CHAPTER 8

The Therapeutic Alliance in Cognitive-Behavioral Therapy

Louis G. Castonguay
Michael J. Constantino
Andrew A. McAleavey
Marvin R. Goldfried

The nature and role of the therapeutic relationship in cognitive and behavioral therapies (CBTs) has long been discussed and debated. Although cognitive-behavioral therapists have from the beginning recognized the importance of the therapeutic relationship in the change process, it has only relatively recently been given considerable attention in the CBT research literature as the operationalized construct of the alliance. Although its conceptual roots are in psychodynamic therapy, the alliance is now considered an integral part of virtually all psychotherapies, including CBTs. Presently commonly viewed as a transtheoretical common factor, the alliance has been deemed "the quintessential integrative variable" (Wolfe & Goldfried, 1988). While controversy continues to exist, especially as to whether or not the alliance contributes causally to symptomatic outcomes (cf. Barber, 2009; Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Crits-Christoph, Connolly Gibbons, & Hearon, 2006; DeRubeis, Brotman, & Gibbons, 2005), the alliance has risen to prominence in empirical, theoretical, and clinical writing. The primary purpose of this chapter is to explore

the evolution of the alliance construct and its determinants in the CBT literature.

CBTs (and treatments heavily influenced by these approaches) focus on the direct reduction of psychopathological symptoms and ascribe to the belief that therapy should (and good therapy does) provide clients with coping skills with which they can approach their daily lives in the absence of a therapist (Barber & DeRubeis, 1989; Castonguay, Newman, Borkovec, Grosse Holtforth, & Maramba, 2005). CBTs have been developed for numerous disorders including, but not limited to, depression, phobias, panic disorder and agoraphobia, posttraumatic stress disorder, social anxiety disorder, obsessive–compulsive disorder, bipolar disorder, eating disorders, borderline personality disorder, and substance abuse (see Barlow, 2008). Moreover, cognitive and behavioral therapies have become very popular theoretical orientations among practicing clinicians (Norcross, Karpiak, & Santoro, 2005). Many CBTs are empirically supported (Nathan & Gorman, 2002), reflecting the epistemological outlook and historical strength of CBTs in establishing, relying on, and encouraging scientific research.

Interestingly, it may be that CBTs' foundation on learning and conditioning is the main reason why the therapeutic relationship went for years as an underrecognized factor in most of these treatments. Although the pioneers of behavior therapy highlighted the importance of the relationship, many described it as strictly context for learning to take place. As Wilson and Evans (1977) postulated, "'Relationship' is not easily defined operationally, unlike contingencies of social attention. Not only could these social contingencies be defined and measured, but they could also be altered, and with them the client's behavior" (p. 545). In this paradigm, it makes sense that CBT techniques have historically received the bulk of attention, considering it took time to operationalize the relationship and to subject it to experimental manipulation. Once empirical evidence supported the operationalization and valid measurement of the relationship as well as its correlation with outcome in CBTs, proponents of this approach have more readily accepted the alliance as a *potentially* potent treatment factor in its own right.

In the remaining pages, we explore the historical, theoretical, and empirical treatment of the alliance within CBTs. First, we describe what can be considered the "traditional" behavioral, cognitive, and cognitive-behavioral approach to the relationship: those qualities of the relationship put forth by CBT pioneers such as Wolpe, Goldfried and Davison, Wilson, and Beck that distinguish a CBT relationship from other therapies. Next, we explore the ways in which CBTs have fostered and maintained this orientation-specific ideal relationship. Then we will examine several pieces of empirical evidence regarding the role of the alliance in CBTs as it is practiced and offer some

conclusions regarding the way CBTs actually make use of the relationship. Finally, we examine how developments within CBTs led to different ways to conceptualize and use the alliance.

NATURE AND FUNCTION OF THE ALLIANCE IN CBTs

When behavior therapy was developing during the 1950s and '60s, there was little empirical support for the effectiveness of relationship variables outside of the Rogerian constructs of therapist empathy, warmth, and genuineness (Rogers, 1951, 1957). However, given the substantial influence of Rogers's work, early behaviorally oriented theorists noted the clinical importance of such relational qualities even in behavior therapy, often directly crediting these contributions to other orientations. Wolpe (1958), for instance, noted that many of his clients who appeared to like him early in treatment showed noticeable improvement before specific treatment methods were used.

Later, Goldfried and Davison (1976), in one of the first full chapters devoted to the therapeutic relationship from a CBT perspective, made the bold statement "Any behavior therapist who maintains that principles of learning and social influence are all one needs to know in order to bring about behavior change is out of contact with clinical reality" (p. 55), going on to state that "the truly skillful behavior therapist … interacts in a warm and empathic manner with his client" (p. 56). Similarly, Brady suggested that the therapist should seek to be perceived as an "honest, trustworthy, and decent human being with good social and ethical values" (Brady et al., 1980). Beck, Rush, Shaw, and Emery (1979), in describing a cognitive approach to therapy, also emphasized the similarity between orientations, noting that "cognitive and behavior therapies probably require the same subtle therapeutic atmosphere that has been described explicitly in the context of psychodynamic therapy" (p. 50). Further, they went on to discuss warmth, accurate empathy, and genuineness as important characteristics of cognitive and behavioral therapists.

The statements and quotes above are characteristic of the way that the relationship was treated by behavior therapists early on (and often currently as well): brief descriptions of warm relationships without explicit elaboration or specification. Such unelaborated descriptions are likely attributable to the fact that CBTs historically considered the alliance to be a "nonspecific" variable, that is, a nontechnical, noninstrumental, and essentially interpersonal factor that is auxiliary to the specific variables (technical procedures) that actually produce change (Castonguay, 1993). Wolpe and Lazarus (1966) famously concluded that a client's positive emotional reaction toward a therapist would engender "nonspecific reciprocal inhibition,"

meaning that the presence of the therapist reduces anxiety and therefore facilitates the aim of specific desensitization through behavioral techniques. Nonspecific factors, historically including the placebo effect, demand characteristics, suggestion, empathy, expectation, and rapport, were treated for some time in the literature as undefined (and possibly indefinable) variables in therapy, with effects that are assumed to be good, yet somehow tangential to therapy.

