Article

Resolution of alliance ruptures: The special case of animal-assisted psychotherapy

Clinical Child Psychology and Psychiatry
2017, Vol. 22(1) 34–45

DOI: 10.1177/1359104516671385
ccp.sagepub.com
SAGE

Sigal Zilcha-Mano
University of Haifa, Israel

Abstract
Many therapists regard alliance ruptures as one of the greatest challenges therapists face in the therapy room. Alliance ruptures has been previously defined as breakdowns in the process of negotiation of treatment tasks and goals and a deterioration in the affective bond between patient and therapist. Alliance ruptures have been found to predict premature termination of treatment and poor treatment outcomes. But ruptures can also present important opportunities for gaining insight and awareness and for facilitating therapeutic change. A process of rupture resolution may lead to beneficial outcomes and serve as a corrective emotional experience. The article describes unique processes of alliance rupture resolution inherent in animal-assisted psychotherapy (AAP). Building on Safran and Muran's model and on clinical examples, the article describes strategies for identifying ruptures in AAP and techniques for repairing them to facilitate a corrective experience in treatment. Implications for clinical practice and future research are discussed.

Keywords
Animal-assisted psychotherapy, rupture resolution processes, animal attachment, alliance ruptures

One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is a predictor of outcomes, where stronger alliance is associated with better therapeutic outcomes (e.g. Horvath, Del Re, Flückiger, & Symonds, 2011). This is true even when controlling for symptomatic improvements before the measurements of alliance (Zilcha-Mano, Dinger, McCarthy, & Barber, 2014). Active collaborative work by patient and therapist on the therapeutic alliance, specifically on resolving ruptures when they occur, may be one of the things that makes alliance an active mechanism of change (Zilcha-Mano, in press). A corrective interpersonal experience with the therapist, through effective resolution of empathic failures (Kohut, 1984), may enable changes in interpersonal relationships outside the therapy room. This article presents a model suggesting how animal-assisted psychotherapy (AAP) may enhance this collaborative work and its effects.

Corresponding author:
Sigal Zilcha-Mano, University of Haifa, Mount Carmel, Haifa 31905, Israel.
Email: sigalzil@gmail.com

Background: ruptures in the therapeutic alliance

The term "alliance" was coined by Sterba (1934), who addressed therapists' ability to ally themselves with patients' capacity for rational observation. Greenson (1965) introduced the term "working alliance," referring to the patient's ability to work in the analytic situation, emphasizing the collaborative aspect of alliance. The most comprehensive theory of the working alliance was developed by Bordin (1979), who proposed a pantheoretical framework consisting of the emotional bond established in the therapeutic dyad, and the agreement between patient and therapist about the goals of therapy and the tasks needed to achieve them. The quality of the working alliance has been consistently correlated with psychotherapy outcome, with stronger alliances being associated with better therapeutic outcomes in a variety of formats and populations, with both adults (Crits-Christoph, Gibbons, & Mukherjee, 2013; Horvath et al., 2011) and children and adolescent (McLeod, 2011). Based on these studies, many researchers have argued that alliance is therapeutic in itself and designated it as an active ingredient in the success of treatment (for a review, see Zilcha-Mano, 2016, in press).

Given the importance of alliance in predicting therapeutic change, it is important to investigate what happens when alliance breakdowns occur. Alliance ruptures are found to be extremely common. Studies estimate that its prevalence ranges from about 100% of the sessions (when indirect signs of rupture are present) to 43% (when direct signs of rupture are present) (Colli & Lingiardi, 2009). Alliance ruptures have been found to predict premature termination of treatment and negative outcomes (see Safran & Muran, 2000, for a review). But ruptures may also provide important opportunities for gaining insight and awareness in interpersonal processes and facilitating therapeutic change. In this article, the unique therapeutic potential of AAP in processes of alliance rupture resolutions will be demonstrated.

I refer to the patient's general tendency to form a strong alliance and to the process of strengthening of the alliance across treatment as two components of the alliance—the former being "trait-like" and the latter being "state-like" (see also Zilcha-Mano, in press). The trait-like component of alliance refers to its general level and permanent characteristics. It can also be conceptualized as the difference between patients in their ability to form a strong alliance. In contrast, the state-like component of alliance refers to changes that take place throughout treatment and can also be conceptualized as changes within the individual.

