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The Therapeutic Alliance in Marital Therapy

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This article considers the nature of the therapeutic alliance in marital therapy and suggests that it is not particularly useful to consider the alliance as a uniform phenomenon across forms of therapy, such as therapies that focus upon cognitive interventions as opposed to therapies that use more affectively oriented interventions. In different forms of therapy and at different times, different aspects of the alliance may be crucial in facilitating change.

INTRODUCTION

The alliance between client and therapist has emerged as a key component of the process of therapeutic change (Greenberg & Pinsof, 1986). It has been stressed as one of the general change factors that may account for change across different modalities and treatment approaches (Frank, 1978). One of the ingredients shared by all approaches is the collaborative nature of the therapeutic relationship. From the safety of the client-centered relationship through Beck's collaborative empiricism to Ellis' rational disputation, what stands out is that unless client and therapist are engaged in a collaborative working alliance, the therapy has very little chance of creating change. Although humanistic

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and psychodynamic theorists have written extensively about the role of the relationship in therapeutic change, its role in cognitive therapies has only recently begun to be addressed (Mahoney & Gabriel, 1987). In cognitive therapy in particular, the clients' compliance with the therapeutic task is an essential ingredient for engaging in the process of therapy. The establishment of a collaborative alliance is one of the best means of obtaining such compliance with therapist suggestions or directions. A collaborative alliance is achieved, according to Bordin (1979), by agreement on goals, perceived relevance of tasks, and a bond appropriate to the demands of the task. An important feature of this view is that the alliance is seen as arising from the interaction between client and therapist; rather than being a therapist or client factor, it is an interactional product.

Marital and family therapy, involving as it does the provision of directions and homework tasks, shares certain features with the relationship required in other directive therapies such as cognitive therapy. Here too then, one of the best means of obtaining compliance is through the establishment of a collaborative working alliance.

In the marital and family field, the alliance has been addressed on a pragmatic clinical level in terms of the necessity for the therapist to join with the client system (Minuchin, 1974) and the necessity for the therapist to be aware of how coalitions are operating in the process of therapy. However, a theoretical and research perspective on the alliance in marital and family therapy has been slow to develop. This paper will consider the therapeutic alliance in marital therapy, particularly as it is operationalized in Emotionally Focused Marital Therapy (EFT; Johnson & Greenberg, 1987).

CONCEPTUALIZATION OF THE ALLIANCE

The first issue to be addressed is that of conceptualization, that is, how the concept of the alliance has been operationalized. In the initial empirical work on the alliance, Alexander and Luborsky (1986) separated the alliance into perceived helpfulness of the therapist and collaboration or bonding with the therapist and found that these factors correlated with positive outcome. Bordin's theoretical conceptualization of the alliance suggested that the alliance is essentially an integration of bond, task, and goal elements (1979). In this latter view, relationship context and technical skill are intertwined. A positive alliance is then one in which the client sees the therapist as appropriately warm and supportive, views the tasks presented as relevant (which implies that the therapist is seen as competent and able to help the client), and

shares the same therapeutic goals as the therapist. In spite of different conceptualizations there seems to be a general consensus that the primary effect of a positive alliance is to facilitate client involvement, collaboration, and participation in the therapy process (Suh, Strupp, & Samples O'Malley, 1986), and therefore to enhance the possibility of positive outcomes.

THE ALLIANCE IN MARITAL THERAPY

In marital therapy there is an added dimension to the alliance in that the client is the *relationship between the two partners* who come for therapy. Pinsof and Catherall (1986) have suggested that the dimensions of the other–therapist and the system–therapist relationships must be added to the self–therapist relationship to adequately conceptualize the alliance in marital therapy. The alliance then becomes a much more complex issue. It involves not only how each partner views the therapist, but how that partner sees his/her spouse responding to the therapist, and judges that the therapist understands and can work with the marital relationship. The most rigorous existing instrument in this area appears to be the Family and Couple Therapy Alliance Scales (Pinsof & Catherall, 1986). This instrument uses Bordin's conceptualization of the alliance as a synthesis of bond, task, and goal elements and also adds the interpersonal systems dimensions of Self, Other, and Group. The instrument is promising in that it discriminates the elements of the alliance in EFT, and preliminary data suggest that high scores are correlated positively with outcome.