However, in keeping with the epistemological foundation of CBT, Wilson and Evans (1977) attempted to specify and observe the constituents of the therapeutic relationship. Drawing on Bandura's (1969) social cognitive theory, they offered a nuanced and advanced operationalization of the relationship in behavior therapy. As these authors wrote:

> Social influence processes such as persuasion, expectancy, attitude change, and interpersonal attraction are integral features of behavior modification thus conceived. Within this expanded context, the reciprocal influence processes which define the therapist–client relationship are viewed as being of the utmost importance to the understanding and effective use of behavioral treatment methods. (Wilson & Evans, 1977, p. 546)

These authors suggested that the relationship is not a diffuse effect but rather an amalgam of many different factors that are endemic to social learning theory. To Wilson and Evans, the relationship provides social reinforcement, elicits client behavior in session, increases therapist influence by improving client attraction to the therapist, allows the therapist to serve as a role model, and fosters therapeutic expectancies.

Thus, CBTs have a long history of recognizing relationship variables as significant contributors to the therapeutic process, generally in the same ways that other orientations defined the relationship. Of course, the alliance in CBTs is different (at least theoretically) in some ways from the types of alliances formed in other orientations. The primary distinction is that a CBT alliance emphasizes collaboration and teamwork more than most other therapies do—especially those that are less directive (Raue & Goldfried, 1994). The model of "collaborative empiricism" has emerged primarily from (Beck et al., 1979, p. 6) and continues to be central to cognitive therapy (e.g., Young, Rygh, Weinberger, & Beck, 2008), with proponents of recent behavioral therapies (e.g., Dimidjian, Martell, Addis, & Herman-Dunn, 2008) and CBTs (e.g., Fairburn, Cooper, Shafran, & Wilson, 2008; Turk, Heimberg, & Magee, 2008) using the construct of a collaborative relationship extensively. In a collaborative relationship, clients and therapists work together to identify the central problems clients face and to identify possible solutions. While all therapists seek to iden-

tify central client problems, a sense of collaboration is eschewed in some treatments. For example, from their Gestalt therapy perspective, Perls, Hefferline, and Goodman (1977) tellingly state, "We employ a method of argument that at first sight may seem unfair, but that is unavoidable" (p. 286). In client-centered therapy, the power for change is theoretically deferred to the client (Rogers, 1951). In contrast, when describing empiricism (which seeks to move past distorted perception and toward verifiable observation), Beck et al. (1979) used the analogy of two scientists who must work together, one providing the "raw data" and the other guiding the research questions.

Another important difference in the way CBTs and other orientations have treated the alliance underscores the role that this treatment factor is assumed to play in the change process. Specifically, as with many directive therapies, CBTs are primarily concerned with orientation-specific techniques that can demonstrably produce change on their own. Therefore, the alliance has typically been treated as a factor that facilitates the use of and adherence to specific techniques not as a change mechanism itself. That is, the main purpose of the therapeutic relationship is to foster engagement in the specific techniques of therapy, and a collaborative relationship is ideally suited for this purpose. Simply put, cognitive and behavioral therapists have generally seen the alliance as a necessary, but not sufficient, therapeutic change factor (Beck et al., 1979; DeRubeis et al., 2005; Friedberg & Gorman, 2007; Wolpe & Lazarus, 1966).

Raue and Goldfried (1994) used a particularly evocative metaphor illustrating this stance:

> From a cognitive-behavioral vantage point, the alliance plays an important role in the change process in much the same way that anesthesia is needed during surgery. The implementation of certain surgical procedures requires an adequate and appropriate level of anesthesia. Great care is taken to ensure that an effective anesthesia is in place before surgery begins. Once surgery is underway, the primary concern is with the effective implementation of the surgical procedures—the primary reason the patient entered the treatment setting. (p. 135)

Just as the anesthetic is not necessarily valuable in and of itself, but because it allows the surgeon to perform complex procedures that directly improve the patient's health, the alliance allows the therapist's use of CBT technical interventions (e.g., identifying automatic thoughts, searching for alternative attributions, systematic desensitization). Linehan (1993) has echoed this sentiment in a more modern CBT treatment (dialectical-behavioral therapy; DBT): "Not much in DBT can be done before [a strong positive] relationship is developed" (p. 98; also see further discussion of the relationship in DBT below).

DEVELOPING AND MAINTAINING A THERAPEUTIC ALLIANCE: GOALS AND TECHNIQUES IN CBT

As summarized above, there are essentially two reasons that CBT therapists seek to have a good relationship with their clients. First, a strong relationship is indirectly beneficial by providing a facilitative context for the specific techniques, and, second, the relationship can be used more or less directly as a vehicle for promoting therapeutic learning, such as by providing empathic responding as a social reinforcer (Krasner, 1962). These two basic functions have led to developing methods that should foster a strong alliance.

Beck et al. (1979), echoing earlier calls from behavior therapy (e.g., Goldfried & Davison, 1976), emphasized relationship variables such as basic trust and rapport, which are now widely valued in CBTs. Basic trust requires that the client have faith in the therapist acting in his or her best interest. Rapport is defined as an interactive experience between therapist and client involving a secure, comfortable, sensitive, and empathic exchange. It has been said that certain populations and treatments may differentially require trust and rapport to be successful. For instance, in working with trauma victims, Hembree, Rauch, and Foa (2003) have noted that trust is an absolutely essential element of the therapeutic relationship in prolonged exposure (PE) therapy, because of the difficult and distressing nature of the PE process. Linehan (1993) suggested that a good relationship, which is high in rapport, is essential to treating clients with borderline personality disorder because these individuals may be unable to fully utilize any other form of reinforcement to change behavior.

Moreover, Beck et al. (1979) argued that the use of CBT techniques in a collaborative manner is in itself relationship building and good for treatment. The main goal of using specific CBT techniques in a collaborative way is to increase client expectancies of succeeding in behavior change. To this end, several authors (e.g., Goldfried & Davison, 1976; Wilson & Evans, 1977) have advanced the importance of the therapist clearly explaining the treatment rationale, structure, and case conceptualization in order to demonstrate an understanding of the client's problems and how they link with plausible solutions. In a sense, what these authors have suggested (and what clinical experience often bears out) is that by focusing on the tasks and goals of therapy and by using the CBT techniques that are designed to produce change, the therapist can develop a sound working alliance without spending valuable time in session explicitly devoted to "just" the relationship. These relationship variables may be seen as direct manipulating several common factors of treatment—particularly Frank's (1961) suggestion

about providing a "myth" that links the cause of a problem and a possible solution—as well as encouraging clients' expectations of change.

