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Is the Alliance Really Therapeutic? Revisiting This Question in Light of Recent Methodological Advances

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The therapeutic value of alliance is a contested supposition. Although many theorists and researchers believe that alliance is therapeutic in itself, others see it as a byproduct of effective treatment or as a common nonspecific factor enabling the truly effective ingredients of treatment to work. For many years, the debate was confined mainly to the domain of theory, and no studies were available to confirm which of these approaches is correct. The only empirical evidence that existed was studies showing a correlation between alliance and outcome, and advocates of the above conflicting opinions used the same correlation to prove the validity of their position. Over the last few years, however, a revolution has taken place in alliance research, which brings this theoretical debate into the realm of the empirical. Several recent alliance studies have applied advanced methodologies to achieve this aim. Based on an integration of these studies, the present article proposes a new model for understanding the potential therapeutic role of alliance as sufficient to induce change by itself. The model stresses the importance of differentiating between patients' general tendencies to form satisfying relationships with others, which affect also the relationship with the therapist ("trait-like" component of alliance), and the *process* of the development of changes in such tendencies through interaction with the therapist ("state-like" component of alliance). The former enables treatment to be effective; the latter makes alliance therapeutic. Based on the literature, this article attempts to determine which of these components is the predictor of treatment outcome.

Keywords: alliance, active therapeutic ingredients, psychotherapy process research, alliance–outcome association

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Background

The Concept of Alliance

In his work with patients, Freud (1937/1964) encountered what we now refer to as alliance ruptures, in which patients were not engaged and did not participate in the therapeutic work as expected. Freud emphasized the importance of positive, "unobjectionable" transference that binds the patient to the person of the therapist and helps keep the patient in treatment despite increased levels of anxiety. 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 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.

In the absence of an agreed definition of alliance, researchers and clinicians have interpreted the term according to their conceptualization of the therapy process (Horvath, Del Re, Flückiger, & Symonds, 2011), each highlighting different functions of the alliance. For example, Safran and Muran (2000) stressed the importance of a dynamic negotiation process in the formation and maintenance of the alliance, which make it curative in itself, whereas Hatcher and Barends (2006) stressed the role of alliance as a work-supporting needed for undertaking the curative tasks of therapy. Though the term is used to refer to each of these roles, it should be highlighted that a strong alliance between patient and therapist from the start of treatment, which is adequate for working collaboratively and deploying effec-

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tive techniques, is different from the process of building alliance or repairing it, which has the potential to create a corrective experience in which alliance serves as a curative factor in its own right (e.g., Hatcher, 2010).

The Existing Body of Empirical Findings About the Role of Alliance in Psychotherapy

Effective psychotherapy is characterized by good working alliance between patient and therapist (Crits-Christoph, Gibbons, & Mukherjee, 2013; Wampold, 2015). The quality of the alliance has been consistently correlated with psychotherapy outcome, with stronger alliances being associated with better therapeutic outcomes (Horvath et al., 2011). Based on this association, many researchers have argued that alliance is therapeutic in itself and designated it as an active ingredient in the success of treatment. This perspective is consistent with many theoretical conceptualizations seeing the alliance as therapeutic in its own right (Zetzel, 1966), and even as the essence of the process of change (Safran & Muran, 2000).

The importance of alliance to therapy seems intuitive, both clinically and theoretically. Still, we must question whether empirical findings support the argument that alliance is therapeutic in itself. That is, do empirical finding suggest that alliance is sufficient to induce change, and is not merely the optimal context in which effective techniques can be used? The present article reviews recent studies examining this view and maps the future studies needed to further test the existence of such an effect. Empirical evidence on the therapeutic qualities of alliance is of particular interest at this time, when new, exciting, and sophisticated analytic methods have been incorporated into the research of the alliance–outcome association.

Until recently, most of the studies on the alliance–outcome association focused on the ability to predict symptomatic change based on the level of the alliance at a given point in time (e.g., the third week of treatment), or on an aggregated score of alliance level (Crits-Christoph et al., 2013). These studies were important in establishing the consistent association between alliance and outcome, but their methods cannot take us beyond this discovery and cannot demonstrate that alliance is therapeutic in itself. The analytic methods used in recent studies, however, help us explore issues that until now were considered mainly theoretical, including the role of alliance as an active ingredient in bringing about therapeutic change.

The New Line of Empirical Findings Regarding the Role of Alliance in Psychotherapy

To answer the question whether alliance plays an active role in bringing about better outcomes, the present article focuses on the importance of distinguishing between the trait-like and state-like components of alliance that characterize the individual patient. Disentangling these two components reveals that some elements of the alliance–outcome association are the result of the patients' trait-like component of the alliance: their general ability to form satisfactory relationships with others, their internal representations of self and others, and expectations from interpersonal relationships. This ability may affect the patient's capacity to form a satisfactory relationship with the therapist, manifested in a strong alliance, and simultaneously also influence the patient's capacity to benefit from treatment. Patients do not come to the therapy tabula rasa (Wampold & Budge, 2012), but have a predisposition or capability of forming an alliance with the therapist (DeRubeis, Brotman, & Gibbons, 2005). In this regard, the alliance–outcome association is at least partly due to existing traits of the patients rather than the result of therapeutic interaction with the therapists, and thus, the trait-like elements are not the ones that make alliance therapeutic in itself.