Both components may contribute to the effect of alliance on outcomes. Some patients tend to form strong, positive trait–based alliances with their therapists and are likely to get better in treatment (Connolly Gibbons et al., 2003; Garfield, 1994; DeRubeis, Brotman, & Gibbons, 2005; Martin, Garske, & Davis, 2000). Studies have demonstrated that representations of significant others in the patient's life before the beginning of treatment predict the alliance formed between the patient and the therapist over the course of treatment (Zilcha-Mano, McCarthy, Dinger, & Barber, 2014; Zilcha-Mano, McCarthy, et al., 2015).A patient's pre-treatment characteristics, such as interpersonal patterns, may determine the creation of the trait-like component of alliance; its state-like component, by contrast, reflects the variability of alliance, describing the ways in which changes take place throughout treatment and predict improvement in symptoms. For example, a rupture may hamper the momentary ability of the patient to benefit from treatment, weaken the alliance, and weaken symptom reduction. But if a formative experience emerges in the process of this rupture being resolved, it can render alliance even stronger than it had been before the rupture, reducing symptoms more drastically than if the rupture had not occurred.

Although both the trait-like and state-like components of alliance are important in predicting outcome, the state-like component fits more closely with the concept of alliance as an *active* ingredient bringing about therapeutic change. Active collaborative work by patient and therapist on the

alliance, specifically on resolving ruptures when they occur, is one of the things that makes alliance an active mechanism of change. A corrective interpersonal experience with the therapist may enable changes in interpersonal relationships outside the therapy room. Conversely, patients with maladaptive patterns of relating to others may reenact these patterns throughout treatment, with no change taking place in alliance and no effective work being done to change these patterns (i.e. repetition compulsion, Freud, 1920). In the absence of such work, the trait-like component of the alliance dominates treatment. Based on Safran and Muran's (2000) seminal work on rupture resolution in the therapeutic alliance, active work on negotiating the alliance with the patient may create formative experiences in the patient's life, enabling changes in interpersonal relationships outside the therapy room. Such work allows the state-like component of alliance to dominate the treatment in a beneficial way.

Alliance ruptures with therapist and animal[1] in AAP

In the past 25 years, alliance ruptures have received increasing attention in the theoretical and empirical literature (see Muran, Safran, & Eubanks-Carter, 2010, for a review). A broad survey of the literature suggests that ruptures take place in the relationship with the therapist even more frequently than most clinicians assume. Based on the literature reviewed below, it can be assumed that ruptures may occur in AAP therapy settings as well, not only in the patient's relationship with the therapist but also with the animal.

The animal seems to be able to play the role of an attachment figure. Studies have shown that in the relationships that people form with their animals, the latter can serve as attachment figures, and that attachment thoughts, feelings, and behaviors can be aimed at animals (for a review, see Zilcha-Mano, 2013). An extensive review of the literature on human–animal bonds leads to the conclusion that they meet the four prerequisites of attachment bond (as detailed by Ainsworth, 1991; Hazan & Zeifman, 1994): proximity seeking, safe haven, secure base, and separation distress. Animals can therefore be viewed as attachment figures.

Empirical findings suggest that it is possible to conceptualize individual differences in human–animal relationships in the same way that such differences are currently conceptualized within human–human relationships, in the context of the two dimensions of attachment avoidance and anxiety (Zilcha-Mano, Mikulincer, & Shaver, 2011b). Zilcha-Mano et al. (2011b) constructed a reliable and valid self-report instrument, the Pet Attachment Questionnaire (PAQ), which includes two subscales reflecting the two main attachment dimensions in human–pet relationships. The first subscale, pet attachment avoidance, reflects the extent to which people feel discomfort with physical and emotional closeness with their pets, seek to maintain emotional distance from them, and prevent their pets from intruding on their personal space (e.g. "I try to avoid getting too close to my pet"). The second subscale, pet attachment anxiety, reflects the degree to which people have intense and intruding worries that something bad might happen to their pets, a strong desire for closeness with them, and serious doubts about their own value in their pets' eyes (e.g. "I'm often worried about what I'll do if something bad happens to my pet"). Individuals who score low on both dimensions are said to be securely attached to their pets.