The nature of a positive alliance in marital therapy appears to have some special characteristics. The most concrete conclusion arrived at in the study of the effect of therapist variables in marital and family therapy is that therapist activity level makes a difference to outcome (Gurman & Kniskern, 1981; Shapiro, 1974; Alexander, Barton, Schiavo, & Parsons, 1976; Shapiro & Budman, 1973). Couples may be more generally interested in task components, such as how active their therapist is and how well he or she structures a session, rather than in how empathic or warm he or she is. This perhaps reflects the fact that the marital therapist tends to be more directive than in many forms of individual therapy. Nevertheless, the therapist also has to become a part of, to join with, the system as well as with each individual partner. In practice this may be done by the therapist validating each partner's position in and experience of the relationship, as well as by showing understanding of the system and its interactional cycles. The initial process of creating an alliance is then more complex than in individual

therapy. The therapist must establish a working relationship with both partners as individuals, and show sensitivity to the shared beliefs or rules of the relationship. The therapist must also be able to provide support for each partner's position in the relationship even though those positions may oppose each other. Partners' positions are based on their current beliefs, emotional responses, and views about themselves, their partner, and the interaction. For the therapist to be able to validate and affirm each person's position, it is necessary to assess each partner's basic beliefs concerning the nature of relationships and issues of separation and closeness and dependence and independence. Thus a husband may feel intruded on and believe that he is unfairly accused of being irresponsible and a failure, while his wife may feel abandoned and believe that she is unfairly accused of being overanxious or perfectionistic. If the therapist violates either of these positions or views of the relationship in the early sessions, the alliance with that partner will be ruptured. Thus the therapist needs to understand each person's point of view and communicate this understanding to both partners without supporting one more than the other. Simultaneously, the therapist must be sure to value shared beliefs such as, "It is important to be an independent person and not need others too much."

In addition to correctly assessing these beliefs and acting in such a way that they may be examined but not immediately violated, therapists in marital and family therapy need to be able to control the session and direct other people to interact in different ways. The therapist must be able to enlist collaborative compliance with both clients, particularly in terms of encouraging them to interact in different ways. In most forms of marital therapy, the negative cycle of interactions is then initially framed in terms of mutuality; that is, in terms of both partners being responsible for the structure of the relationship as it now exists. Exactly how this mutuality is framed, however, will vary across approaches to marital therapy. In behavioral marital therapy this frame is generally constructed in terms of skills; the couple is encouraged to see that the ways they interact are a result of their lack of skills and their cognitive attributions as to their partner's behavior. In more purely systemic therapies, the partners will be encouraged to understand how each partner evokes negative behavior from the other and thus helps to create the interactional cycle; that is, they will be helped to understand the pattern of interactions rather than being given the cognitive framework that each person lacks the skill to be really close or to create a really positive relationship.

In contrast to individual therapy, the major context for a corrective emotional experience in most marital therapies is the relationship with the other spouse, rather than the relationship with the therapist. It

seems logical to presume that the intensity of the bond between therapist and individual client would be lessened in marital therapy, since the primary object of each partner's affections and emotional life is present in the session. As suggested previously, there may then be more general emphasis from the client's perspective on the therapist's directiveness and task-oriented interventions. From the therapist's viewpoint it is necessary to be more directive in marital therapy since the therapist is intervening in a complex, self-reinforcing interpersonal process. If the therapist is not able to be directive, the patterns that brought the clients into therapy will continue and be perpetuated. It is also true, however, that the task component of the alliance has been found to be most highly correlated with positive outcome in individual therapy (Horvath & Greenberg, 1986), suggesting that perceived task relevance is particularly important in involving clients in treatment whether in individual or marital therapy.