By contrast, the state-like component of the alliance refers to changes in alliance during treatment (e.g., time-specific strengthening of the alliance) that can predict changes in outcome. This component brings into focus the therapeutic nature of alliance, an active ingredient sufficient in itself to bring about therapeutic change. Recent developments in analytic methods, applied to psychotherapy research, have made it possible to explore empirically the theoretical distinction between the state-like and trait-like components of alliance. These ground-breaking methodologies will play a critical role in the design of future psychotherapy research. The present review presents the find-

ings of such studies and discusses their influence on critical issues in psychotherapy research.

What Can We Learn From Previous Studies About Whether Alliance Can Predict Outcome?

Many studies attempted to address the question whether alliance can predict outcome, but in practice, most of them examined whether alliance at one specific time point correlates with outcome. The consistent association between alliance and outcome in these studies appears to suggest that the former predicts the latter, but this interpretation faces several challenges. For example, several researchers have suggested that good alliance may be the result of changes in symptoms rather than the other way around (e.g., Barber, 2009; DeRubeis et al., 2005; DeRubeis & Feeley, 1990). Support for this suggestion is found in studies of the alliance–outcome correlation, which accounted for symptomatic change before measuring the alliance. These studies showed that early symptomatic change predicted alliance (Puschner, Wolf, & Kraft, 2008), and that *only* early symptomatic change, and not alliance, can predict subsequent changes in symptoms (e.g., Barber et al., 1999; Hendriksen, Peen, Van, Barber, & Dekker, 2014; Strunk, Brotman, & DeRubeis, 2010). Other studies, however, have found that alliance makes a unique contribution to predicting outcome even after controlling for early symptomatic change (e.g., Arnow et al., 2013; Crits-Christoph et al., 2009; Huppert et al., 2014; Webb et al., 2011; Xu & Tracey, 2015; for a review, see Crits-Christoph et al., 2013), leaving us with mixed findings.

It is possible to challenge the methodology used in studies that controlled for early symptomatic change by pointing out that most of them did not take into account the development of alliance across treatment, but focused on it as a fixed factor, measuring it only at one time point in the treatment (generally in the early weeks). Such a design treats alliance as static and does not take into account its role as a dynamic element of treatment. It is therefore important to measure changes in alliance across treatment to determine whether or not they precede changes in symptoms. Not having done so may have contributed to the mixed results reported in the literature.

What Can We Learn From the New Line of Alliance Research About Whether Alliance Can Predict Outcome?

A few recent studies have focused on the development of alliance across treatment to explore whether alliance levels precede symptomatic levels, above and beyond previous symptomatic levels across the course of treatment. Using autoregressive cross-lagged modeling (Selig & Little, 2012; Shahar & Davidson, 2003) and other similar methods, the majority of these studies demonstrated that alliance indeed precedes symptom reduction (e.g., Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Falkenström, Granström, & Holmqvist, 2013; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014; Zilcha-Mano & Errázuriz, 2015, but see also Strunk, Cooper, Ryan, DeRubeis, & Hollon, 2012 and Webb, Beard, Auerbach, Menninger, & Bjorgvinsson, 2014). However, temporal relationships alone do not inform us about which of the alliance's components affect outcome. Is it the variation in individuals' general tendencies to form strong alliances (the trait-like component), or deviations in the course of treatment from this individual tendency (state-like component), which actually predicts outcome? A few recent studies have used statistical methods such as centering (Wang & Maxwell, 2015) and detrending (Curran & Bauer, 2011) to disentangle the effects of between- and within-patient variability in alliance on outcome,[1] and thus differentiate between trait-like and state-like components of alliance. The findings of these studies are presented in Table 1 and discussed below to answer the question whether alliance is therapeutic in itself.

Alliance as Curative in Itself: Can State-Like Changes in Alliance Predict Outcome?

Several studies have attempted to disentangle the state-like from trait-like components of alliance, and test their ability to predict outcome. The findings of these studies support the argument that it is possible to identify the state-like component of alliance, and that this component has significant effects on outcome. For example, Falkenström et al. (2013) showed that state-like improvements in alliance (i.e., within-patient variability) predicted symptom reduction in a sample of 646 patients in primary care psychotherapy in Sweden. Similar findings were obtained in a sample of 547 patients from an outpatient mental health clinic in Chile (Zilcha-Mano & Errázuriz, 2015), and in a sample of 149 patients from a randomized controlled trial for depression in the Unites States (Zilcha-Mano, Solomonov, et al., 2015). In other words, state-like changes in the alliance across treatment can predict outcome, independently of the patient's general trait-like ability to form a strong and satisfying alliance. These findings support the ability of alliance to actively bring about changes in outcome.

The above studies focused mainly on the patients' perspective of the alliance. Despite theoretical arguments for a two-person approach to psychotherapy (see Safran & Muran, 2000, for a review), most studies have not taken into

[1] It is important to differentiate between the patient's perspective of the alliance and variability between and within patients in the alliance. Both state-like and trait-like components can be viewed from different perspectives: the patient's self-report, the therapist's self-report, and the evaluation of an external observer.