It was found that individual differences in pet attachment orientation uniquely contributed to specific patterns of cognition, emotion, and behavior in a person's relationship with a pet (Zilcha-Mano, Mikulincer, & Shaver, 2011a, 2011b, 2012). Pet attachment orientation was also found to significantly and uniquely contribute to the owners' general mental health, above and beyond their attachment orientations toward people (Zilcha-Mano et al., 2011b, 2012): people who were securely attached to their pets were found to undertake a richer exploration of life goals in the presence of their pets and to see themselves as more competent in achieving these goals than did their

insecure peers. They also showed lower cardiovascular arousal during a distress-eliciting task in the presence of their pet than did individuals insecurely attached to their pets (Zilcha-Mano et al., 2012). Individual differences in attachment orientation may be the missing link in understanding *who* may benefit from a relationship with a pet. The empirical literature has indicated that the type of attachment people form with pets is associated with their generic representations of attachment relationships (Zilcha-Mano et al., 2011b, 2012): higher levels of attachment insecurity in interpersonal relationships have been associated with higher levels of attachment insecurity toward the pet. Therefore, interpersonal attachment may determine whether people would form a secure relationship with a pet and enjoy a satisfying relationship with their pet.

Animals functioning as attachment figures hold advantages as far as the processes of alliance rupture resolution are concerned. The fact that an animal present in the therapy setting and can function as an attachment figure (Zilcha-Mano, 2013) may suggest that the trait-like attachment orientations of patients may be automatically projected onto their trait-like alliance component with both the therapist and the animal. In some circumstances, patients with rigid maladaptive interpersonal patterns outside of the therapy room may project the same pattern toward the alliance with the therapeutic animal, resulting in ruptures in the alliance with the therapeutic animal. Resolving ruptures in the therapeutic alliance with the animal may result in a corrective relational experience, which is a powerful way of facilitating therapeutic change, because the animal is perceived as an attachment figure. Even if ruptures do not occur in the relationship with the animal, the mere perception of the animal as an attachment figure has important consequences because the animal can fulfill the need of secure base for the patient when ruptures in the alliance with the therapist occur.

Identifying alliance ruptures and searching the appropriate resolution strategy in AAP

There is great heterogeneity in therapists' ability to form strong alliances with their patients (Baldwin, Wampold, & Imel, 2007). The empirical literature shows that many therapists, including experienced ones, may have considerable difficulty recognizing poor alliance, especially in the case of withdrawal ruptures in alliance. Regan and Hill (1992) found that most thoughts and feelings that patients and therapists were unable to express in treatment were negative. Hill, Thompson, Cogar, and Denman (1993) also found that experienced therapists were often unaware of the patients' unexpressed thoughts or feelings. They found that patients were particularly likely to hide negative feelings, and that even experienced therapists were able to identify when patients had hidden negative feelings only 45% of the time. Moreover, 65% of the patients in the study left something, usually a negative thought, unexpressed, owing to avoidance, and only 27% of therapists were accurate in their answers about what it was that their patients were withholding. Similarly, Rhodes, Hill, Thompson, and Elliott (1994) found that although some patients were able to talk openly about their negative feelings toward the therapist, other patients concealed a misunderstanding from their therapists, leaving it unaddressed and often leading to termination of the therapy. Similar findings were reported by Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996), who conducted an analysis of therapists' recollections of ruptures ending in termination. The authors found that patients did not reveal their dissatisfaction until they had quit therapy. Therapists in the same study reported that they became aware of patients' dissatisfaction only with the announcement of termination, which often took them by surprise. Importantly, studies have shown that a therapist's ability to form a strong alliance can be developed (Muran et al., 2010). Based on Safran and Muran's (2000) model, this article presents techniques integrating animals into the psychotherapy setting that may sensitize therapists to patterns that are likely to occur in the

course of treatment and may aid them in diagnosing alliance ruptures, which in turn may increase their ability to intervene.

Identifying signs of rupture in AAP

Safran and Muran (2000) differentiated between two markers of alliance ruptures: withdrawal and confrontation. According to this model, the withdrawal marker includes the patient's avoidance and movement away from the therapist. Patients who behave in a withdrawing manner may disengage from an emotional state, from the therapist, or from the animal (e.g. avoiding physical contact with the animal when the animal approaches them or tries to play with them), or from some aspect of the treatment. Some patients may react with long silences and minimal response to the therapist's effort to explore and understand the patient's experiences. Others may change the subject occasionally or adopt an abstract language when talking about difficult interpersonal situation, making vague, general statements rather than directly stating their feelings. Still others may use avoidant storytelling or change the subject in order to avoid distressing situations. In these ways, patients make explicit their desire for autonomy and isolation.

The other aspect of withdrawal is movement toward the therapist or the animal and away from the self. This pattern can manifest in begrudgingly or readily complying with the therapist or the animal, such as touching the animal begrudgingly, looking like one who is forced to do so in order to look interested and connected with the animal. By these acts, the patients express compliance and appeasement, being at the same time excessively deferential and overly submissive to the therapist, the treatment and the animal. According to theory, autonomy/isolation and compliance/appeasement are both different signs of withdrawal markers (Safran & Muran, 2000).