As in any other form of psychotherapy, problems in developing or maintaining an alliance occur in CBTs. Such alliance ruptures can occur in many forms and degrees of severity. For example, clients may lack trust in the therapist, may fail to attend sessions regularly, may outright argue or disagree with the therapist, and so on (see Samstag, Safran, & Muran, 2004). Many traditional views (such as Beck et al., 1979; Goldfried & Davison, 1976) on relationship problems in CBTs entail essentially two options, both of which assume that the problem can best be addressed by focusing on the client's problems: first, try to identify the client's symptoms (e.g., maladaptive automatic thoughts or avoidance patterns) that are contributing to the impasse, and work directly on those by using the typical CBT techniques; second, attempt to reengage the client in treatment by directly manipulating his or her expectancies for treatment success. The latter option is primarily achieved in CBT by reiterating the rationale of the approach, providing realistic time courses for therapy gains, and challenging the client's expectations with rational collaborative empiricism. These traditional approaches to problems with the relationship remain popular in the CBT literature (e.g., J. S. Beck, 1995). It has also been noted that problems in therapy may arise not owing to client factors but to therapist or technique factors (such as improper diagnosis or conceptualization, unskilled application of therapeutic procedures, etc.). As discussed below, cognitive and behavioral therapists have often been encouraged to reconsider their case formulations and assumptions about the client when therapeutic alliance breaks occur (e.g., Goldfried & Davison, 1976; Persons, 1989). Thus, the standard techniques of CBT can be used to address the relationship directly and have been used in this way for many years.

EMPIRICAL EVIDENCE FOR THE ALLIANCE IN CBTs

As described above, the relationship in CBTs has often been conceptualized as a secondary factor contributing to therapeutic change by increasing social influence, instilling hope for change in the client, and providing a context within which to make use of techniques. Underscoring the ameliorative primacy of techniques, some CBT clinicians have endorsed a view of the alliance as a *consequence* of good therapeutic technique rather than a constituent of productive therapeutic process (e.g., DeRubeis et al., 2005). However, from the beginning, evidence has suggested that the therapeutic relationship may be used in different ways and have more power to create change than the historical CBT theories suggest.

Breger and McGhaugh (1965) offered a detailed analysis of therapist-

reported case studies in behavioral treatments, finding many more similarities between behavioral and psychodynamic therapy than were typically acknowledged at the time. Relationship variables were among those prominently observed in the behavioral therapies, including clients' emotional attachment to therapists and therapist empathy. Observations like these have been fairly common over the years. For instance, Brown (1967) published a detailed description of J. Wolpe's therapeutic practice following 2 years of direct observation. Brown's description included a number of therapist–client relationship variables and client cognitions that were not highlighted in systematic desensitization theory, and Brown suggested that these may act as important mediators of the change process. As Brown noted: "The behavior therapy of Joseph Wolpe is a multifaceted therapeutic tool consisting of his personality, his rapport with his patients, his skilled verbal responses, and his specific behavior techniques. To concentrate on the last factor alone produces a disturbing bias" (p. 857).

Klein, Dittmann, Parloff, and Gill (1969), with the cooperation of Wolpe and Lazarus, conducted a similar clinical observation study and concluded that the therapeutic relationship in behavioral therapy directly increases client expectancies and motivation for treatment, beyond the traditional stance of behavior therapists. Marmor (1971) examined the relationship factors present in three major behavioral therapy approaches of the time (including systematic desensitization, aversive conditioning of homosexuality, and Masters and Johnson's techniques for sexual impotence and frigidity), in each case highlighting infrequently noticed aspects of the relationships that may well have been operative in producing therapeutic change.

Since these initial clinical observations, there have been numerous studies comparing relationship variables among orientations. Much of this literature has been reviewed elsewhere (see Lejuez, Hopko, Levine, Gholkar, & Collins, 2006; Morris & Magrath, 1983; Raue & Goldfried, 1994; Waddington, 2002; Wright & Davis, 1994); so, we instead discuss only selected works here. In a classic study, Sloane, Staples, Cristol, Yorkston, and Whipple (1975) found that behavior therapists displayed significantly more empathy, genuineness, and interpersonal contact, as well as comparable warmth, than did psychoanalysts. This finding, obviously counter to the idea of behavior therapists as simply dry conduits for techniques, was highly unexpected, though these differences in ratings were not associated with outcome. Brunink and Schroeder (1979) studied verbal utterances of expert therapists in psychoanalytic, Gestalt, and behavioral therapies, finding no differences in empathy, rapport, or structure of the session. Notably, however, behavior therapists were more supportive than the other therapists, likely a result of their emphasis on positive reinforcement.

Raue and colleagues (Raue, Castonguay, & Goldfried, 1993; Raue,

Putterman, Goldfried, & Wolitzky, 1995) conducted two studies on psychodynamic-interpersonal therapy and CBTs. In the first study using CBT-trained coders, the authors found that CBT therapists were rated as significantly higher on the alliance measure than psychodynamic therapists (Raue et al., 1993). However, repeating the study with psychodynamically trained coders yielded different results: not only did the psychodynamic coders rate the alliances universally lower than the CBT coders, but also they did not find any difference in alliance quality according to therapy type (Raue et al., 1995). While there are many possible explanations for these conflicting findings, they (as well as others, e.g., McMain, Guimond, Links, & Burckell, 2009; Salvio, Beutler, Wood, & Engle, 1992) nevertheless suggest that CBT-oriented therapists can be rated as high or higher than therapists in other orientations on alliance scores.