Table 1
The Effects of Within- and Between-Patients Working Alliance on Outcome in Individual Treatments

Study and year	Population	Sample size	Type of psychotherapy	Alliance measure	Outcome measure	Treatment length	Research type
Crits-Christoph et al. (2011)	MDD	$N = 45$	Alliance-fostering therapy	Patient-rated CALPAS	BDI and Hamilton	16 weekly sessions	Study focused on training therapists to improve their alliances[a]
Falkenström et al. (2013)	Heterogeneous population	$N = 646$	Diverse, most common: 30% supportive, 24% psychodynamic, 18% CBT	Patient-rated WAI	CORE-OM	Diverse: mean length of treatment 4.6 ($SD = 4.0$; $Mdn = 4$) sessions	Primary care psychotherapy
Hoffart et al. (2013)	PTSD	$N = 65$	Standard prolonged exposure ($N = 33$) or modified prolonged exposure ($N = 34$)	Patient-rated WAI-SR	PSS-I, PSS-SR	10 Weekly sessions	RCT
Marker et al. (2013)	Children with separation anxiety disorder, generalized anxiety disorder, or social phobia	$N = 86$	Manual-based family treatment for child anxiety disorders	Child, therapist, and parent TASC-r	STAIC	16 Weekly sessions	RCT
Zilcha-Mano and Errázuriz (2015)	Heterogeneous population, mainly MDD	$N = 547$	Integrative	Patient-rated WAI	OQ	Diverse: mean length of treatment 7.82 ($SD = 6.62$; $Mdn = 6$) sessions	Primary care psychotherapy setting
Zilcha-Mano, Solomonov, et al. (2015)	MDD	$N = 149$	Supportive-expressive treatment ($N = 49$) and case management with SSRI ($N = 51$) or placebo ($N = 49$)	Patient-rated and therapist-rated WAI	Hamilton	16 weekly sessions	RCT
Zilcha-Mano, Muran, et al. (2016)	Heterogeneous population, mainly mood disorder	$N = 241$	Alliance focused treatment ($N = 133$) and cognitive behavioral treatment ($N = 108$)	Patient-rated and therapist-rated WAI	Single-item session outcome and SCL	30 weekly sessions	RCT
Falkenström et al. (2016)	MDD	$N = 84$	CBT with interpersonal psychotherapy	Patient-rated and therapist-rated WAI-SH	BDI-II	14 weekly sessions	RCT

Note. The table may not be inclusive but represents most of the available literature in the field. MDD = major depression disorder; PTSD = posttraumatic stress disorder; PSS-I = PTSD Symptom Scale–Interview; PSS-SR = PTSD Symptom Scale–Self-Report; WAI-SR = Working Alliance Inventory–Short Revised; WAI = Working Alliance Inventory; WAI-SR = Working Alliance Inventory–Short; CALPAS = California Psychotherapy Alliance Scale–Patient Version; BDI = Beck Depression Inventory; MINI = Mini International Neuropsychiatric Interview; TASC-r = Therapeutic Alliance Scale for Children–Revised; RCT = randomized controlled trial; STAIC = State-Trait Anxiety Inventory for Children; BDI-II = The Beck Depression Inventory–II; OQ = Outcome Questionnaire; CORE-OM = Clinical Outcomes in Routine Evaluation–Outcome Measure; SCL = Symptom Checklist-90–Revised; CBT = cognitive–behavioral therapy; APIM = Actor Partner Interdependence Model; IE = imaginal exposure; IR = imagery rescripting; AFT = alliance focused treatment.
[a] Two replication samples were also used. Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, and Peri (2016) was not included because they focus on alliance-experience associations, and did not include a model that does not include experience.

Addressing therapist effect	Accounting for the temporal relationship	Accounting for therapist and patient interdependence in their reports	Examining both between- and within-patients effects? (method used)	Can between- and within-patient alliance predict outcome?	Differences between conditions?	Potential moderators of the alliance–outcome association (other than condition)?
Yes	Yes	N/A	Yes, within-patient effect (using first differences, i.e., subtracting each score from the previous score on the same variable) and between-patient effect (aggregation across several sessions)	Within-patient and between-patient alliance significantly predicted outcome	N/A	Was not examined
Yes	Yes	N/A	Only within-patient effect (detrending method)	Within-patient alliance significantly predicted outcome	N/A	Patients' personality problems, treatment length
Yes	Yes	N/A	Yes (detrending method)	Within- patient alliance (task component) significantly predicted outcome Between- patient alliance (task and bond components) significantly predicted outcome	Stronger effect for within-patient alliance in IE than in IR	Treatment condition
Yes	Yes	No	Only within-patient effect (bivariate latent difference score)	Within-patient alliance as rated by the mother and therapist significantly predicted changes in child anxiety	N/A	Was not examined
Yes	Yes	N/A	Yes (detrending method)	Both within and between-patient alliance significantly predicted outcome	N/A	Symptom severity, treatment length, therapist level of integrative theoretical orientation
Yes	Yes	Yes, both patient-rated and therapist-rated alliance were entered as predictors into the same model; only patient-rated outcome was available	Yes (centering)	Within-patient patient-rated but not therapist-rated alliance significantly predicted outcome	No	Was not examined
Yes	Yes	Yes (APIM)	Yes (centering)	Within-patient and between-patient alliance as rated by patients and therapists significantly predicted outcome	Yes, within patient therapist-reported alliance and outcome had a stronger effect in AFT than in CBT	Treatment condition
Yes	Yes	No	Only within-patient effect (using first differences)	Within-patient alliance as rated by patients and therapists significantly predicted outcome	No	Was not examined (No significant moderator for both first and second lag of alliance)

