THE WORKING ALLIANCE: WHERE ARE WE AND WHERE SHOULD WE GO?

LOUIS G. CASTONGUAY
Penn State University

MICHAEL J. CONSTANTINO
University of Massachusetts at Amherst

MARTIN GROSSE HOLTFORTH
Penn State University and University of Bern

This article describes important findings that have emerged from decades of research on the working alliance, as well as some of the clinical implications of these findings. In addition, future directions of research on this construct are suggested. Our hope is that this article will provide useful heuristics for better understanding the alliance, the therapeutic relationship more broadly, and the process of therapeutic change in general.

Keywords: working alliance, psychotherapy, process of change

Theorists from different psychotherapeutic approaches have long recognized the client-therapist alliance as a crucial component of change. We venture to guess that there are no textbooks about psychotherapy published in the last ten years or so that have not referenced the alliance, and that most current treatment manuals emphasize its importance (including modalities that had not traditionally highlighted the patient-therapist relationship as a central change mechanism). Empirically, the alliance appears to be the most frequently studied process of change. One could also argue that, in addition to dominating process research, the alliance has crossed-over into the domain of outcome studies. In fact, we cannot imagine that a psychotherapy study in the near future (including clinical trials) would be funded without a measure of alliance included in its design. Clinically, the alliance occupies such an important place in our conceptualization of what good therapy entails that not paying attention to its quality during practice or supervision could be viewed as unethical.

By generating interest from so many perspectives, the alliance has provided an optimal venue for convergence between researchers and clinicians. As a case in point, the response of Division 29 (Psychotherapy) of the American Psychological Association to the empirically supported therapy movement (EST; Chambless & Ollendick, 2001) was to create a task force (Norcross, 2002) aimed at delineating and disseminating the empirical evidence supporting the role of the relationship in therapy, at the forefront of which has been the alliance. In essence, Division 29 (an organization recognized as an advocate of practitioners) has used research to lend credence to and to promulgate what most clinicians have always believed: The relationship matters! Such convergence of interest, as well as conciliation efforts, led us to recently label the alliance as the "flagship" of the scientist-practitioner model (Constantino, Castonguay, & Schut, 2002).

Consistent with the Division 29 task force, we view the alliance as a component of the therapeutic relationship, along (and more than likely in interaction) with a number of other interpersonal constructs (e.g., therapist empathy, positive regard, and congruence). We also argue that there

Louis G. Castonguay, Department of Psychology, Penn State University; Michael J. Constantino, Department of Psychology, University of Massachusetts at Amherst; Martin Grosse Holtforth, Department of Psychology, Penn State University and University of Bern.

Correspondence regarding this article should be addressed to Louis G. Castonguay, Department of Psychology, 308 Moore Building, Penn State University, University Park, PA 16802. E-mail: Lgc3@psu.edu

is an increasing consensus in the field with respect to the characteristics that define the alliance. As we wrote elsewhere, it "is generally agreed that the alliance represents interactive, collaborative elements of the relationship (i.e., therapist and client abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment" (Constantino et al., 2002; p. 86). With this definition in mind, the goals of the current paper are to describe briefly what we believe are the core empirical findings on the alliance to date, to discuss the most obvious clinical implications of such findings, and to highlight what we think are the most important directions for future research on this construct. We hope that our reflections lead to useful heuristics with respect to the alliance, the therapeutic relationship, and more generally to the process of change in psychotherapy.

What Do We Know?

1. Perhaps the most important finding that has emerged from a considerable number of studies is that the alliance correlates positively with therapeutic change across a variety of treatment modalities and clinical issues (Castonguay & Beutler, 2005a; Constantino et al., 2002). Based on multiple meta-analyses, the effect size for the alliance-outcome association ranges from .22 to .26 (see Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). Although the size of this relationship is not large, it appears to be robust. Furthermore, as Horvath and Bedi (2002) have argued, the effect size is substantial for a variable being measured within the complex entity of psychotherapy. Thus, it seems safe to assume that irrespective of the clinical problem or the treatment modality that therapists should strive to establish, monitor, and maintain a positive bond and a strong level of collaboration with their clients.