Along with such observational evidence, phenomenologically both patients and therapists report that the relationship is one of the most important factors influencing therapy success and failure in cognitive therapies, behavioral therapies, and CBTs. For example, in a study of behavioral therapy, Ryan and Gizynski (1971) found that the proportion of behavioral therapy techniques used did not correlate with outcome judgments by clients, therapists, or experimenters. Further, therapists emphasizing techniques during treatment was correlated with client reports indicating less liking of the therapist, viewing the therapist as less competent, and experiencing the techniques as less pleasant.

In contrast, a number of studies during the 1970s that used retrospective self-reports of clients in behavioral therapies suggested that clients believe relationship factors play a key role in these treatments. In the Sloane et al. study (1975) introduced above, the authors found that successful patients of both behavioral therapy and psychodynamically oriented therapy identified many of the same factors as being most important to their treatment. Nearly all of these factors were closely related to relationship variables such as encouragement and reassurance. Mathews et al. (1976) found that agoraphobic patients in behavioral therapy rated therapist encouragement and sympathy as being more important to the success of their treatment than such factors as behavioral practice and learning to cope with panic. Rabavilas, Boulougouris, and Perissaki (1979) found that at 1 year posttreatment, client reports of therapists' understanding, interest, and respect all correlated positively with outcome among phobic and obsessive–compulsive patients of flooding techniques. Studies like these suggested what was already known in other psychotherapies (e.g., Feifel & Eells, 1963), namely, that clients in behavioral therapy consistently report relationship variables as central processes in producing therapeutic gains while therapists frequently put less emphasis on the same variables.

Such self-report studies, though obviously limited, provided consistent

support for a link between relationship variables (broadly defined) and outcome in psychotherapy in general and CBTs in particular. In an attempt to further substantiate this link, Persons and Burns (1985) studied single sessions of cognitive therapy to uncover the relative contributions of cognitive change in session and relationship variables on mood change. The authors found that client-reported relationship quality and changes in the strength of automatic thoughts (a specific mechanism of change in this orientation) made independent contributions to mood changes from pre- to postsession. That is, relationship quality explained additional variance of change in mood over and above change in automatic thoughts. The authors suggested that "training therapists to handle interpersonal issues skillfully is as important in cognitive therapy as in any other form of psychological or medical treatment" (p. 548).

Similarly, Burns and Nolen-Hoeksema (1992) investigated therapist empathy and symptom severity in CBTs for depression. The authors found that not only did therapist empathy have a substantial effect on depression when controlling for homework compliance (which also showed an effect on depression scores), but also the corresponding effect of depression change on empathy ratings was small by comparison. This study was among the first to attempt to separate the effects of therapeutic relationship on symptom outcome from the reciprocal effect of symptomatic improvement on relationship quality ratings in any orientation. While this does not definitively establish the direction of causality, it provides support for the notion of the alliance as an important piece of the therapy process in CBTs.

Further correlational studies on relationship variables and outcome in CBTs are numerous and have been detailed elsewhere (see Waddington, 2002). While some studies have failed to find a positive correlation between outcome and relationship factors (notably DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999), the majority have (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Muran et al., 1995; Raue, Goldfried, & Barkham, 1997; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998).

While these findings are all suggestive (as correlational studies cannot truly answer questions of causality), researchers have been attempting for years to address these questions with rigorously controlled experimental studies. Morris and Suckerman (1974) conducted an experimental study in which they compared the effects of automated systematic desensitization when delivered in a warm versus cold manner. This study found that not only did participants in the warm condition show better outcomes, but also participants in the cold therapist condition were not significantly improved at posttreatment as compared to a no-treatment control. Though perhaps using relatively crude methodology, this study highlights the potential role of relationship factors even in such well-developed behavioral techniques

as systematic desensitization. It should be noted that Morris and Magrath (1983), however, found that a colder therapist had better outcomes than a warm therapist in using contact desensitization, and other studies on balance have been inconclusive, some finding clear support for warmth in CBT and others, especially earlier studies, finding the opposite. The reasons for this inconsistency (especially in the early years of CBTs) may be related to the specific behavioral techniques implemented, study design, population sampled, or many other factors (see Morris & Magrath, 1983, for further discussion). Generally speaking, however, therapist warmth and empathy are empirically supported as facilitative variables in most contemporary therapies (see Burns & Auerbach, 1996; Castonguay & Beutler, 2005).

The alliance, of course, is only one possible mechanism for change in CBTs, and research into other mechanisms has been prominent as well. A number of studies have suggested that specific techniques prescribed in cognitive therapies (e.g., homework) are predictive of outcome (e.g., Burns & Spangler, 2000; DeRubeis & Feeley, 1990). Yet, over the past several years, evidence has emerged that suggests that the orientation-specific techniques of any psychotherapy, including CBTs, account for a much smaller percentage of outcome variance than initially thought. For instance, Ilardi and Craighead (1994) reviewed the temporal sequencing of symptomatic changes in cognitive therapy for depression and concluded that much of the therapeutic effect is achieved prior to the introduction of cognitive restructuring techniques, suggesting that these technical variables cannot account for the changes nearly so well as "nonspecific" factors.

Taking all of this evidence (and more) into account, several authors have developed theoretical extensions of CBTs, which may help account for the rather large role that the therapeutic relationship, and the alliance in particular, appears to play in these treatments. We now turn our attention to strategies that seek to improve the CBT approach to the therapeutic alliance.

DEVELOPMENTS AND VARIATIONS OF CBTs: THERAPEUTIC RELATIONSHIP VARIABLES AND TECHNIQUES FROM THEORETICAL AND CLINICAL PERSPECTIVES

Based in part on research findings on the alliance in CBTs, several advances have taken place under the umbrella of CBTs with the aim of improving the way that therapists understand and use the therapeutic relationship. In large part, these efforts have involved the assimilation of theory and technique from other orientations, especially relying on psychodynamic–interpersonal and humanistic techniques. These contributions have come largely in two

changes to CBT practice and conceptualization: identifying new ways to resolve alliance ruptures and reevaluating the theoretical role of the alliance itself.

Resolving Alliance Ruptures

Several authors have examined ways of handling alliance ruptures in CBTs (e.g., Safran & Muran, 1996). What does a therapist do when there is an obvious impasse in treatment because the relationship is suffering? In broad terms, two approaches to an alliance rupture can be distilled from the literature.