account the interdependence between the partners' views of the therapeutic dyad, or its effect on treatment outcome, ignoring the probable influence that patients' and therapists' perspective on alliance may have on each other (Rozmarin et al., 2008). This is arguably a conceptual and methodological shortcoming because the patient's and therapist's views on their relationship are not independent, but rather based on the same interactions, and nested within the same dyad (Krasikova & LeBreton, 2012). Studies led by Kivlighan (2007) have focused on the interdependence between patients' and therapists' alliance levels in predicting outcome, using the actor–partner interdependence model analysis (Ledermann & Kenny, 2012). The authors have shown that both patient- and therapist-reported alliance at a specific time point in treatment are important to predict outcome (Kivlighan, 2007; Kivlighan, Marmarosh, & Hilsenroth, 2014). However, some inconsistencies were found in their work. In the initial study, Kivlighan (2007) noted that the therapists' ratings of alliance correlated significantly with their patients' ratings of session outcome, but in their later work, Kivlighan et al. (2014) demonstrated that patient ratings of the alliance predicted the therapist ratings of several session outcome measures.

Applying the analytic methods used by Kivlighan (2007), a recent study examined the effects of both therapist and patient ratings of alliance on outcome, as they unfolded over the course of treatment, separating between the state-like and trait-like components of alliance (Zilcha-Mano, Muran, et al., 2016). The findings show that the state-like component of changes in alliance within treatment—as reported by patients—predicted both patient and therapist reports on the subsequent session outcome. This suggests that alliance has a dyadic therapeutic effect in itself, in which the therapeutic effect of changes in alliance across treatment, as evaluated by the patient, can be perceived by both patients and therapists. Future studies should incorporate into their design measurements obtained from both patients and therapists, and use adequate analytic methods to account for such interdependence (Kivlighan, 2007), such as the actor–partner interdependence model of dependencies within nested dyadic data.

Using advanced statistical methods, the above findings regarding the ability of state-like changes in alliance to predict outcome support the notion that alliance is therapeutic, because changes in alliance across treatment preceded changes in outcome. However, to conclude that changes in alliance *cause* better outcomes, dismantling randomized clinical trials[2] specifically designed to manipulate the alliance must be used. Such a design involves randomizing patients to two conditions: one in which therapists are instructed to maintain a steady alliance, and the other in which they are instructed to strengthen the alliance over the course of treatment. It is unlikely that such a design can be carried out because of ethical barriers. An ethical design based on a similar concept was implemented in a study in which patients were randomized to several feedback conditions, including one providing no feedback to therapists and another providing feedback on the alliance reported by the patient, as it changed over the course of treatment. The assumption was that feedback would help the therapists strengthen the alliance, facilitating state-like changes, and use it to improve treatment success. The study found a greater effect of the state-like components of alliance on outcome in the second condition (Zilcha-Mano & Errázuriz, 2015), suggesting that not only can the state-like component of alliance predict outcome, but that this effect can be manipulated.

Alliance as Enabling Other Therapeutic Processes: Is Alliance a Product of the Patient's (and Therapist's) Trait-Like Tendencies to Form Satisfying Relationships?

The trait-like component of the alliance is important for understanding the alliance–outcome association. Some people are generally more capable of forming a strong and satisfying relationships with others, and it stands to reason that such patients most likely have a better chance of forming a strong alliance with their therapist as well, and benefit from a better treatment outcome. The trait-like component does not make alliance sufficient to induce change by itself, but it can enable the use of other aspects of treatment that may induce change, such as effective techniques. Although the assumption that patients with a more adaptive trait-like alliance component will benefit more from treatment sounds intuitive and provides the basis for many theories of interpersonal relationships (such as attachment theory, Bowlby, 1988), it is important to examine it empirically.

One form of empirical support for the importance of the trait-like component of the alliance comes from measuring the patients' pretreatment interpersonal characteristics, and testing the ability of these characteristics to predict the development of alliance over the treatment. Two main frameworks have been used to examine this association: attachment theory (Bowlby, 1988) and the core conflictual relationship theme method (Luborsky & Crits-Christoph, 1998). Findings show that insecure representations of others predict poorer alliance (Diener, Hilsenroth, & Weinberger, 2009; Smith, Msetfi, & Golding, 2010), and that maladaptive major relationship themes predict maladaptive representations of the therapist (e.g., Barber, Foltz, DeRubeis, & Landis, 2002; Connolly et al., 1996). A recent study examined the ability of pretreatment representations of others to

[2] "Dismantling design" is a method used in therapy outcome studies to identify the effects of specific components of treatment. The components are examined separately and in combination to disentangle their relative utility. Dismantling studies aim to take apart treatments to determine which of the components were responsible for the outcome.

predict alliance as it develops across treatment (Zilcha-Mano, McCarthy, et al., 2014). The findings show that the percentage of alliance explained by pretreatment representations of others ranged from 32% to 54%, depending on the phase of treatment.