In marital therapy, other dimensions besides the self–therapist relationship may be crucial. One study (Gruman, 1986) has found that how the client sees the therapist and the other spouse relating to each other may be the most powerful aspect of the alliance here. Why this may be so is a matter of speculation. Interviews with clients in an outcome study of EFT (Johnson & Greenberg, 1985) suggested that the most easily identifiable mechanism of change for these clients was that their perception of their spouse changed in therapy. More specifically, the particular change that seemed to occur was that partners who initially appeared to be dominant in the interaction patterns changed how they saw and thought about their withdrawn partners and began to view them as lonely or afraid, rather than as rejecting and indifferent. In addition, partners who were initially withdrawn in the relationship also began to view the more dominant and pursuing spouse as desperately trying to make contact rather than as aggressive or attacking. It may be crucial that in a marital interaction, one partner observes the therapist and the other spouse interacting in such a way as to access some new aspect of that spouse, which is never exhibited in the marital relationship. For example, when a therapist helps a detached passive husband access his anger, his defiance, and his fear of his wife, this then changes his wife's view of him and has the potential to restructure the interaction.

The subgoals inherent in this modality then change the definition of a positive alliance. In individual therapy, the depth and stability of the alliance, particularly the bond aspect, may be crucial to help individuals gain insight into themselves, while in marital therapy it may be that the chief relationship skill for a therapist is that of flexibility. The therapist requires considerable flexibility to manipulate alliances in specific ways

in order to be a catalyst for new interaction patterns, and to support each spouse at crucial moments in ways that challenge the patterns in the relationship, including emotional responses and core beliefs concerning the nature of self in relation to attachment figures. The marital therapist, in many approaches, has to be able to move fluidly from supporting one spouse's position to supporting the other's stance, to a relationship focus or to choreographing new interactions between the spouses.

ALLIANCE DIFFERENCES ACROSS APPROACHES

The therapist's position in relation to his or her clients varies according to the approach used. As in the marital relationship itself, in the therapeutic alliance power and affiliation may vary according to the approach used. The therapist may be an expert, a coach, or a partner in exploration and discovery, or simply another person responding to the system of which he or she is now a part. The therapist may be closer and warmer to his or her clients, or adopt a rather neutral or even distant position to implement different therapeutic goals. The alliance may also be viewed as either more or less essential to the process of therapy, and as playing different roles in the process of change (Prochaska, 1979). For example, the alliance may be considered as a precondition for therapy (Behavioral Marital Therapy, EFT), an essential part of the change process (Experiential Family Therapy as espoused by Kempler, 1981), or as the primary content of therapy (as in some analytic approaches, although the main transference relationship would still be with the other spouse).

Different therapeutic goals also suggest different kinds of requisite bonds. Bonds will vary depending on goals and tasks since different tasks and goals require different levels of involvement and compliance. Cognitive behavioral approaches which attempt to teach skills would focus more on technique and require less of a bond between therapist and client than the more analytic approaches. Compliance and collaboration in skill assignments or the examination of attributions and beliefs require a different relational context than an emotional re-experiencing of past traumas. A cognitive approach requiring collaborative inspection of evidence would require a collegial teacher–student type of bond. A client-centered approach which considers the provision of unconditional regard by the therapist as essential to change would require a very sensitive caring bond, whereas a gestalt marital therapist would place authenticity before positive regard and empathic understanding.

All conjoint marital and family therapies, whatever their theoretical slant, have to deal with the fact that the therapist becomes a part of the interactional system that he or she is trying to change. This is a system where paying attention to one client is potentially entering a coalition against the other. The use of the therapist's "weight," however, may vary. A behaviorist, for example, will maintain a rather neutral position as a mediator during contract negotiation and as a teacher of skills. A cognitive therapist also would strive toward neutrality. The accessing of beliefs and perceptions, and interventions involving the provision of new evidence, would require a teaching or challenging style of relationship to achieve the goal of cognitive change. However, systemic structural therapists such as Minuchin and Fishman (1981) will at various times deliberately ally with one client to unbalance the relationship. The systemic viewpoint speaks of joining a system rather than of bonding with each individual, of accommodating to the rules of the relationship rather than empathizing with each partner. However, when Minuchin and Fishman (1981) speak of the therapist as "activating self segments that are congruent with the family" (p. 32), the concept of empathy seems innate, even though it is applied to the family system and the position each person takes in that system, rather than to individual experience. The structural systemic viewpoint also advocates affiliation through confirmation, and requires the therapist to take flexible positions, close, neutral, or disengaged as the process of therapy demands, rather than one consistent stance throughout the therapy process. It seems then that the nature and role of the bond will vary in different approaches. Therapists make different kinds of bonds for different reasons and to facilitate different goals. The bond is then best talked of in the context of a specific task and a specific approach.