First, if the therapist determines that there is a therapy process variable or therapist effect that might be contributing to the alliance break, the therapist has historically been advised to use the rupture as an opportunity to reconsider the case conceptualization and treatment plan in a collaborative way and to realign client and therapist shared goals (e.g., Beck 1996; Beck et al., 1979; Goldfried & Davison, 1976; Persons & Mikami, 2002). Ideally, this opportunity is used to encourage client reengagement in therapy. However, it has a major downside that makes it difficult to implement in practice: sometimes the client resists treatment, against his or her best interests. If the therapist blindly concedes the case conceptualization and treatment plan when clients do not want to, or are ambivalent about, change, it is possible that treatment itself will stall (though the client may be more comfortable in the short term). In addition, ruptures may not be attributable to the choice of treatment or intervention use per se, but rather to the way that the treatment is conducted.

Alternatively, if the therapist determines that the rupture is a manifestation of a problem or symptom the client is experiencing, the therapist is advised to attempt to directly address that problem. This possibility may at times be accurate. Clients who are depressed, for example, may have an inaccurate view of the therapist's skills (or genuine empathy) and/or possess a pessimistic prognosis about the therapy's ability to reduce depression; in this case, the client's inaccurate beliefs may contribute directly to the relationship problem, and addressing these automatic thoughts about the relationship may be a fruitful intervention. Yet, if CBT therapists automatically assume that their clients' reluctance to engage in therapy is primarily the result of distorted thoughts, then they may not be fully aware of how they are contributing to the alliance rupture. This shortcoming, in turn, may lead therapists to adhere too blindly and rigidly to the prescribed techniques and lose sight of another, more pressing, problem in the relationship, such as an empathic failure (Burns & Auerbach, 1996) or a case formulation based on incomplete or outdated information (see Beck et al., 1979; Persons, 1989).

Such rigid patterns of interactions have been observed in different

approaches (Henry, Schacht, & Strupp, 1986, 1990; Piper et al., 1999; Schut et al., 2005), including cognitive therapies. For example, Castonguay et al. (1996) found that, when confronted with alliance rupture, cognitive therapists frequently increased their attempts to persuade clients of the validity of the cognitive therapy rationale and/or the beneficial impact of the cognitive therapy techniques. This increased adherence, however, did not appear to repair the alliance breach and may have actually exacerbated it by creating a vicious cycle of misattunement to the client's experiences.

A number of CBT therapists have made valuable contributions toward more skillfully resolving alliance ruptures. For example, Burns (1989; Burns & Auerbach, 1996) developed a set of "listening skills" to address client disagreement or disengagement from therapy. First, therapists invite the client to express his or her present emotional and subjective state, particularly inviting disclosure of perceived therapeutic failures. Second, therapists empathically relate to the client's response, hopefully making the client feel validated and understood. Finally, using the "disarming" technique, therapists explicitly validate the client's negative feelings or criticisms of treatment (and/or the therapist) by finding some truth in them (even if the reaction is seemingly excessive). According to Burns, doing so signals to the client that the he or she is respected and that the therapist is willing to assume equal—if not more—blame for the relationship problems.

Similarly, Safran and colleagues (Safran & Muran, 1996; Safran & Segal, 1990) have developed methods of alliance rupture repair that start with the therapist's recognizing his or her contribution to the problem. This technique, which is similar to Burns's (1989) disarming, is then used as the catalyst to encourage clients to share their own feelings about treatment. Further, the goal is to encourage clients to discuss their own contribution to the therapeutic impasse and, by extension, to interpersonal problems outside of therapy. Also like Burns's disarming technique, Linehan's (1993) "techniques of acceptance" involve the therapist's ability to see reasonableness in the client's dysfunctional behaviors, accept the client's hostile affect, and recognize his or her own mistakes. Like Burns and Safran, Linehan has argued that alliance problems are frequent and that their resolution can lead to the client's acquiring skills that can be used in interpersonal difficulties outside the sessions.

The techniques of addressing alliance ruptures developed by Burns and Safran have been associated with some empirical support. For example, Safran, Muran, and colleagues (e.g., Muran et al., 2009; Safran, Crocker, McMain, & Muran, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994) have found that the in-session exploration of the experiences of both the therapist and client facilitates rupture resolution and contributes to treatment outcome. The researchers have also developed brief relational therapy (BRT; Muran, Safran, Samstag, & Winston, 2005), which as a stand-

alone alliance-based treatment has been shown to produce lower dropout from and higher engagement in treatment than short-term psychodynamic and cognitive and behavioral therapies (Muran, Safran, Samstag, & Winston, 2005; Safran, Muran, Samstag, & Winston, 2005). Assimilating the rupture repair techniques directly into a more traditional cognitive therapy, Castonguay et al. (2004) developed integrative cognitive therapy (ICT) for depression. ICT has performed well in two preliminary trials. In a comparison to a wait-list control involving 21 outpatients, ICT achieved a pre–post effect size of $d = 1.91$ on the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), more than twice the size of comparable studies of traditional cognitive therapies (Castonguay et al., 2004). In a second study, ICT was compared to standard cognitive therapy with 11 clients in each group, and results favored ICT with a medium effect size, $d = 0.50$, also on the BDI (Constantino et al., 2008). In the latter study, the ICT clients not only evidenced greater posttreatment improvement than the CT clients but also reported higher alliance and therapist empathy ratings across treatment. Taken together, these findings suggest (albeit preliminarily) that alliance ruptures can be effectively addressed in the context of specifically relational therapies as well as more traditional cognitive therapies, and that such rupture resolution strategies might have a positive impact on treatment engagement and outcome. Indeed, many additional authors have described ways of managing problems in the therapeutic relationship in CBTs as essential skills with numerous therapeutic benefits (e.g., Leahy, 1993; Newman, 1998; Persons, 1989; Young, 1999).

The Corrective Role of the Alliance in CBTs

Several authors have suggested that therapists would be wise to foster strong alliances not just as indirect facilitation of but also as part of a theoretically cohesive system of CBT designed to achieve a direct path toward changing cognitions, changing interpersonal behavior, and providing corrective experiences to clients (e.g., Arnkoff, 1981; Goldfried, 1985; Goldfried & Padawer, 1982; Grosse Holtforth & Castonguay, 2005; Safran & Segal, 1990). This postulation is in line with Linehan's (1993) argument that the therapeutic relationship is "of value in its own right, apart from any changes that the patient makes as a result of therapy" (p. 98).