To examine whether the trait-like component of the alliance indeed affects outcome, it is not enough to show that alliance levels are to some extent a product of the patient's trait-like characteristics. Such findings prove only that the trait-like component of alliance exists; it is also necessary to show that it can specifically predict outcome. Recent findings suggest that when the trait-like component of alliance is separated from the state-like component, the former significantly predicts outcome. These studies operationally defined the trait-like component of alliance as the mean alliance level that the patient is able to form with the therapist, and showed that this component predicted outcome (Zilcha-Mano, Solomonov, et al., 2015). Another possible operational definition of the trait-like component of alliance is the level of alliance early in the treatment. This definition has the advantage of more efficiently clearing away state-like changes in alliance, which take place later in treatment. Studies that used this definition also demonstrated the ability of early alliance to predict outcome (Hoffart, Øktedalen, Langkaas, & Wampold, 2013; Zilcha-Mano & Errázuriz, 2015).

It is still possible to argue, however, that interactions with the therapist at the beginning of the treatment influence the alliance, as these assessments were conducted after the patient had already met the therapist. According to this argument, the trait-like components of the alliance become contaminated by state-like components as early as the first session of treatment. Because each patient in the above studies worked with only one therapist, it is impossible to know whether the same patient would have formed the same early alliance with other therapists. Yet, the trait-like capabilities of forming an adaptive alliance are potentially present (although not yet realized) even before the patient meets the therapist, and can be assessed before the beginning of treatment. Assuming that the alliance–outcome association is affected in part by trait-like components, at least part of the alliance may exist—and therefore partly determine outcome—even before the first patient–therapist encounter. Studies that examined whether pretreatment alliance can predict symptoms found that pretreatment alliance levels were significantly related to alliance later in therapy (Barber et al., 2014; Hilsenroth, Peters, & Ackerman, 2004), and that alliance later in treatment significantly predicted outcome (Barber et al., 2014), but pretreatment alliance cannot directly predict outcome (Barber et al., 2014). An inherent problem with examining alliance before the initiation of treatment is that it may be based on the patient's hopes and fantasies (Barber et al., 2014) rather than reflecting strictly interpersonal trait-like tendencies and can also be affected by the characteristics of the intake specialist (Hilsenroth et al., 2004).

In contrast to patients, who generally work with only one therapist in the course of a treatment, therapists usually work with more than one patient. Studies reflecting this nesting of patients within therapists have used a "one-with-many" design (Marcus, Kashy, & Baldwin, 2009) that enables examining the therapists' trait-like characteristics and determine whether their ability to form a strong alliance across patients predicts outcome. Several studies that examined the ability of variance in alliance between therapists to predict outcome suggested that therapists' trait-like tendencies to form a strong alliance can indeed predict better outcomes (e.g., Baldwin, Wampold, & Imel, 2007; Crits-Christoph et al., 2009; Marcus et al., 2009; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010; for review, see Baldwin & Imel, 2013), but other studies failed to find such an effect (e.g., Huppert et al., 2014; Xu & Tracey, 2015; Zilcha-Mano & Errázuriz, 2015). Several explanations are possible for this great variability in findings (Baldwin & Imel, 2013), including statistical reasons (Crits-Christoph et al., 2011), the fact that in naturalistic studies some therapists (e.g., those perceived as more competent) may have treated the more challenging patients, and a potential variability in homogeneity versus heterogeneity of therapists' trait-like characteristics across different clinical centers.

Can Changes in the State-Like Component of Alliance Predict Changes in the Trait-Like Component and, in Turn, Result in Symptomatic Change?

What is the function of the trait-like components, and are they in fact unimportant in discovering the therapeutic role of alliance? I would like to argue that they become valuable later in the treatment, after the state-like components have already brought out specific changes in the patient, enabling a deeper process of change in the patients' trait-like component of alliance.

According to theories on transference, defined either as pure enactments of early relationships (Westen, 1998) or as the coconstruction of patient and therapist (Mitchell, 1988), the therapeutic work focusing on a patient's internal representations, as they appear in the here and now of the therapeutic relationship, may bring about a general change in how the patient perceives the self and others. The result is therapeutic change, with subsequent reduction in symptoms. This conceptualization of therapeutic change is consistent with many interpersonal and psychodynamic theories. For example, according to attachment theory (Bowlby, 1988), after a secure base is established between patient and therapist, the two should explore the therapeutic relationship together and consider how it may relate to relationships or experiences outside of therapy, and how current relation-

ship experiences are related to those in the past. This process may help patients discover specific tendencies for representing self and others (their "attachment working models"), and eventually lead to a revision of maladaptive and pathogenic representations (Mikulincer, Shaver, & Berant, 2013; Zilcha-Mano, 2013). Many psychodynamic theories have emphasized the importance of working on the "here and now" of the interpersonal relationship with the therapist (i.e., causing state-like changes in alliance); some even argued that interventions focused on conflicts and interpersonal patterns in the patients' relationships outside therapy only, often provoke intellectualized rather than deep emotional work (Gabbard & Westen, 2003).

