), and significantly increased interest in methodological and conceptual questions within psychotherapy research. These discussions fueled efforts to identify constructs that reliably "predict," "demonstrate," and "remain stable" across different psychotherapy modalities, contributing to the evolution of the therapeutic alliance as a pivotal concept in clinical practice and research.

CONCEPT OF THERAPEUTIC ALLIANCE

The concept of "therapeutic alliance" was first introduced by Zetzel (1956) and later expanded upon by Greenson (1965) with the notion of the "working alliance" and Luborsky (1976) with the "helping alliance." Additionally, Sandler et al. (1992) coined the term "treatment alliance." Bordin (1979) proposed a transtheoretical framework for the therapeutic alliance, identifying three core components: bond, task, and goal. This model demonstrated that the therapeutic alliance is not confined to psychodynamic therapies but is equally significant in other psychotherapy approaches. Bond refers to the social relationship between the therapist and patient, shaped by factors that either facilitate or hinder its development. Task represents the techniques employed by the therapist and the patient's roles and behaviors in therapy. Goal pertains to the desired outcomes of therapy and the collaborative efforts of both therapist and patient to achieve these objectives. According to Bordin (1979), these three components form an integrated whole that underpins the strength of the alliance, which is directly linked to the

therapist and patient's agreement on tasks and goals and the quality of their relationship.

Zetzel (1956) emphasized that the therapeutic alliance is the most critical factor for the success of psychiatric interventions. For the patient, the therapeutic alliance represents a secure and positive bond with the analyst, rooted in the individual's early developmental experiences. Establishing this secure relationship through the therapeutic alliance mirrors the process by which a caregiver instills a sense of trust and security in a child, making the relationship inherently healing. Through this bond, the therapist can effectively address the patient's needs. As the therapeutic alliance gained prominence, various psychotherapy disciplines sought to incorporate and adapt this concept. This recognition underscored the necessity of a transtheoretical approach to therapeutic alliance, establishing it as a pivotal parameter for effective psychotherapies.

In the 1970s, Luborsky and Bordin (1985) independently endeavored to conceptualize the therapeutic alliance within a transtheoretical framework (Luborsky et al., 1985). This approach proposed that the alliance develops in two stages: the first stage (type 1) emerges early in therapy, when the patient believes in the therapy's potential to help and perceives the therapist as supportive, warm, and nurturing. The second stage (type 2) arises in later phases, as the therapist and patient collaboratively work to address the patient's challenges and develop a shared sense of progress (Luborsky et al., 1985).

This transtheoretical conceptualization highlighted that the therapeutic alliance extends beyond psychodynamic therapies, encompassing various therapeutic modalities. Furthermore, it challenged the traditional dichotomy between technique and relationship factors, proposing instead that these elements are interdependent and integral to the therapeutic process. Safran and Muran (1996) expanded upon this model, suggesting that the therapeutic alliance is a negotiable and dynamic process, requiring continuous adjustment within the therapeutic relationship. Despite its transtheoretical nature, the therapeutic alliance is understood differently across approaches, with some emphasizing its centrality and even positioning it at the core of their work. Recent research confirms the strong relationship between therapeutic alliance and positive therapy outcomes. A meta-analysis by Flückiger et al. (2018) found a significant correlation between the therapeutic alliance and treatment outcomes, establishing it as one of the most consistent predictors of change in psychotherapy.

The therapeutic alliance is also influenced by attachment styles. Diener and Monroe (2011) found that individuals with secure attachment styles form therapeutic alliances more easily, whereas those with insecure attachment styles face challenges in collaborating with the therapist and agreeing on therapeutic goals. Similarly, the therapist's attachment style significantly impacts the quality of the alliance (Degnan et al., 2016). Moreover, research has shown that the therapeutic alliance affects not only psychotherapy outcomes but also responses to pharmacological treatments (Totura et al., 2018).