The second type of alliance rupture marker is confrontation, which includes the patient's direct expression of anger or dissatisfaction with the therapist, the animal, or some aspect of the therapy. In this type of alliance rupture, the patient moves against the therapist or the animal. Some patients exhibiting this type of rupture may act in a controlling or aggressive way toward the therapist, the animal, or both. Patients may express negative feelings about the therapist or the animal, criticize the therapist's interpersonal style or the animal's temperament, or express doubts about the therapist's competence or the role of the animal in treatment. Patients may also reject the therapist's interpretations in an overly non-collaborative manner. These conceptualizations can become even more complex in practice because both patient and therapist, indeed even the animal, may contribute to the rupture.

Effective rupture resolution strategies in AAP

Even therapists who are aware of their patients' tendencies for such ruptures may be challenged to address them constructively. According to Safran and Muran's (2000) typology of rupture resolution strategies can be classified based on two criteria: direct versus indirect and surface versus depth-level strategies. The two dichotomous criteria form four combinations. The first combination results in a direct surface approach, which may involve simple clarification of the treatment rationale, the role of the animal in treatment, or the misunderstanding that occurred between the therapist, the patient, and the animal (e.g. "she (the animal) didn't meant to hurt you, she was just searching for her ball"). The second combination is that of the indirect surface approach, which may involve changing a treatment task or goal (permanently or for a short duration, until the patient feels more secure in therapy) when there is a disagreement or explaining that the animal does not "have" to take part in each and every treatment session. The third combination is that of the direct

depth approach, which may involve exploring a core relational theme. The fourth combination, that of the indirect depth approach, may involve providing a new, refreshing relational experience.

When resolving a rupture, the therapist may elaborate on the justification underlying the treatment goals and tasks, as well as the role of the animal, and provide the rationale for treatment. The therapist may also explain that focusing on the here-and-now relationship between the patient and therapist or the patient and the animal may help shed some light on how the patient tends to perceive other people, the patient's expectations from others, and the ensuing interactions with them. In this way, the therapist can invite the patient to discuss thoughts or feelings regarding the therapist and the animal. In some instances, therapists may also find it beneficial to self-disclose their internal experiences of the relationship with the patient or their own experience of the relationship with the animal. In this context, therapists may explicitly acknowledge their own contribution to a problem that occurred in the relationship or validate the patient's perception of difficulties interacting with the individual animal when the therapist discloses similar experiences (e.g. "I also feel it's hard for me to understand what she wants from me today. Something is bothering her and it's not clear to me what"). The therapist may also link the ruptures in the relationship with the therapist or the animal to a recurring interpersonal pattern in the patient's relationships outside the therapy room.

Rupture resolution patterns unique to AAP

Some processes of rupture resolution may have unique manifestations in AAP. In cases in which the patient is starting treatment with a highly rigid trait-like alliance component, we expect ruptures in the alliance with both the therapist and the animal. This circumstance is most likely to occur when patients start treatment with rigid maladaptive patterns of relating to others which manifest across distinct relationships (with father, mother, best friend, romantic partner, boss, etc.). In this scenario, the patient's rigid maladaptive patterns may be automatically projected onto any figure in the therapy room (Zilcha-Mano et al., 2014), therapist, or therapeutic animal, and it may be advisable for the therapist to use the above-mentioned techniques of rupture resolution referencing the patient's patterns of interaction with both the therapist and the animal. In some cases, the therapist chooses to focus first on the maladaptive patterns within the context of the patient's interactions with the animal, and only after those patterns have been worked through, shows the patient the parallel processes that take place in the alliance between the therapist and the patient. There are advantages to this sequential process, including the fact that some patients find it easier and safer to deal with the pain of working through a rupture with the animal first, before addressing the rupture with the therapist.

When patients start treatment with several distinct patterns of relating to others in their life, their patterns of relating to others are not as rigid, and the ruptures may occur with either the therapist or the animal, but not with both. For example, patients may form a close and intimate relationship with their mother, but a distant and cold one with their father. Such a circumstance offers a unique opportunity to explore ruptures in one relationship, using the other relationship as a secure base. Below, two main circumstances are discussed (a) "animal-over-therapist" circumstance, in which the patient can form a stable, good alliance with the therapeutic animal, but an alliance characterized by ruptures with the therapist and (b) the opposite, "therapist-over-animal" circumstance, in which the patient enjoys a stable, good alliance with the therapist, but an alliance characterized by ruptures with the animal.