Many theories hold that working on the relationship between patient and therapist is important for treatment success across modalities of psychotherapy (Gelso & Bhatia, 2012). Although the direction of change from perception, thoughts, and emotions to behavior is greatly emphasized in psychodynamic and interpersonal literature, there are multiple routes to therapeutic change (Wachtel, Kruk, & McKinney, 2005; Wachtel, 1977). State-like changes in alliance may also be achieved through work focused on behavioral change, such that both inside-out and inside-in directions of change can contribute to the process of change (Wachtel et al., 2005). In many cases, the therapist follows a more didactic approach and employ explicit, purposeful behavioral methods, which would enable the patient to acquire desirable interpersonal skills (Goldfried, 1985; Stricker & Gold, 2005; Wachtel et al., 2005).

Changes in the state-like component of alliance, presumably the result of in-session work between patient and therapist on the relationship between them, may contribute to trait-like changes in patients. For example, changes during therapy in the patient's patterns of relating to the therapist may affect general internal representations of the self and others (Bowlby, 1988), representations of social interactions, and in turn the patients' ability to enjoy satisfactory relationships with others. Theoretical conceptualizations and case studies argue that profound trait-like character changes take place after long-term psychotherapy (McWilliams, 2004). To what extent, however, are there empirical evidence to suggest that representations of others and interpersonal abilities change during treatment, especially during short-term treatments, which are most common nowadays? Studies suggest that even short-term treatment is followed by a significant reduction in negative representations of the self and others, and in significant increase in positive representations (e.g., Zilcha-Mano, Chui, et al., 2016). Following short-term treatments, patients show fewer interpersonal problems, greater satisfaction derived from interpersonal relationships, and higher quality of interpersonal relationships (for a review, see Driessen et al., 2015).

It can be suggested that trait-like changes in interpersonal patterns and in the quality of interactions with others may not be meaningful in themselves, and may be merely a byproduct of changes in symptoms. In effective treatment for depression, for example, one expects patients to feel less depressed as treatment progresses, and therefore better able to engage in beneficial interactions with others. Yet, a valid question is whether changes in interpersonal patterns and quality of interactions with others are merely a byproduct of changes in symptoms, or do they play a substantial role themselves. This question can be subdivided into two parts, regarding the possible roles of representations of others and of interactions with others: (a) Can changes in quality of relationships with others predict symptom reduction and not only reflect previous symptomatic change? (b) Can changes in representations of the self and others predict symptoms and not only reflect previous symptomatic change?

Can changes in quality of relationships with others predict symptom reduction and not only reflect previous symptomatic change? Many interpersonal and behavioral theories of therapeutic change argue that trait-like changes in the quality of interpersonal relationships may contribute to changes in symptoms. Several scholars have argued that changes in how individuals react to others may lead to changes in the context in which these individuals live, and therefore in how others react to them, resulting in a reduction in symptoms. Thus, changes in the way individuals react to others shape their own interpersonal environment, which in turn affects their wellbeing and symptoms (Shahar, 2006). Only a few studies have attempted to separate changes in the quality of interpersonal relationships from symptomatic change, and examined whether the former can predict the latter, rather than only vice versa. In one such study, the extent to which patients reported enjoying more adaptive social relations preceded symptomatic change, and was not only its product (Zilcha-Mano, Dinger, McCarthy, Barrett, et al., 2014).

Can changes in representations of the self and others predict symptoms and not only reflect previous symptomatic change? The fact that trait-like changes in the quality of interpersonal relationships can temporally precede symptom reduction does not necessarily mean that changes in the representations of the self and others play the same role in preceding symptomatic change. Many theories, especially psychodynamic and interpersonal, however, support such an argument (Luborsky, 1984). According to these theories, changes in internal interpersonal representations apply to real-life interactions with others and ultimately lead to symptom reduction (Book, 1998; Shedler, 2010). Few studies have attempted to examine the temporal relationship between changes in representations of the self and others and symptomatic change, and to determine whether the former can predict the latter, after taking into account the ability of the latter to predict the former. One such study on treatment for depression found a decrease in negative relational representations and an increase in positive represen-

tations across treatment, and showed that changes in relational representations were not merely the product of previous symptomatic change but also the predictor of subsequent symptomatic change (Zilcha-Mano, Chui, et al., 2016).

An important avenue for future research is to directly manipulate the state-like component of the alliance to examine potential effects on its trait-like component, and in turn on outcomes. Studies can achieve a better understanding of the mechanism underlying the effect of state-like changes in alliance on the patient's presenting symptoms, through the mediating role of subsequent changes in the patients' trait-like interpersonal characteristics. Although no study directly examines this question, several studies have shown how promising this path is for future work. Some studies have focused on interventions aimed at strengthening the alliance. In a pilot study, Crits-Christoph and colleagues (2006) examined the effect of training therapists in a 16-session alliance-fostering therapy. The treatment identified alliance ruptures, facilitated agreement on goals, and explored underlying feelings in the patient's relationship with the therapist. The training resulted in moderate-to-large, although not statistically significant increases in alliance (state-like strengthening of the alliance). The training also produced small, nonsignificant improvements in symptoms, and larger ones in quality of life, including satisfaction with romantic relationships and friendships. Thus, interventions focusing on inducing state-like improvements in alliance during treatment can result in trait-like changes in patients' general quality of life, possibly affecting generalized trait-like patterns of relating to others. Another important contribution to the literature on the effects of alliance training on outcome was made by the research group of Safran, Muran, and colleagues. In one study, 128 patients with Cluster C personality disorders were randomly assigned to 30 sessions of brief relational therapy, aimed at inducing state-like improvements in alliance, short-term dynamic psychotherapy, or cognitive–behavioral therapy (CBT). The three treatments were equally effective, but brief relational therapy produced fewer dropouts (Muran, Safran, Samstag, & Winston, 2005). This study suggests that focusing on facilitating state-like changes in alliance may result in greater commitment to treatment. In another study by the same research group, patients receiving brief relational therapy aimed at inducing state-like improvements in alliance showed changes in interpersonal trait-like characteristics, including greater self-assertion and lower levels of submissiveness (Safran et al., 2014).