In the 1950s, the introduction of recording technologies in counseling sparked significant debates. Hans et al. (1977) argued for the importance of real therapy session materials in establishing a scientific foundation for psychotherapy practices. They advocated for the creation of audio and data archives to enable researchers to access and utilize these materials for further study. Hans's contributions to psychotherapy research earned him recognition as a pioneer in studying the "therapeutic process and change." His research focused on two main areas: the impact of patient-therapist relationship qualities on the potential for therapeutic change and strategies for therapists to establish effective relationships with challenging patients. In this context, Hans developed the "tripartite model of therapeutic change" (Hans et al., 1977). This model integrated seemingly conflicting findings, emphasizing that psychotherapy is fundamentally a human relationship rather than a medical intervention. From a contemporary perspective, this model still holds relevance, emphasizing the collaborative nature of therapy in achieving improved mental health outcomes.

FUNCTIONALITY OF PSYCHOTHERAPY AND IMPORTANCE OF THERAPEUTIC ALLIANCE

Discussions on the therapeutic alliance have brought to light critical questions about how psychotherapy provides benefits and how its outcomes can be objectively measured and demonstrated. While debates on the efficacy and differences of psychotherapy techniques persist (Stiles et al., 1986), post-Eysenck meta-analyses have demonstrated that psychotherapy is generally effective. However, considering that the efficacy does not vary significantly across different types of psychotherapy, the concept of "common factors" driving therapeutic success has gained prominence. Among these factors, the healing potential of the relationship between the patient and therapist is recognized as a cornerstone of the therapeutic process. It can be suggested that ongoing debates reflect the complexity of defining the therapeutic alliance and determining whether its effects on outcomes are direct or indirect.

Historically, the significance of the therapeutic relationship was first thoroughly explored by Freud (1912/1913) through the concept of transference. Freud argued that analyzing the transference dynamics between patient and therapist could yield therapeutic benefits. While positive transference was identified as a potent tool for facilitating recovery, negative transference was seen as a factor that could impede the therapeutic process. Over time, the concept of the therapeutic alliance has been examined through different theoretical lenses. Ego psychology shifted the focus from the therapeutic relationship to the concept of "alliance," emphasizing the therapist's efforts to interact effectively with the patient (Safran & Muran, 2000). In contrast, the British object relations theory framed the therapeutic relationship as the patient's ability to establish a positive and trust-based bond with the therapist.

Empirical studies consistently highlight the significant role of a strong therapeutic alliance in improving therapy outcomes and underline the critical role of the therapist-patient relationship in the therapeutic process. For instance, Zuroff and Blatt (2006) emphasized the positive impact of a strong alliance on therapy outcomes, while Barrett et al. (2007) linked a weak alliance to undesirable outcomes, such as therapy dropout.

The therapeutic alliance has also been identified as one of the most robust predictors of psychotherapy success across

various studies (Horvath & Greenberg, 1989; Flückiger et al., 2018). These studies demonstrate that the therapeutic alliance has a direct effect on the progress of therapy, with a universal validity across different therapeutic approaches. Notably, recognizing and addressing challenges within the therapeutic relationship in a timely manner can foster a stronger alliance, which, in turn, significantly contributes to meaningful changes in the patient's psychotherapy experience. In this regard, the therapeutic alliance is regarded as a pivotal factor for both the sustainability of the therapeutic process and the achievement of positive outcomes for the patient.

RUPTURES IN THERAPEUTIC ALLIANCE AND THERAPY DROP-OUT

The concept of rupture in the therapeutic alliance, while a relatively new term, has long been recognized for its importance in the psychotherapy process. In ego psychology, although not explicitly referred to as "rupture," it has been conceptualized similarly to "resistance," which disrupts the sustainability of the alliance. A strong therapeutic alliance is typically associated with positive treatment outcomes, whereas a weak alliance can lead to undesirable situations, such as premature termination of therapy. Recognizing and addressing issues that arise during the therapeutic process is therefore critical for maintaining the continuity of therapy. Swift and Greenberg (2012) emphasized that identifying, repairing, and managing moments of rupture in the therapeutic alliance is essential for ensuring the success of treatment.

Moments of strain or rupture in the therapist-patient relationship are common in therapy. During such instances, both parties may experience emotions such as anger, frustration, a sense of failure, or defensiveness. Ruptures can manifest dramatically or subtly, making them difficult to detect. Kohut (1971) defined ruptures as empathic failures, highlighting their potential to provide significant emotional experiences for the patient. Addressing and resolving these ruptures not only serves the therapeutic goals but also offers valuable insights into the patient's deeper personal or interpersonal conflicts.