Arnkoff (1981) wrote a detailed clinical and theoretical chapter on ways of expanding cognitive therapy, including a section on incorporating the relationship itself. In this, she provided a series of case studies illustrating, for example, that the relationship can provide much the same information in cognitive therapies as it does in a transference-focused psychodynamic therapy. Goldfried and Davison (1976) have also suggested that behavior in-session, including the relationship, can be viewed as a sample of

behavior of the client itself, likely very relevant to the way the client behaves in nontherapy situations. Taking this a step further, Goldfried (1985) has suggested that cognitive and behavior therapists can conceptualize interventions focused on the relationship as *in vivo* interventions: "We know that in vivo interventions are much more powerful than imaginal or described ones. So if we can look at the person's actions right at the time—when they are being upset about something, or when they are being inhibited and cannot act in a given way or say something within the session itself—we have broadened our therapeutic focus" (p. 143). Using this conceptualization, a CBT therapist might be able to address important events in the therapy sessions with the ultimate goal of identifying and altering major interpersonal patterns that affect not only the therapy relationship but the client's other relationships as well. These techniques also lend themselves to the development of corrective experiences, which may be the central common factor of therapy (Goldfried, 1980).

Kohlenberg and colleagues (Kanter et al., 2009; Kohlenberg & Tsai, 1991; Tsai, Kohlenberg, & Kanter, Chapter 9, this volume) have also developed CBT treatments that use the therapeutic relationship extensively and that are based largely on research into *in vivo* interventions. Young (1999), in an influential work on cognitive therapy for personality disorders, suggests that therapists use references to the therapy relationship to better activate schemata, and indicates that this technique is very similar to using transference in psychoanalysis (p. 34).

Hayes and colleagues, in developing acceptance and commitment therapy (ACT), have also incorporated a view of the relationship that is simultaneously an independent positive force promoting client change while also functioning in the background of the more specific technical and theoretical influences. Thus, Hayes, Strosahl, and Wilson (1999) suggest that, while the relationship is not the end purpose of therapy, it is curative inasmuch as it is based on love, acceptance, respect, and openness toward oneself and others (p. 279). This perception suggests that the relationship between therapist and client can—if predicated on and conducted according to the right conditions—serve as an important learning event and corrective experience for the client, a position frequently cited over the years (e.g., Safran & Segal, 1990).

CONCLUSION

The therapeutic relationship has been an integral part of behavioral and cognitive therapies for decades, despite the fact that this orientation has frequently been described as mechanical. Although relationship factors have been traditionally viewed in this approach as secondary to learning and

cognitive techniques, the therapeutic alliance has consistently been regarded as necessary for successful therapy. And while many CBT scholars (e.g., DeRubeis, Brotman, & Gibbons, 2005) have referred to relationship variables as nonspecific (i.e., not yet clearly defined or fully understood), some leaders of this orientation have offered detailed descriptions (based on basic research and social learning theory) and even developed a new construct (collaborative empiricism) to explain the role of the therapeutic relationship in the change process as well as to provide guidelines on how to enhance the relationship for the sake of implementing behavioral and cognitive interventions (Beck et al., 1979; Wilson & Evans, 1977). Over the years, clinical observations and empirical investigation (including clients' perceptions of helpful elements of therapy) have provided support for the role of relationship variables in CBTs. In particular, studies on the working alliance have found that, as a whole, the quality of the bond and the level of collaboration between client and therapist are robust predictors of clients' improvement in CBTs. Furthermore, based in part on this empirical evidence as well as on clinical experience, scholars and therapists have developed and/or integrated within their general CBT framework a number of interventions aimed at resolving treatment impasses as well as fostering the curative impact that the alliance is believed (at least by some) to have.

There are, however, important questions that remain to be addressed. For example, one of the most important debates in the field is whether or not the alliance contributes causally to client change or, rather, whether its predictive quality is mostly an epiphenomenon (see Barber, Khalsa, & Sharpless, Chapter 2, this volume). As argued elsewhere, while some research has begun to address the direction and nature of the alliance impact on the outcome, it is likely that if a consensus is achieved it is not going to reflect an "either–or" answer. In our view, the process of change "involves interdependent, non-orthogonal, and/or synergistic relationships between different variables" (Castonguay, Constantino, & Grosse Holthforth, 2006, p. 274). Another crucial question is whether interventions that have been recently integrated into CBTs may be necessary for all clients. For example, a substantial number of clients do benefit from the standard cognitive therapies for depression, and, as such, the treatment progress of these individuals may not require the addition of techniques aimed at repairing alliance ruptures. It will therefore be important for future research not only to determine whether or not the addition of such techniques can improve cognitive therapies in general but also to identify the clients for whom these techniques may be particularly indicated. Such research, especially if guided by theoretical models attending to complex interactions between technical, relationship, and participants variables (Castonguay & Beutler, 2005), are likely to further improve the beneficial impact of CBTs on psychological suffering.

REFERENCES

Arnkoff, D. B. (1981). Flexibility in practicing cognitive therapy. In G. Emery, S. D. Hollon, & R. C. Bedrosian (Eds.), *New directions in cognitive therapy* (pp. 203–223). New York: Guilford Press.

Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston.

Barber, J. P. (2009). Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research*, *19*, 1–12.

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, P., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology*, *68*, 1027–1032.

Barber, J. P., & DeRubeis, R. J. (1989). On second thought: Where the action is in cognitive therapy for depression. *Cognitive Therapy and Research*, *13*(5), 441–457.

Barlow, D. H. (Ed.). (2008). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.). New York: Guilford Press.

Beck, A. T., Rush, J. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Beck, A. T., Ward, C. H., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Brady, J. P., Davison, G. C., Dewald, P. A., Egan, G., Fadiman, J., Frank, J. D., et al. (1980). Some views on effective principles of psychotherapy. *Cognitive Therapy and Research*, *4*, 271–306.