For many patients in animal-over-therapist circumstances, painful memories and emotions are guarded by rigid defenses, and the patients may find it too painful to gain awareness of their previously unrecognized biases and failed relational strategies, as they are manifested in ruptures in the

alliance with the therapists. In most of these cases, patients have a long history of self-destructive misinterpreting of their own goals, leading in the opposite direction from the emotional outcomes intended and hurting other people with whom they had hoped to have rewarding relationships. In this context, the ability of the therapeutic animal to provide a secure base to the patient while negotiating the ruptures in the alliance with the therapist can be crucial.

It is difficult, and at times impossible for therapists to provide patients with a sense of security at the specific moments in treatment when ruptures in the relationship with the therapist occur (Mallinckrodt, 1991; Mallinckrodt, Coble, & Gantt, 1995). Criticism, disapproval, expectations and feelings of abandonment and rejection, which characterize a patient's working models, may be projected onto the therapist despite the latter's sensitivity, attentiveness, and empathetic responsiveness. In these cases, the therapist may fail to become a source of the patient's unmet needs for a safe haven and secure base in the face of ruptures. Even if the therapist does not fall into the complementary roles required by a patient's habitual dramas (Fonagy, 1988), the therapist's useful observations and interpretations during the rupture may not get through the patient's rigid, unconscious defenses. If a stable and satisfactory working alliance cannot be established, patients might not recognize that the therapist's interventions and insights are based on good intentions and true concern for their welfare (Martin et al., 2000).

It is not uncommon that the relationship with the animal suffers less from the ruptures that characterize the relationship with the therapist. An animal has unique characteristics that may "protect" it from such ruptures. As Levinson and Mallon (1997) noted, individuals tend to experience relationships with an animal in ways that are different from other interpersonal relationships. Animals are nonjudgmental, offer love, do not criticize, retaliate, feel overwhelmed, or reject and may lend social support (Alper, 1993). With an animal, patients may feel secure, accepted, and loved, without automatically projecting their maladaptive working models, which generally produce ruptures in their close relationships. It is possible that even individuals who do not allow themselves to trust another human being, as a consequence of early traumas with human attachment figures, may trust an animal. Levinson (1972) believed that in the case of children whose parents do not meet their developmental needs, animal companions could fill in the gaps. "These children have experienced so much hurt at the hand of people in their environment. It is only after they have had a satisfactory relationship with an animal that they can make a start at developing a human relationship" (p. 35). A therapy animal may serve as a calming agent during rupture sessions and create reinforcing experiences that increase commitment to therapy.

The animal can help the patient feel more comfortable taking the risks involved in reflecting on painful experiences during the rupture with the therapist by offering a substantial, concrete, and physical haven of safety in times of stress. Animals are in a unique position in this regard because they can display physical behaviors of comfort, warmth, and reassurance, which may not be professionally appropriate for the therapist to display (Phelana, 2009). Moreover, it is socially acceptable for both men and women to touch, stroke, and hug an animal. At times, the mere presence of an animal can promote relaxation in stressful moments. Numerous studies have found evidence that interactions with animals lead to physiological changes demonstrating decreased distress (Krause-Parello & Gulick, 2015; Nagasawa, Kikusui, Onaka, & Ohta, 2009; Odendaal, 2000; Odendaal & Meintjes, 2003; Zilcha-Mano et al., 2012) and can lower feelings of anxiety (Hoffmann et al., 2009; Shiloh, Sorek, & Terkel, 2003) in humans. According to Fine (2015), "on numerous occasions, the author [A.H. Fine] has witnessed that when a dispute would take place, the animal presence seemed to lend some comfort and stability to the environment" (p. 143; see also Lockwood, 1983).

With its similarities and differences, the parallel new secure relational experiences with the animal may help the therapist make patients more aware of how they may construct and distort

their current relationship with the therapist, as manifested in alliance ruptures and help patients reflect on earlier attachment experiences. In this way, the therapy animal can facilitate the processes of change by developing a secure base for patients, which in turn helps them explore their internal working models, as these are reflected in the ruptures in alliance with the therapist.

Forming a secure attachment and a strong, stable alliance with the animal in AAP can help patients see the therapy room as a haven of safety and pave the way to forming a more secure attachment relationship with the therapist by working through processes of negotiating the therapeutic alliance. Researchers, theoreticians, and clinicians suggest that the relationship individuals establish with the animal may be generalized to their relationships with human beings (Alper, 1993; Granger, Kogan, Fitchett, & Helmer, 1998; Katcher & Wilkins, 1997; Levinson & Mallon, 1997).