Equally important to therapeutic ruptures is the issue of therapy dropout. Vogel et al. (2007) reported that the dropout rate for long-term therapies is as high as 62%, while for short-term therapies, it is approximately 32%. Preventing dropout requires therapists to anticipate potential ruptures and respond effectively. Suggested strategies include selecting appropriate patients, educating them about the duration and patterns of change expected in therapy, clearly defining roles within the therapeutic process, utilizing appointment reminders, and considering patient preferences. Additionally, fostering hope early in therapy, facilitating emotional expression, and engaging patients in discussions about the course of their treatment are critical steps in maintaining therapy continuity. Regularly evaluating the treatment process and addressing concerns collaboratively with the patient can also be effective in reducing dropout rates (Hatchett & Park, 2003; Ogrodniczuk et al., 2005; Swift & Greenberg, 2012).

Both therapeutic ruptures and therapy dropout present significant challenges in psychotherapy. However, with the right approaches and strategies, these issues can be mitigated. Effectively addressing ruptures and taking proactive measures to prevent dropout can contribute substantially to the successful continuation of the therapeutic process.

CAN THERAPEUTIC ALLIANCE BE MEASURED?

Various methods have been developed to evaluate therapeutic alliance, including qualitative, observation-based analyses and assessment tools that consider perspectives from patients, therapists, and independent observers. These tools enable a multidimensional examination of the therapeutic process, offering valuable insights into the dynamics of the alliance.

Several scales are widely used to assess therapeutic alliance. For instance, the Therapeutic Alliance Scale (Soygüt & Işıklı, 2008) and its shorter version, the Therapeutic Alliance Scale-Short Form (Gülüm, Uluç & Soygüt, 2018), are prominent instruments in this field. Additionally, the Penn Helping Alliance Questionnaire (Luborsky et al., 1985) provides a comprehensive framework for evaluating the therapeutic alliance between the patient and therapist. These tools contribute significantly to understanding the nature of the alliance and provide critical data for clinical practice.

Despite growing interest in the "therapeutic alliance" concept, several unresolved questions remain. These include: What defines therapeutic relationships and their ethical boundaries? What constitutes a therapeutic relationship versus what does not? How can unlimited relationships undermine professionalism? How should situations involving inadequate intervention, such as self-harm or involuntary hospitalization, be addressed? Furthermore, how should a therapist manage disclosing personal information or forming friendships with patients? Questions also arise regarding the therapeutic alliance in online therapy settings. Such issues often compel therapists to navigate multiple roles, adding complexity to their professional boundaries.

Additional inquiries focus on whether there are patients inherently more suited to collaboration in therapy or therapists better equipped to foster therapeutic alliances. Research indicates that therapists' attachment styles influence the patient's therapeutic alliance and directly impact the psychotherapy process. Consequently, therapists should be aware of their attachment styles, cultivate self-awareness, and reflect on how these factors manifest in therapy. Engaging in supervision can further enhance their growth in this area. Moreover, therapists must possess essential communication skills, such as active listening and empathy, to strengthen the alliance.

The therapeutic alliance is not confined to psychotherapy but is integral to all aspects of psychiatry and the broader physician-patient relationship. A strong alliance enhances treatment adherence, while a secure bond between the therapist and patient facilitates the achievement of therapeutic goals. However, maintaining ethical boundaries within the therapeutic relationship is critical. Violating these boundaries can lead to a loss of professionalism, ultimately compromising the therapeutic process and patient outcomes.

CONCLUSION

As a result, the therapeutic alliance has a historical importance in psychiatry, especially in the effectiveness of psychotherapies. The therapeutic alliance is a critical concept

that reflects the quality of the relationship between the patient and the therapist in the psychotherapy process and for many clinicians it is the main factor in the patient's recovery. While a strong alliance increases the success of the therapy, in cases of weak alliance, it is difficult to achieve therapeutic goals. Although different psychotherapy approaches position the concept of therapeutic alliance differently, in the future, in-depth exploration of the therapeutic alliance in different contexts and populations will contribute to the scientific knowledge in this field. The therapeutic alliance is a valuable concept not only in psychotherapy, but also in every field of psychiatry, and even wherever there is a physician-patient relationship.

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The authors have no conflicts of interest to declare.

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All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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