Breger, L., & McGhaugh, J. L. (1965). Critique and reformulation of "learning theory" approaches to psychotherapy and neurosis. *Psychological Bulletin*, *63*, 338–358.

Brown, B. M. (1967). Cognitive aspects of Wolpe's behavior therapy. *American Journal of Psychiatry*, *124*(6), 162–167.

Brunink, S. A., & Schroeder, H. E. (1979). Verbal therapeutic behavior of expert psychoanalytically oriented, gestalt, and behavior therapists. *Journal of Consulting and Clinical Psychology*, *47*, 567–574.

Burns, D., & Auerbach, A. (1996). Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? In P. Salkovskis (Ed.), *Frontiers of cognitive therapy*. New York: Guilford Press.

Burns, D. D. (1989). *The feeling good handbook: Using the new mood therapy in everyday life*. New York: William Morrow.

Burns, D. D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology*, *60*, 441–449.

Burns, D. D., & Spangler, D. L. (2000). Does psychotherapy homework lead to improvements in depression in cognitive-behavioral therapy or does improvement lead to increased homework compliance? *Journal of Consulting and Clinical Psychology*, *68*(1), 46–56.

Castonguay, L. G. (1993). "Common factors" and "non-specific variables:" Clarification of the two concepts and recommendations for future research. *Journal of Psychotherapy Integration*, *3*, 267–286.

Castonguay, L. G., & Beutler, L. E. (Eds.). (2005). *Principles of therapeutic change that work*. New York: Oxford University Press.

Castonguay, L. G., Constantino, M. J., & Grosse Holtforth, M. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, and Training*, *43*, 271–279.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64*, 497–504.

Castonguay, L. G., Newman, M. G., Borkovec, T. D., Grosse Holtforth, M., & Maramba, G. G. (2005). Cognitive-behavioral assimilative integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 241–260). New York: Oxford University Press.

Castonguay, L. G., Schut, A. J., Aikins, D., Constantino, M. J., Laurenceau, J. P., Bologh, L., et al. (2004). Repairing alliance ruptures in cognitive therapy: A preliminary investigation of an integrative therapy for depression. *Journal of Psychotherapy Integration*, *14*, 4–20.

Constantino, M. J., Marnell, M., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., et al. (2008). Integrative cognitive therapy for depression: A randomized pilot comparison. *Psychotherapy*, *45*, 122–134.

Crits-Christoph, P., Connolly Gibbons, M. B., & Hearon, B. (2006). Does the alliance cause good outcome?: Recommendations for future research on the alliance. *Psychotherapy: Theory, Research, Practice, Training*, *43*(3), 280–285.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science & Practice*, *12*, 174–183.

DeRubeis, R. J., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy Research*, *14*, 469–482.

Dimidjian, S., Martell, C. R., Addis, M. E., & Herman-Dunn, R. (2008). Behavioral Activation for Depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 328–364). New York: Guilford Press.

Fairburn, C. G., Cooper, Z., Shafran, R., & Wilson, G. T. (2008). Eating disorders: A transdiagnostic protocol. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 578–614). New York: Guilford Press.

Feeley, M., DeRubeis, R., & Gelfand, L. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, *67*, 578–582.

Feifel, H., & Eells, J. (1963). Patients and therapists assess the same psychotherapy. *Journal of Consulting Psychology*, *27*(4), 310–318.

Frank, J. D. (1961). *Persuasion and healing*. Baltimore: Johns Hopkins University Press.

Friedberg, R. D., & Gorman, A. A. (2007). Integrating psychotherapeutic processes

with cognitive behavioral procedures. *Journal of Contemporary Psychotherapy*, *37*, 185–193.

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, *35*(11), 991–999.

Goldfried, M. R. (1985). In vivo intervention or transference? In W. Dryden (Ed.), *Therapists' dilemmas*. London: Harper & Row.

Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy*. New York: Holt, Rinehart, & Winston.

Goldfried, M. R., & Padawer, W. (1982). Current status and future directions in psychotherapy. In M. R. Goldfried (Ed.), *Converging themes in psychotherapy* (pp. 3–49). New York: Springer.

Grosse Holtforth, M., & Castonguay, L. G. (2005). Relationship and techniques in cognitive-behavioral therapy—a motivational approach. *Psychotherapy: Theory, Research, Practice, Training*, *42*(4), 443–455.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hembree, E. A., Rauch, S. A. M., & Foa, E. B. (2003). Beyond the manual: The insider's guide to prolonged exposure therapy for PTSD. *Cognitive and Behavioral Practice*, *10*, 22–30.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Effectiveness of targeting the vulnerability factors of depression in cognitive therapy. *Journal of Consulting and Clinical Psychology*, *64*, 623–627.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, *58*, 768–774.

Ilardi, S., & Craighead, W. (1994). The role of non-specific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice*, *1*, 138–155.

Kanter, J. W., Rusch, L. C., Landes, S. J., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Theory, Research, Practice, Training*, *46*, 220–232.

Klein, M. H., Dittmann, A. T., Parloff, M. B., & Gill, M. M. (1969). Behavior therapy: Observations and reflections. *Journal of Consulting and Clinical Psychology*, *33*, 259–266.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: A guide for creating intense and curative therapeutic relationships*. New York: Plenum Press.

Krasner, L. (1962). The therapist as a social reinforcement machine. In H. H. Strupp & L. Luborsky (Eds.), *Research in psychotherapy* (vol. II). Washington, DC: American Psychological Association.

Leahy, R. (1993). *Overcoming resistance in cognitive therapy*. New York: Guilford Press.

Lejuez, C. W., Hopko, D. R., Levine, S., Gholkar, R., & Collins, L. M. (2006). The therapeutic alliance in behavior therapy. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 456–468.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Marmor, J. (1971). Dynamic psychotherapy and behavior therapy: Are they irreconcilable? *Archives of General Psychiatry*, *24*, 22–28.

Mathews, A. M., Johnston, D. W., Lancashire, M., Munby, M., Shaw, P. M., & Gelder, M. G. (1976). Imaginal flooding and exposure to real phobic situations: Treatment outcome with agoraphobic patients. *British Journal of Psychiatry*, *129*, 362–371.