2. The empirical literature also seems to indicate that alliance quality correlates positively with some client characteristics and behaviors (e.g., psychological mindedness, expectation for change, quality of object relations) and negatively with others (e.g., avoidance, interpersonal difficulties, depressogenic cognitions; see Constantino et al., 2002). Furthermore, some of these associations tend to hold even when accounting for symptom change prior to when the alliance is measured, suggesting that the variance explained in the alliance is not solely due to symptomatic improvement (e.g., Connolly Gibbons et al., 2003; Constantino, Arnow, Blasey, & Agras, 2005). Clinically, these findings suggest that therapists may be able to forecast patients with whom they will have a more or less difficult time establishing and maintaining an alliance. In those instances where alliance quality is challenged, therapists should be prepared to address such relationship problems, as well as to modify their approach in order to be responsive to their clients' needs (Grosse Holtforth & Castonguay, 2005; Safran, Muran, Samstag, & Stevens, 2002).

3. Research also suggests that certain therapist characteristics and behaviors are positively associated with quality alliances (e.g., warmth, flexibility, accurate interpretation; see Ackerman & Hilsenroth, 2003). Certain therapist characteristics and behaviors may also contribute to alliance difficulties (e.g., rigidity, criticalness, inappropriate self-disclosure; see Ackerman & Hilsenroth, 2001). In a theoretically-driven study examining interpersonal history and in-session behavior, Henry, Strupp, Butler, Schacht, and Binder (1993) showed that therapists who are hostile toward themselves appear to be particularly at risk for counter-therapeutic interactions with their clients. Similarly, Rosenberger and Hayes (2002) examined in a single-case study how the alliance can be affected if the material discussed in the session touches the therapist's own unresolved issues. Based on qualitative analyses, a few studies have also suggested that when faced with alliance ruptures or therapeutic impasses, therapists' increased or rigid adherence to prescribed techniques or the therapeutic rationale may fail to repair such ruptures and may even exacerbate them (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Piper et al., 1999).

Although more studies need to be conducted before definite conclusions can reached, the above findings lend themselves to a number of suggestions. First, therapists may consider practicing the wise adage of "know thyself." If and when therapists begin to observe negative feelings or counterproductive states (e.g., boredom, frustration), it might be wise for them to adopt consciously and systematically Sullivan's stance of participant-observer (and perhaps to seek supervision) in order to minimize the probability of being hostile with their clients. Second, rather than persevering in their emphasis on specific

techniques or rationales when faced with alliance ruptures, therapists might consider using meta-communication skills described by Safran and his colleagues (Safran & Muran, 2000; Safran & Segal, 1990), as well as Burns (1990; e.g., invite the client to talk about alliance ruptures, explore the client's experience of the ruptures, recognize their own contribution to alliance difficulties). When used skillfully to address the various markers of alliance ruptures (see Safran, Crocker, McMain, & Murray, 1990), these metacommunicative interventions may not only improve the quality of the bond (e.g., helping the client to feel more understood and respected by the therapist), but also foster the collaborative engagement of both participants (e.g., agreeing on therapy tasks and goals that are more attuned with the client's needs, while remaining in sync with the therapist's conceptual and practical expertise). Although mostly preliminary, a few studies have begun to provide support for the use of these metacommunication skills (e.g., Castonguay et al., 2004; Safran et al., 2002).

4. Evidence also suggests that the alliance is particularly predictive of outcome when measured early in treatment. Furthermore, poor early alliance predicts client dropout (see Constantino et al., 2002). A clear implication of these findings is that therapists would be wise to pay attention to the alliance as soon as therapy begins. Rather than assuming that initial problems of collaboration or early signs of disengagement will automatically decrease with time, therapists should start fostering the alliance with the first minute of therapy and be prepared to address alliance ruptures at their first sign of emergence. However, therapists should not restrict their assessment of the alliance to the early phase of treatment. The mixed findings with regard to the mid-treatment alliance-outcome association, for instance, may be partly due to the fluctuating nature of some processes of change. For example, in a study by Stiles and colleagues (2004), brief V-shaped deflections in the alliance over time (interpreted as rupture-repair sequences) were associated with greater therapeutic gains. Such findings underscore the possible therapeutic benefits of alliance rupture-repair processes over the course of treatment (see Constantino et al., 2002; Safran et al., 2002).