DIFFERENCES IN THE THERAPEUTIC RELATIONSHIP ACROSS THE THERAPY PROCESS

Therapy involves an active and evolving relationship that will be different at different stages and may have a very particular quality or a greater role to play at various crucial points in the process of a session. The particular quality of the relationship at particular points may then inhibit or facilitate the client's response to certain interventions (Greenberg & Pinsof, 1986). The delineation of key stages and change events in therapy and the interpersonal context that allows for these events would improve the replicability of treatment and allow the alliance to be studied in a more concrete and meaningful fashion.

This kind of approach suggests various new research directions that would have considerable clinical relevance; for example, how does the therapeutic relationship evolve in particular approaches? What is the difference between the relationship in beginning stages and in the middle stages of therapy? In marital therapy, it is conceivable that the relation of self to therapist and the dimension of bond may be the most crucial for facilitating initial client involvement in the therapy, whereas in the working stage, the dimensions of task and the relationship between the other partner and the therapist may assume greater importance.

Even more promising is considering the alliance in terms of the task analytic approach to process research (Rice & Greenberg, 1984). Here specific change events are identified, and specific client markers or problem states are linked to specific therapist interventions. These interventions then lead to client performances associated with change. This approach raises these kinds of questions: in cognitive behavioral marital therapy, when clients attempt to problem-solve around a major issue in their relationship, what kind of bond and task facilitate the goal of successful problem resolution? In a cognitive approach to marital therapy, when attempting to access a core belief in one partner, what kind of relationship stance is best adopted towards each partner to achieve the goal of rational restructuring by disputing cognitive distortions or errors? When the client indicates distrust for the therapist, a breach in the alliance, what therapist interventions in each particular approach facilitate renewed collaboration, and when in different therapies are such breaches likely to occur?

THE ALLIANCE IN EFT

EFT brings together systemic approaches which focus on changing patterns of interactions and experiential approaches which focus on the reprocessing of cognitive/affective experiences, particularly emotional responses, to create change. In this method, which is elaborated elsewhere (Greenberg & Johnson, 1988) there is an emphasis on restructuring affective/cognitive schemata. Emotion is viewed from an information processing perspective, as a synthesis of perceptual-motor processing, schematic or emotional memory, and conceptual rules about emotional experience (Leventhal, 1979; Greenberg & Safran, 1987). Emotion is therefore not seen as separate or independent from cognition. In EFT, the therapist accesses and explores the emotional responses underlying interactional positions and uses newly synthesized emotional experiences to restructure interaction patterns.

In general, the alliance in EFT is considered to be a prerequisite to effective therapy. It is a general prerequisite to one of the major tasks, that is to facilitate high levels of client experiencing which have been found to be associated with positive outcomes in EFT (Johnson & Greenberg, 1988). The type of alliance considered necessary reflects the systemic and experiential roots of EFT. At the beginning of therapy, in order to establish an alliance, the therapist has to create a relationship with both spouses and with the couple system. Specifically, the therapist has to be able to establish a warm, accepting, genuine relationship with each spouse in the presence of the other, and to validate each partner's views of reality and experience of the relationship without blaming or alienating the other. The main therapeutic subtask here is to engage the couple in therapy and to form a therapeutic contract, as well as to obtain as much accurate assessment data as possible. The cognitive differentiation between one partner's experience and the intent of the other is useful here. The therapist accepts that the husband may feel attacked and criticized while allowing for the other perspective that the wife's primary intention is to attract her husband's attention. After the assessment of core issues and the power and affiliation structure of the relationship, the therapist describes the dysfunctional interactional cycle to the couple. This presentation helps to build the alliance, as it is a formulation that includes both partners in the maintenance of the problem without blaming any one person for the problems in the relationship. Each partner's position is validated and placed in the context of the cycle.