Although the above studies did not specifically examine the proposed mediation model, in which state-like changes in alliance bring about trait-like changes that in turn result in symptom reduction, they suggest that strengthening the state-like component of the alliance has the ability to induce changes in the patients' trait-like personality characteristics. The direct examination of the suggested mediation model is a task for future studies interested in a systematic evaluation of the therapeutic role of alliance.

Discussion and Implications

The Two Components of the Proposed Model

The present article reviewed the value of alliance as a therapeutic ingredient in psychotherapy, and proposed a new model for understanding and examining its effect on treatment outcome based on new advances in statistical methods of analysis and on key psychodynamic and interpersonal theories. As the pieces of the model have been assembled, a two-part model is proposed, with the first part focusing on the trait-like component of the alliance and the second part on its state-like component. Patients' trait-like characteristics, which determine their ability to form strong and satisfying relationships with significant others, also affect their ability to form such a relationship with their therapist. The trait-like component of the alliance in turn predicts treatment outcome. According to the proposed model, the trait-like component is perceived as a byproduct of the patient's trait-like characteristics (general ability to form satisfactory relationships with others). It is not perceived as therapeutic in itself, but rather as enabling other active ingredients, such as the use of certain techniques, to bring about therapeutic change. The second part of the model focuses on the state-like component of the alliance, which is perceived as capable of inducing therapeutic change in itself. During this process, the patient develops abilities to form a strong and satisfactory alliance with the therapist, resulting in better outcomes. The mechanism by which the state-like component of alliance affects outcome operates through the trait-like component. Improvements in the patients' ability to form a satisfactory relationship with the therapist affect their general ability to form better relationships outside of treatment, resulting in a reduction in their presenting symptoms.

Why Do We Need to Disentangle the Trait-Like and State-Like Components of the Alliance?

It is important to differentiate between trait-like and state-like effects for both statistical reasons (as neither effect can generally be inferred from the other) and conceptual ones (as each may serve a different function in treatment, and have different implications for clinical practice; Curran & Bauer, 2011). To foster change utilizing alliance as a primary engine, the therapist must differentiate between components that are trait-like, and therefore less capable of change, and those that have the potential to change in the course of psychotherapy and other social interventions. The trait-like component can moderate treatment outcome by

determining which type of treatment works best for each subgroup of patients. It may also help predict the patient's capacity to make progress and the difficulties that may arise in the early stages of treatment. For example, the therapist may expect to form a more distant relationship and poorer agreement on tasks that involve talking about emotional experiences with patients with avoidant attachment orientation (as a trait-like characteristic), than with more securely attached patients (Mallinckrodt, 2010). This trait-like alliance component may be associated with poorer outcome. However, a between-patients association between alliance and outcome cannot be interpreted as evidence that improving the alliance for a given patient (a within-patient effect) improves outcome (Falkenström et al., 2013). The state-like component, by contrast, has the potential to change during treatment, and as a result of this change, facilitate symptomatic change. Thus, whereas the trait-like component may be a precondition for therapeutic work, the state-like component may be curative in itself. Understanding the influences of state-like changes in alliance may thus contribute to the therapist's ability to bring about change in the patient's interpersonal relationship capabilities and symptomatic levels.

Without disentangling the two effects, we are liable to overlook or misjudge them because the two may have different magnitudes. For example, when the within-person and between-persons components of alliance were not differentiated, treatment orientation was not found to moderate the alliance–outcome association (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). After disentangling these two effects, potentially differences may be found in the relative importance of each component of alliance for treatment outcome (e.g., Hoffart et al., 2013), so that in some treatment orientations the alliance may turn out to be a predominantly a precondition for therapeutic change, whereas in other orientations it may also be curative in itself. Such differences have been found when disentangling the alliance–outcome association in CBT versus alliance-focused treatment, where state-like alliance served as a mechanism of change in both treatments but to a greater extent in AFT (Zilcha-Mano, Muran, et al., 2016; but see Falkenström et al., 2013).