5. As a consequence of the many years of research on the alliance, we now have a number of psychometrically sound instruments to mea-sure this construct from client, therapist, and observer perspectives (see Constantino et al., 2002; Horvath & Greenberg, 1994). While several of the alliance scales have been anchored within the psychodynamic tradition, at least one of them, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), has been developed from a transtheoretical perspective. Thus, the alliance can be measured in any form of therapy. Conceptually, one implication of the availability of such instruments is that the alliance can no longer be viewed as a "nonspecific" variable, i.e., a variable for which the nature and impact is not yet understood (see Castonguay, 1993; Castonguay & Grosse Holtforth, 2005). Contrary to the way relationship factors have been viewed for many years, the alliance has now been clearly operationalized. It is probably fair to say that it has been measured, in a reliable way, more frequently than many other process variables (including psychotherapy techniques). As mentioned earlier, we also know that the alliance predicts outcome, suggesting that it might have an impact on client improvement (although, as discussed later, the cause and effect relationship between alliance and outcome has not been firmly established). Thus, while the alliance can be viewed as a common factor, it is clearly not an undefined or non-specified one.

The most obvious clinical implication of having viable measures of alliance is that therapists should be using them–and they should especially ask their clients to fill them out! Although most therapists feel that they are generally able to judge accurately the quality of the relationship that they have with their clients, evidence suggests that client and therapist views of alliance diverge (especially during the early part of therapy, see Horvath & Bedi, 2002), and that the client's perspective tends to be more predictive of outcome (again, this is most pronounced early, see Horvath & Bedi, 2002). Thus, while we recommended earlier that we, as therapists, should know ourselves, we should also exercise caution about how much faith we put into our perception of what is going on in the therapy room. Although it may not provide them with the most accurate predictor of their clients' final outcome, therapists are nevertheless likely to benefit from completing alliance measures. Discrepancies between their own evaluation of the alliance and that of a client, for instance, may reflect an alliance rupture that should be addressed, but could

otherwise go unnoticed. Furthermore, there is some evidence that similarity between client and therapist alliance ratings at the middle and late phases of treatment is positively linked with outcome (see Horvath & Bedi, 2002).

What Do We Need to Know?

1. Although the alliance has been linked with outcome, the causal direction (if any) of this relationship has not been clearly established. The fact that the alliance measured early in treatment is a strong predictor of post-therapy change increases the likelihood that its quality precedes, rather than follows, substantial improvement. Moreover, some studies have found that the alliance predicts outcome when controlling for previous change (e.g., Barber, Connolly Gibbons, Crits-Cristoph, Gladis, & Siqueland, 2000; Klein et al., 2003), further suggesting that the alliance-outcome association is not just an artifact of clients getting better over time. In other studies, however, the alliance has failed to correlate significantly with outcome when accounting statistically for prior symptom change (e.g., DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Gaston, Marmar, Gallagher, & Thompson, 1991).

More studies are needed to clarify this issue. One recently emerging direction is to examine the alliance within mediational models that approximate causal pathways by virtue of temporal precedence within prospective treatment designs. For example, analyzing data from the Treatment of Depression Collaborative Research Program (TDCRP; Elkin, 1994), Meyer and colleagues (2002) found that the alliance mediated a previously established positive relationship between clients' pretreatment expectations for change and treatment outcome. Hardy and colleagues (2001), in a study of cognitive therapy for depression, found that the relationship between clients' underinvolved style and outcome was mediated through the therapeutic alliance. Thus, some research has begun to address the issue of the direction and nature of the alliance's impact on the process and outcome of treatment. It is probable, however, that if and when a resolution is achieved, the consensus will be more complex than an "either/or" type of answer. The process of change, in our view, involves interdependent, non-orthogonal, and/or synergistic relationships between different variables.

2. In addition to clarifying the relationships among alliance, improvement, and outcome, it seems important to add more theoretically-based explanations to alliance-outcome linkages. Presently, there is a dearth of such hypotheses, which may be an outgrowth of the field's quest to define the alliance pantheoretically. As Horvath (2005) has argued, there needs to be heightened theoretical discourse and debate around the construct of the patient-therapist relationship. Hilliard, Henry, and Strupp (2000) provided one good example of an alliance study that placed the hypotheses, measures, and findings within a specific (psychodynamically-oriented) theoretical framework that involved early interpersonal histories, the quality of the therapeutic alliance during therapy, and treatment outcome. The authors found that the early interpersonal histories of both the clients and therapists had various types of direct or indirect influences on the process and outcome of treatment. More work of this nature is needed, perhaps by using more theoretically specific measures to complement the use of pantheoretical ones.