The potential role of the animal as a bridge may enable patients to establish secure attachment and a stable, strong alliance with them. Extending this attachment to the therapist and others (Katcher, 2000) may be understood in light of Winnicott's (1951) conceptualization of "transitional objects," in that the animal can act as a link between the patient's internal fantasies and external reality (Bady, 2004; Parish-Plass, 2013). This may be true especially in the case of a rupture with the therapist. By filling the intermediate space between fantasy and reality, the animal may serve as a self-object and facilitate the self-soothing function some patients lack, which is especially important in times of rupture.

For some patients, the opposite pattern of therapist-over-animal, albeit less common, is evident. These patients may demonstrate a stable and strong alliance with the therapist, feeling that it is safer and less scary to demonstrate ruptures in their relationship with the animal. On these occasions, the patients' maladaptive, insecure working models block the opportunity to form a refreshing, secure, or compensative relationship with the animal. Examination of their attitudes and feelings toward the animal and of the patterns in which they relate to it, under the supervision of the therapist, may provide an opportunity to understand how their working models are expressed and how they may possibly distort the course and experience of social interactions. The therapist can observe how the patient may be unconsciously overbearing, manipulative, or suspicious with regard to the animal's intentions and gestures. As one patient said,

> If she really wanted to be with me, she would stay near me the entire session. She is like everybody else, pretending that she wants to be near me, and then going away when I'm trying to get closer to her.

The competent therapist serves as a safe haven and secure base from which patients can explore and reflect on painful memories and experiences raised while working through the rupture with the animal. For example, a patient may display the same pattern session after session, being gentle toward the therapy animal but exhibiting hostility every time the animal leaves the patient to get some fresh water. As a result, the therapy animal moves away from the patient to the other side of the room. In response, the patient exhibits anger and frustration. The therapist's interpretations of the rupture can help the patient understand and deescalate this "vicious cycle," which subsequently can be generalized to other frustrating cycles in the patient's life. This unique microcosm of social interaction can help broaden and build the patient's skills with regard to nonverbal behavioral gestures and ambivalent verbal situations.

Finally, another unique opportunity that arises in the course of AAP is for the patient to see the therapist handling ruptures with the animal during the session. For example, when the patient asks the therapist for protection from the animal (usually in the first session, in the case of patients who are not used to the presence of animals), the therapist can ask the animal to stay

away from the patient. The animal may not follow the therapist's orders,[2] and the therapist may benefit from a unique situation in which to demonstrate interaction in situations of disagreement. The therapist may take the opportunity to observe the patient's response, for example, being angry that the animal is not doing what the animal should do or understanding the different needs that arise in this situation, both for the therapist and for the animal. Observing the interaction of the therapist with the animal in the face of rupture may demonstrate that ruptures do not have to be destructive and can help the patient see the therapist as attentive, sympathetic, and caring.

Summary

Alliance ruptures occur commonly in psychotherapy and have the potential to lead to dropout or deterioration or alternatively to corrective experience resulting in successful treatment. Accumulating empirical studies and clinical experience have proposed techniques for resolving ruptures in the therapeutic relationship, turning them into a formative experience that contributes to the shaping of an intimate, close relationship with the therapist.

Many patients can benefit from such relationship-based work, but some patients may benefit more than others. Those who arrive for treatment with more adaptive representations of self and others, and more satisfactory relationships with others, may be better able to create a strong alliance early in the treatment and maintain its level throughout, with minimal alliance ruptures. For such patients, the alliance may not be highly therapeutic by itself, but it can enable other therapeutic processes. By contrast, patients who find it difficult to form and maintain strong and satisfactory relationships with others may also have difficulty forming a strong alliance with the therapist or the therapy animal. For these patients, such alliance-focused work may be essential for treatment success, allowing them to improve their ability to form adaptive intimate relationship in the therapy room and thereby improve interpersonal relationships outside of treatment. This argument is based on the assumption that for individuals with a maladaptive interpersonal abilities, the interpersonal dysfunction may play a greater role in their presenting problems, and therefore changes in these abilities through alliance-focused work are of great importance.

Although alliance rupture resolution in AAP still awaits direct empirical examination, based on available theoretical conceptualization and clinical experience, it is a promising path for future research and clinical work. The concurrent formation of two alliance relationships, one between the patient and the therapist and another between the patient and the animal, offers exceptional opportunities for working through ruptures in one alliance relationship while using the other alliance relationship as a secure base and safe haven, enabling a deep and formative experience of rupture resolution. Empirical studies are needed to examine the utility of AAP techniques in resolving alliance ruptures.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Notes

1. Although I use of the word "animal" and not "pet," I would like to emphasize the importance of the therapist's personal relationships with the animals present in the therapy setting.
2. For many animal-assisted activities, dogs are expected to be highly trained and to pass an obedience test before being certified as a therapy dog. In animal-assisted psychotherapy (AAP), the dog's basic temperament (friendly and not anxious, aggressive, or intrusive) is important, and much less emphasis is placed on obedience.