At this stage in EFT, all the elements of bond, goal, and task may be equally relevant. The therapist creates a therapeutic contract with the couple which reflects their goals, deals with their expectations for therapy, begins to outline the elements of the task, and creates an atmosphere of safety so that they feel connected enough to the therapist to begin to explore their emotional experience. If any aspect of the alliance comes to the forefront here, it is perhaps the bonding aspect, since this acts as an antidote to the considerable interpersonal anxiety that is usually present in a first marital session.

In the middle stage of EFT, the therapeutic task is to access emotional experience and attendant core beliefs concerning self and other and begin to use the experience to restructure the relationship. For example, a dominant distant spouse may experience and express his fear of being vulnerable and out of control with his wife and his need for her caring. This interaction redefines his position as relatively close and less controlling and allows his wife to respond differently.

At this point, both task and bond aspects of the alliance are crucial. It is with the therapist that a partner first accesses and begins to repro-

cess emotional experience. Clients have to feel accepted and secure with the therapist to acknowledge aspects of themselves they do not usually attend to. This involves expressing newly accessed emotional responses which in turn evoke core schemata concerning issues of trust and safety with others and a recognition of what each partner desperately longs for and fears in the relationship. Each client has to be willing to allow the therapist to evoke emotion, set up new interactions, and suggest or interpret feelings and thoughts when necessary. (For a full description of interventions, see Greenberg & Johnson, 1988.)

THE CHANGE PROCESS

The change process components of the alliance may vary at various points in therapy and in a session. If it is possible to identify key change events or client performances in EFT, how does the alliance figure in such events? The occurrence of a softening event has been found to be related to positive outcomes in EFT (Johnson & Greenberg, 1988). Softening is an empirically identifiable sequence in which a previously aggressive, dominant, or pursuing spouse moves to a focus on self rather than other, to a high level of experiencing (as measured by the Experiencing Scale; Klein, Matthieu-Coughlan, & Keisler, 1986), and to noncoercive, disclosing, affiliative behavior (as measured by the Structural Analysis of Social Behavior Scale; Benjamin, 1974). In this interaction, the pursuing spouse discloses a new vulnerable aspect of self (as "I get so terrified that you'll never respond to me that I panic, I can't bear the feeling of aloneness and you turning away . . . I need someone to take care of me") and requests the other spouse (now more open and accessible) to respond. When the other spouse does indeed respond this then constitutes a powerful redefinition of the relationship.

In interventions that focus primarily on a cognitive level key change events would presumably occur when the therapist successfully challenges the client's theory of the relationship and its problems and encourages the translation of this new perspective into new behaviors. In this kind of change event the most crucial aspect of the alliance may be that the therapist is perceived as a valid partner in a collaborative reprocessing of the client's key beliefs and cognitions, as an expert in this task rather than as a person with whom one has any kind of bond.

At this particular point in EFT, however, the bond is an essential part of the context which allows the softening event to occur. The client is in effect invited to experience vulnerability and experiment with a new way of being with the spouse. The client's mode of constructing self in relation to other and emotionally charged cognitions concerning the

nature of the attachment between the self and the other are then challenged by this event. Without the safety provided by the close bond which allows the therapist to structure such an experiment, the experiencing spouse will simply continue, even in the face of a newly accessible and responsive partner, to pursue, blame, or dominate, since up until this point this strategy has been this client's only means of attaining any security in the relationship. One way of viewing change in systems theory terms is that therapy supports fluctuations in the repetitive, dysfunctional cycles distressed couples exhibit. The therapist, in this case, has to be able to block the usual pattern of interactions and focus the experiencing client on his or her underlying feelings as well as to direct the interaction between the spouses. This will not occur unless the client is comfortable with including the therapist as a partner in the processing of his or her experience. The issue of confidence in the therapist's ability would presumably be part of the task aspect of the alliance here. The notion of positive regard (Rogers, 1951) and acceptance is also relevant in that clients must be able to rely on the fact that the unfamiliar newly evoked, aspects of themselves will be accepted and prized by their therapists, especially with the risk of rejection by the spouse. This disclosing of new aspects of self followed by therapist and then other partner responsiveness builds a bond between the couple and between each partner and the therapist. It is not surprising then that at the end of EFT, the alliance has been found to be particularly high (Gruman, 1986).