3. Grawe (1997) has argued that a particularly fruitful way to improve the outcome of effective treatments is to derive mechanisms of change from process research and use them to modify therapeutic procedures. Because the alliance is arguably the most robust predictor of change, training therapists on how to foster the alliance, as well as how to negotiate any emergent alliance problems is likely to be the first and most logical step to follow in order to test this research strategy. Several studies have examined the effectiveness of implementing techniques specifically designed to foster the alliance (Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005; Grawe, Caspar, & Ambühl, 1990) and to address alliance ruptures (Castonguay et al., 2004; Safran et al., 2002; Whipple et al., 2003). While the preliminary findings are promising, we need more convincing evidence, in both efficacy and effectiveness studies, that such techniques have direct, unique, and causal effects on improvement.

Of course to test rupture-repair strategies, you need to be able to detect the alliance problems! In this regard, Safran and colleagues (Safran et al, 1990; Safran & Muran, 1996; Safran et al., 2002; Samstag, Muran, & Safran; 2004) have delineated useful markers, including those characterized predominately by withdrawal (e.g., client avoidance maneuvers) or confrontation (e.g., dis-

agreement between client and therapist on the goals of treatment). These markers deserve more empirical attention in order to firmly establish their validity, as well as to determine whether some of them are more prevalent with certain types of clients, or whether some others are more likely to emerge in specific contexts.

In our opinion, one rupture marker that should receive particular attention is client anger or hostility toward the therapist. The difficulty of dealing therapeutically with such powerful and negative reactions has been addressed by expert psychodynamic and cognitive therapists (Binder & Strupp, 1997; Burns, 1990; Newman, 1997). Recent empirical findings have provided useful heuristics for how therapists can effectively address this issue. For example, Dalenberg (2004) found that clients who completed long-term trauma therapies reported more satisfaction with therapists who were perceived as being more self-disclosing in response to anger as opposed to therapists who maintained a "blank screen" in the face of anger. Hill and colleagues (2003) found that several therapist factors were associated with the effective resolution of hostile anger events, including genuinely expressing their own feelings of annoyance and frustration with the client, as opposed to turning their feelings inward. While more research is needed in this respect, we are convinced that trying to match specific interventions to significant in-session events such as anger (as opposed to matching theoretical orientation to client diagnosis) is likely to enhance significantly our understanding of the process of change, as well as to make research efforts more meaningful and relevant to practitioners.

4. Although substantial evidence points to the importance of a good alliance for treatment success, we need to have a better understanding of how it develops. This is a particularly crucial issue for training. While neophyte therapists are constantly reminded of the need to establish good rapport with their clients, there are few empirically based strategies to guide this essential work. Although there is preliminary evidence that therapists who undergo structured psychotherapy training establish better alliances than therapists with unstructured training (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002), more research is needed to determine the impact of specific alliance-fostering guidelines defined both within and across therapy approaches.

In our efforts to better understand how the alliance develops, it might be wise to pay particular attention to its very first step. It has been argued that the early alliance may distinguish itself from later alliance in terms of the impact, manifestations, and sources of alliance ruptures that tend to occur (Maramba & Castonguay, 2004). Furthermore, a number of clients' nondiagnostic characteristics (a focus of the aforementioned Division 29 Task Force) may influence their capacity to develop a collaborative engagement with and/or to form a positive attachment to the therapist early in treatment. For example, recent evidence suggests that clients' inherent self-verification strivings (Constantino et al., 2005) or avoidance motivations (Grosse Holtforth et al., 2005) may impact early alliance development.

Perhaps one route to better understanding alliance development, maintenance, and negotiation is to study expert therapists to determine, for example, how they first establish a good alliance, the flow that the alliance tends to take during the course of their treatment with responsive and less responsive clients, how they attempt (successfully and unsuccessfully) to repair breaches of alliance, how they find balance (to use Linehan's, 1993, eloquent words) between the skillful use of techniques and the provision of therapeutic acceptance and support, and how they address all of these complex issues with different type of clients.

5. Related to the previous point, more research is also needed on the developmental patterns of alliance during the course of treatment. Some evidence suggests that different patterns of alliance development (linear, quadratic, brief V-shape deflections) may be linked with positive outcome (Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997; Stiles et al., 2004; Tracey & Ray, 1984). However, the findings have demonstrated some inconsistency and, thus, more studies are needed for definite conclusions to be reached about such dynamic patterns. These studies would provide useful information to clinicians who could use different types of alliance patterns as feedback on the progress of therapy. For example, if a quadratic (or U–shape) pattern does appear to be a reliable indicator of treatment responsiveness for some clients, then a decrease of alliance scores after initially high scores need not be viewed as an alarming sign. Instead, it may reflect that things have to get worse before they get better. Reliable

findings from such studies may in turn generate both quantitative and qualitative investigations in order to determine if and how differential patterns of development of alliance may be a cause, an effect, or a manifestation of improvement.