References

Ainsworth, M. D. S. (1991). Attachment and other affectional bonds across the life cycle. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 33–51). New York, NY: Routledge.

Alper, L. S. (1993). The child-animal bond. In A. Goldberg (Ed.), *Progress in self psychology, vol. 9. The widening scope of self psychology* (pp. 257–270). Hillsdale, NJ: Analytic Press.

Bady, S. L. (2004). The creative use of animals in psychotherapy. *New York State Society for Clinical Social Work*, *15*, 1–5.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842–852.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*, 252–260.

Colli, A., & Lingiardi, V. (2009). The Collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research*, *19*, 718–734.

Connolly Gibbons, M. B., Crits-Christoph, P., de la Crus, C., Barber, J. P., Siqueland, L., & Gladis, M. (2003). Pretreatment expectations, interpersonal functioning and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychotherapy Research*, *13*, 59–76.

Crits-Christoph, P., Gibbons, M. B. C., & Mukherjee, D. (2013). Psychotherapy process outcome research. In M. J. Lambert (Ed.), *Bergin and garfield's handbook of psychotherapy and behavior change* (pp. 298–340). New York NY: John Wiley & Sons.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecific argument. *Clinical Psychology: Science and Practice*, *12*, 174–183. doi:10.1093/clipsy.bpi022

Fine, A. (2015). Incorporating animal-assisted interventions into psychotherapy: Guidelines and suggestions for therapists. In A. Fine (Ed.), *Handbook on animal-assisted therapy: Foundations and guidelines for animal-assisted interventions* (pp. 143–157). San Diego, CA: Academic Press.

Fonagy, P. (1988). An attachment theory approach to treatment of difficult patient. *Bulletin of Menninger Clinic*, *62*(22), 147–169.

Freud, S. (1920). Beyond the pleasure principle. *SE*, *18*, 7–64.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin, & S. L. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 190–228). New York, NY: John Wiley.

Granger, B. P., Kogan, L., Fitchett, J., & Helmer, K. (1998). A human-animal intervention team approach to animal-assisted therapy. *Anthrozoös*, *11*, 172–176.

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, *34*, 155–179.

Hazan, C., & Zeifman, D. (1994). Sex and the psychological tether. In K. Bartholomew, & D. Perlman (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 151–178). London, England: Jessica Kingsley.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, *43*, 207–217.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, *40*, 278–287.

Hoffmann, A. O., Lee, A. H., Wertenauer, F., Ricken, R., Jansen, J. J., Gallinat, J., & Lang, U. E. (2009). Dog-assisted intervention significantly reduces anxiety in hospitalized patients with major depression. *European Journal of Integrative Medicine*, *1*, 145–148.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research & Practice*, *48*, 9–16. doi:10.1037/a0022186

Katcher, A. (2000). The future of education and research on the human-animal bond and animal-assisted therapy. Part B: Animal-assisted therapy and the study of human-animal relationships: Discipline or bondage? Context or transitional object. In A. H. Fine (Ed.), *Handbook of animal assisted therapy: Theoretical foundations for guidelines and practice* (pp. 461–473). San Diego, CA: Academic Press.

Katcher, A., & Wilkins, G. (1997). Animal-assisted therapy in the treatment of disruptive behavior disorders. In A. Lundberg (Ed.), *Environment and mental health* (pp. 193–204). Mahwah, NJ: Lawrence Erlbaum.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

Krause-Parello, C. A., & Gulick, E. (2015). Forensic interviews for child sexual abuse allegations: An investigation into the effects of animal-assisted intervention on stress biomarkers. *Journal of Child Sexual Abuse*, *24*, 873–886.

Levinson, B. M. (1972). *Animals and human development*. Oxford, UK: Charles C Thomas.

Levinson, B. M., & Mallon, G. P. (1997). *Animal-oriented child psychotherapy*. Oxford, UK: Charles C Thomas.

Lockwood, R. (1983). The influence of animals on social perception. In A. H. Katcher, & A. M. Beck (Eds.), *New perspectives on our lives with companion animals* (pp. 64–71). Philadelphia: University of Pennsylvania Press.

Mallinckrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. *Journal of Counseling Psychology*, *38*, 401–409.

Mallinckrodt, B., Coble, H. M., & Gantt, D. L. (1995). Working alliance, attachment memories, and social competencies of women in brief therapy. *Journal of Counseling Psychology*, *42*, 79–84.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450.

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review*, *31*, 603–616. doi:10.1016/j.cpr.2011.02.001

Muran, J. C., Safran, J. D., & Eubanks-Carter, C. (2010). Developing therapist abilities to negotiate alliance ruptures. In J. C. Muran, & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 320–340). New York, NY: Guilford Press.

Nagasawa, M., Kikusui, T., Onaka, T., & Ohta, M. (2009). Dog's gaze at its owner increases owner's urinary oxytocin during social interaction. *Hormones and Behavior*, *55*, 434–441.

Odendaal, J. S. J. (2000). Animal-assisted therapy—Magic or medicine? *Journal of Psychosomatic Research*, *49*, 275–280.

Odendaal, J. S. J., & Meintjes, R. A. (2003). Neurophysiological correlates of affiliative behaviour between humans and dogs. *The Veterinary Journal*, *165*, 296–301.

Parish-Plass, N. (2013). The contribution of animal-assisted psychotherapy to the potential space in play therapy. In N. Parish-Plass (Ed.), *Animal-assisted psychotherapy: Theory, issues and practice* (pp. 79–109). Lafayette, IN: Purdue University Press.

Phelana, J. E. (2009). Exploring the use of touch in the psychotherapeutic setting: A phenomenological review. *Psychotherapy: Theory, Research & Practice*, *46*, 97–111.

Regan, A. M., & Hill, C. E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology*, *39*, 168–174.

Rhodes, R., Hill, C., Thompson, B., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Counseling Psychology*, *41*, 473–483.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Shiloh, S., Sorek, G., & Terkel, J. (2003). Reduction of state-anxiety by animalting animals in a controlled laboratory experiment. *Anxiety, Stress, & Coping*, *16*, 387–395.

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis*, *15*, 117–126.

Winnicott, D. W. (1951). Transitional Objects and Transitional Phenomena.

Zilcha-Mano, S. (2014). Animal-assisted psychotherapy from an attachment perspective. In N. Parish-Plass (Ed.), *Animal-assisted psychotherapy: Theory, issues and practice* (pp. 111–145). Lafayette, IN: Purdue University Press.

Zilcha-Mano, S. (in press). Is alliance really therapeutic? A systematic answer based on recent methodological developments. *American Psychologist*.

Zilcha-Mano, S. (2016). New analytic strategies help answer the controversial question of whether alliance is therapeutic in itself. *World Psychiatry*, *15*, 84–85.

Zilcha-Mano, S., Dinger, U., McCarthy, K. S., & Barber, J. P. (2014). Does alliance predict symptomatic change, or is it the other way around? *Journal of Counseling and Clinical Psychology*, *82*, 931–935.

Zilcha-Mano, S., McCarthy, K. S., Dinger, U., & Barber, J. P. (2014). To what extent is the alliance affected by transference? Some empirical findings. *Psychotherapy: Theory, Research & Practice*, *51*, 424–433. doi:10.1037/a0036566

Zilcha-Mano, S., McCarthy, K. S., Dinger, U., Chambless, D. L., Milrod, B. L., Kunik, L., & Barber, J. P. (2015). Are there subtypes of panic disorder? An interpersonal perspective. *Journal of Consulting and Clinical Psychology*, *83*, 938–950.

Zilcha-Mano, S., Mikulincer, M., & Shaver, P. R. (2011a). Animal in the therapy room: An attachment perspective on animal-assisted therapy. *Attachment and Human Development*, *13*, 541–561.

Zilcha-Mano, S., Mikulincer, M., & Shaver, P. R. (2011b). An attachment perspective on human-animal relationships: Conceptualization and assessment of Animal Attachment Orientations. *Journal of Research in Personality*, *45*, 345–357.

Zilcha-Mano, S., Mikulincer, M., & Shaver, P. R. (2012). Animals as safe havens and secure bases: The moderating role of animal attachment orientations. *Journal of Research in Personality*, *46*, 571–580.

Author biography

Dr. Zilcha-Mano is a licensed clinical psychologist and a senior lecturer of clinical psychology in the Department of Psychology, University of Haifa. Dr. Zilcha-Mano is most interested in the study of mechanisms of change in psychotherapy and of the interplay between interpersonal factors and processes of change.