McMain, S., Guimond, T., Links, P., & Burckell, L. (2009, August). *The therapy alliance as a mechanism of change in the treatment of persons with borderline personality disorder*. Paper presented at the 11th International Society for the Study of Personality Disorders Congress. New York.

Morris, R. J., & Magrath, K. H. (1983). The therapeutic relationship in behavior therapy. In M. J. Lambert (Ed.), *Psychotherapy and patient relationships* (pp. 154–189). Homewood, IL: Dow Jones-Irwin.

Morris, R. J., & Suckerman, K. R. (1974). Therapist warmth as a factor in automated systematic desensitization. *Journal of Consulting and Clinical Psychology*, *42*, 244–250.

Muran, J. C., Gorman, B. S., Safran, J. D., & Twining, L., Samstag, L. W., & Winston, A. (1995). Linking in-session change to overall outcome in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology*, *63*, 651–657.

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 233–248.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an Alliance-Focused Treatment for Personality Disorders. *Psychotherapy*, *42*, 532–545.

Nathan, P. E., & Gorman, J. M. (2002). *A guide to treatments that work* (2nd ed.). New York: Oxford University Press.

Newman, C. F. (1998). The therapeutic relationship and alliance in cognitive therapy. In J. D. Safran & J. C. Muran (Eds.), *The therapeutic alliance in brief psychotherapy* (pp. 95–122). Washington, DC: American Psychological Association.

Norcross J. C., Karpiak C. P., & Santoro S. O. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology*, *61*, 1467–1483.

Perls, F., Hefferline, R. F., & Goodman, P. (1977). *Gestalt therapy: Excitement and growth in the human personality* (rev. ed.). New York: Bantam Books.

Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton.

Persons, J. B., & Burns, D. D. (1985). Mechanisms of action of cognitive therapy: The relative contributions of technical and interpersonal interventions. *Cognitive Therapy and Research*, *9*, 539–551.

Persons, J. B., & Mikami, A. Y. (2002). Strategies for handling treatment failure successfully. *Psychotherapy: Theory, Research, Practice, Training*, *39*(2), 139–151.

Piper, W. E., Joyce, A. S., Rosie, J. S., Ogrodniczuk, J. S., McCallum, M., O'Kelly, J. G., et al. (1999). Prediction of dropping out in time-limited interpretive individual psychotherapy. *Psychotherapy, 36*, 114–122.

Rabavilas, A. D., Boulougouris, J. C., & Perissaki, C. (1979). Therapist qualities related to outcome with exposure in vivo in neurotic patients. *Journal of Behavior Therapy and Experimental Psychiatry*, *10*, 293–294.

Raue, P., Goldfried, M., & Barkham, M. (1997). The therapeutic alliance in psychodynamic–interpersonal and cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology*, *65*, 582–587.

Raue, P., Putterman, J., Goldfried, M. R., & Wolitzky, D. (1995). Effect of rater orientation on the evaluation of therapeutic alliance. *Psychotherapy Research*, *5*(4), 337–342.

Raue, P. J., Castonguay, L. G., & Goldfried, M. R. (1993). The working alliance: A comparison of two therapies. *Psychotherapy Research*, *3*, 197–207.

Raue, P. J., & Goldfried, M. R. (1994). The therapeutic alliance in cognitive-behavior therapy. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 131–152). New York: Wiley.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, *22*, 95–103.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.

Ryan, V. L., & Gizynski, M. N. (1971). Behavior therapy in retrospect: Patients' feelings about their behavior therapies. *Journal of Consulting and Clinical Psychology*, *37*, 1–9.

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy*, *27*(2), 154–165.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology*, *64*(3), 447–458.

Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 225–255). New York: Wiley.

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy*, *42*, 512–531.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.

Salvio, M., Beutler, L. E., Wood, J. M., & Engle, D. (1992). The strength of the therapeutic alliance in three treatments for depression. *Psychotherapy Research*, *2*(1), 31–36.

Samstag, L. W., Muran, J. C., & Safran, J. D. (2004). Defining and identifying alliance ruptures. In D. P. Charman (Ed.), *Core processes in brief psychodynamic psychotherapy: Advancing effective practice* (pp. 187–214). Mahwah, NJ: Erlbaum.

Schut, A. J., Castonguay, L. G., Flanagan, K. M., Yamasaki, A. S., Barber, J. P.,

Bedics, J. D., et al. (2005). Therapist interpretation, patient–therapist interpersonal process, and outcome in psychodynamic psychotherapy for avoidant personality disorder. *Psychotherapy: Theory, Research, Practice, Training*, *42*(4), 494–511.

Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. J., & Whipple, K. (1975). *Psychotherapy versus behavior therapy*. Cambridge, MA: Harvard University Press.

Stiles, W. B., Agnew-Davies, R., Hardy, G., Barkham, M., & Shapiro, D. A. (1998). Relations of the alliance with psychotherapy outcome: Findings in the second Sheffield psychotherapy project. *Journal of Consulting and Clinical Psychology*, *66*, 791–902.

Turk, C. L., Heimberg, R. G., & Magee, L. (2008). Social anxiety disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 123–163). New York: Guilford Press.

Waddington, L. (2002). The therapy relationship in cognitive therapy: A review. *Behavioural and Cognitive Psychotherapy*, *30*, 179–191.

Wilson, G. T., & Evans, I. M. (1977). The therapist–client relationship in behavior therapy. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 309–330). New York: Pergamon Press.

Wolfe, B. E., & Goldfried, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology*, *56*(3), 448–451.

Wolpe, J. (1958). *Reciprocal inhibition therapy*. Stanford, CA: Stanford University Press.

Wolpe, J., & Lazarus, A. (1966). *Behavior therapy techniques*. New York: Pergamon Press.

Wright, J. H., & Davis, D. (1994). The therapeutic relationship in cognitive-behavioral therapy: Patient perceptions and therapist responses. *Cognitive and Behavioral Practice*, *1*(1), 25–45.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (3rd ed.). Sarasota, FL: Professional Resource Press.

Young, J. E., Rygh, J. L., Weinberger, A. D., & Beck, A. T. (2008). Cognitive therapy for depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 250–305). New York: Guilford Press.