Additional research should also be conducted on the effect of tracking and responding to alliance patterns during therapy. In an innovative study, Whipple et al. (2003) examined the impact on treatment duration and client outcome of providing therapists with feedback on various patient-rated dimensions (including the quality of the alliance) and recommending clinical strategies (Clinical Support Tools [CST]) to address any deficiencies. Compared to a no-feedback, treatment-as-usual control group, clients in the feedback plus CST group attended more sessions, achieved higher recovery rates, and demonstrated less deterioration. These promising findings should generate further studies on the effect of helping therapists to monitor and to react therapeutically to alliance fluctuations.

6. We also believe that when investigating each of the issues and questions raised above, the field should pay attention to specific populations of clients and therapists. In particular, more research needs to be conducted with minority clients. For example, it seems important to identify culture-specific markers of alliance rupture, which may or may not resemble the markers more generally defined and discussed above (see Constantino & Wilson, in press). Furthermore, while there is a small literature that suggests that ethnic minority clients are more likely to prematurely terminate therapy (when being treated by Caucasian therapists [Reis & Brown, 1999]), the reasons for this phenomenon are not well known. It is possible that the link between ethnicity and dropout is mediated by alliance quality. What is clear is that much more research is needed to flesh out the relationships between minority status, therapeutic interventions, alliance negotiation, and outcome.

We should also conduct more alliance research with personality disorders (Bender, 2005). Studies with personality-disordered clients have suggested that the alliance is linked with outcome, and that alliance repair techniques appear to be promising (Smith, Barrett, Benjamin, & Barber, 2005). Many questions, however, remained largely unexplored. For example, do different types of alliance ruptures and alliance patterns tend to emerge for different types of personality

disorders? Are different strategies of interventions required for different personality disorders with regard to the establishment and repair of the alliance?

It also seems important to determine the type of clients for whom the addition of alliance repair techniques might not be necessary or not sufficient to improve the effectiveness of therapy. Given that a substantial number of clients benefit from treatment protocols that do not explicitly prescribe alliance repair interventions, the addition of such interventions may not show significant incremental change for these clients. Furthermore, alliance ruptures may not be the reason (or at least not the only one) for which some individuals fail to respond to empirically supported treatments. With such clients, alliance ruptures, if and when they emerge, may be a reflection of other issues or may simply be less important than other treatment difficulties. For example, the recognition of empathic failure may not add much to a therapist's effectiveness when treating a person with substance abuse who is not willing to change his/her drinking behavior.

In contrast, the addition of alliance repair techniques might be particularly beneficial for some individuals. For example, cognitive behavior therapists treating depressed clients with high levels of reactance (i.e., reluctance to being controlled by others) should be aware that directive treatments do not fair well with these clients (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2005). However, it is possible that reactant clients might still benefit from cognitive behavioral therapy if it is used by a therapist mindful of and ready to deal with clients' potential negative reactions to perceptions of being controlled (see Castonguay, 2000; Goldfried & Castonguay, 1993). Alliance repair techniques may also be particularly beneficial with clients with moderate problems of attachment or interpersonal relationships. These strategies may pave the way for corrective relational experiences and the disconfirmation of cyclical maladaptive patterns.

Conclusion

We believe that after several decades of process and outcome research, relationship variables have reached a new, more balanced status in the field of psychotherapy. Although the current empirical evidence cannot support Rogers's (1957) hypothesis that specific interpersonal conditions

are sufficient for change, research on alliance, in particular, has clearly demonstrated that the therapeutic relationship cannot be viewed as a non-specific variable that is merely auxiliary to other active components of treatment. This balanced view is also indicated by the evidence supporting the role that other factors play on clients' change, such as techniques and participant pre-therapy characteristics (see Castonguay & Beutler, 2005b). Hence, it is time to recognize that the complexity of the process of change is not reflected by a sole emphasis on relationship variables, such as the alliance, or any other types of therapeutic factors. Instead, we need to recognize that a variety of elements play an important role, and that these factors are in constant interaction with each other (Castonguay & Beutler, 2005a). Our quest to better understand the principles of change embedded in these interrelated processes remains paramount.

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