The safety provided by secure bond not only allows for the experiencing of new responses and reprocessing of highly significant personal experience, but facilitates then the restructuring of emotional schemata and core beliefs concerning representations of self and other. The client accepts the therapist's help in the cognitive task of constructing new meanings from this new experience. Core schemata (for example, "I am an unlovable person, and no one will ever be there for me") only emerge when the client is in an aroused affective state. These kinds of schemata often emerge as part of a softening event.

A positive strong alliance with each spouse and with the system as a whole in all aspects—bond, task, and goal—is an essential prerequisite of key change events in EFT. Throughout EFT, the alliance with both spouses and the therapist's position in the couple system has to be monitored. If there is any reason for the therapist to think that the alliance with a client is threatened, he or she must put aside other tasks and address this issue directly.

How does the marital therapist repair a damaged alliance when it is necessary? Therapists have to ask themselves what action of theirs evoked the distant, defensive, or hostile behavior the client is exhibit-

ing. Did the therapist go too fast, assume too much, or not respond to the client's concerns? Were tasks not perceived as relevant or was there a disagreement on goals? The vulnerability each client exhibits with the partner may also be evoked by the therapist, especially when the therapist is challenging particular blocks or defensive stances that clients use to protect themselves. At this point, the alliance is particularly vulnerable to damage and the therapist has to pay particular attention to this aspect of the process. The repair process in EFT and perhaps in all marital therapies involves: (1) Recognizing the breach in the alliance and focusing deliberately upon it rather than upon the intrapsychic experience of the client or the relationship between the spouses, as, "I get a sense that you feel very uncomfortable with me right now"; or if the therapist wishes to relate to the alliance with the other partner, "I have a sense that you feel that I'm being hard on your partner and you feel protective of him"; or relating to the relationship, "You're not sure that I'm really seeing your relationship as it is and approaching it in the right way?" (2) Probing as to the client's experience of the breach, as, "I don't quite understand. Is it that you're angry with me for supporting your husband when he tells you his concerns?" or "You sense that I might not understand your relationship accurately." (3) Validating and legitimizing the client's experience, and relating the therapist's actions to therapeutic goals and concern for self, other, and the relationship, as, "I can understand how it might seem unfair to you that I'm giving your spouse so much support right now, but I think it's important for him to be able to tell you all his resentments so that you know what they are and the two of you can begin to deal with them." (4) Restoring the partnership in terms of bond, goal, and task, as, "Do you feel reassured as to my concern for you and the importance of what we are exploring right now if we are to help the two of you get closer?" It is important for the therapist to acknowledge and take responsibility for any unnecessary pain he or she may have evoked in the client while at the same time reserving the right to challenge and question, as "Perhaps I did not support you enough; it is very hard to experience this kind of fear. I think it is important to continue to explore it, but maybe you can tell me how I can support you more."

Marital therapies that focus on changing present interactions such as EFT or the cognitive behavioral approaches (Jacobson & Margolin, 1979) consider the therapeutic alliance as more of a prerequisite than a direct ingredient of change; yet this does not mean that the alliance is unimportant or peripheral to the therapist's technical interventions. The therapist is a consultant to the clients' relationship with each other rather than a primary player; however, the effectiveness of his or her interventions will depend on the context, that is, on an intact and

robust alliance. The various aspects of the alliance may also vary in quality and relevance according to the treatment approach used, the stage of therapy, and the change events and processes that are operationalized in each approach.

If we are to describe, predict, and explain the operations of the therapeutic alliance, we need then to place the concept more specifically in context and study aspects of it as it operates in facilitating specific client processes in specific change events at specific times in therapy.

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