In some cases, state-like and trait-like components may act in opposite directions. For example, theoretically, in a given population of patients with high levels of anxious attachment, high levels of trait-like alliance may reflect their hyperactivating strategies (Mallinckrodt, 2010; Mikulincer & Shaver, 2007): a strong desire for enmeshment or merger, energetic attempts to achieve greater proximity, support, and love, or a sense of an overly good bond that interferes with patient independence and autonomy. Therefore, in this population, high levels of trait-like alliance may be associated with poorer outcomes. In contrast, in the same population, an increase in state-like alliance may reflect a process of earned security and be associated with better outcome. Thus, in this case, the components may have opposite effects.

Individual Differences in the Operation of the Model

The model designates state-like changes in alliance throughout treatment as the essence of the therapeutic quality of alliance. Are these changes important for every patient? I suggest that 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 (better trait-like characteristics), may be better able to create a strong alliance early in the treatment and maintain its level throughout, with minimal state-like fluctuations. 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. For these patients, state-like changes in the alliance may be essential for treatment success, allowing them to improve trait-like interpersonal characteristics, and thereby improve interpersonal relationships outside of treatment. Therefore, a cross-level interaction is suggested in which the trait-like component of the alliance determines who can benefit most from changes in the state-like component. This argument is based on the assumption that for individuals with a maladaptive trait-like component, the interpersonal dysfunction may play a greater role in their presenting problems, and therefore changes in the state-like component, especially in the bond factor of alliance, are of great importance.

Support can be found in the literature for potential individual differences in the operation of the proposed model. It has been argued that patients with more severe interpersonal difficulties (i.e., less adaptive trait-like characteristics) have a greater chance of encountering difficulties in collaboration and dependence, and show avoidance in treatment. Their ability to commit to the relationship with the therapist and to treatment is also poorer (Andersen & Przybylinski, 2012; Levy & Scala, 2012). These individuals' maladaptive trait-like interpersonal characteristics are manifested in the trait-like component of their alliance with their therapist. It has also been shown that patients with a low trait-like quality of object relations benefited significantly more from therapy focusing on facilitation of state-like changes in the alliance with the therapist (through transference work), when compared with therapy without such a focus (Høglend et al., 2006). It has also been shown that patients with low trait-like ego strength did better in dynamic psychotherapy focusing on facilitation of state-like changes in the alliance

(through transference work) than in therapy without such focus (Kernberg et al., 1972). The specific effect of this focus proved most helpful for patients with low quality of object relations within the context of a weak trait-like therapeutic alliance (Høglend et al., 2011). A recent study has shown that patients' pretreatment psychological functioning moderates the alliance–outcome association in a way that state-like changes in the alliance predict symptoms for patients with low but not with high pretreatment psychological functioning (Zilcha-Mano & Errázuriz, 2015). Individual differences may also exist in the specific patterns of developments in the state-like changes in alliance, so that trait-like interpersonal tendencies may affect patterns of state-like changes in alliance during treatment (Zilcha-Mano, McCarthy, et al., 2015). Additional studies are needed to examine individual differences in the importance of state-like changes for treatment success.

Trait-Like and State-Like Components of Alliance Across Treatment Orientations

Although many of the studies presented in this article are coming from psychodynamic orientation, the proposed model is pantheortical and relevant across orientations. For example, CBT traditionally emphasizes the trait-like component of the alliance, where the patients' general trust that the therapist is acting in their best interest makes it possible to use specific techniques effectively in a collaborative atmosphere (Beck, Rush, Shaw, & Emery, 1979; Castonguay, 1993; Castonguay, Constantino, McAleavey, & Goldfried, 2010; Raue & Goldfried, 1994). But the importance of state-like changes in alliance has also been emphasized in recent years. For example, when a poor alliance is a manifestation of the patients' symptoms, the therapist is often advised to address it directly by attending to automatic dysfunctional thoughts about relationships. Specific techniques can be used in such instances, such as "listening skills" (Burns & Auerbach, 1996) and methods aimed at repairing alliance ruptures (Castonguay et al., 2004), serving as in vivo interventions (Goldfried, 1985).

Similarly, dialectical behavior therapy has emphasized the role of alliance as both a precondition for effective treatment (the trait-like component of alliance) and as valuable in its own right (the state-like component), where resolution of alliance problems can lead to the patient acquiring skills that can be used to address interpersonal difficulties outside of therapy (Burckell & McMain, 2011; Linehan, 1993). Similarly, in acceptance and commitment therapy, the alliance serves as background for the use of specific techniques (trait-like component) but can also be curative in itself, when based on acceptance, respect, and openness toward oneself and others (state-like component; Hayes, Strosahl, & Wilson, 1999). In emotion-focused therapy, the alliance is also perceived as fulfilling this dual role: a warm and close relationship with an empathically attuned therapist, based on shared goals, is considered to be an important therapeutic mechanism, playing an affect-regulation role and serving as a corrective emotional experience (state-like component). The alliance is also considered to provide a safe environment in which the patient can face dreaded feelings and painful memories, facilitating deep emotional processing (trait-like component).

Although alliance is an integral part of virtually all psychotherapies, it may play different roles in each, as manifest in the relative importance of trait-like versus state-like components in various forms of therapy. For example, it is an open question for future research whether in CBT the trait-like components may have a greater effect on outcome than state-like components, whereas in treatments focusing on alliance as curative, the state-like components may have a greater effect on outcome. Supporting this assumption, one study found differences between treatment conditions in the effect of alliance on outcome, with a greater effect of state-like changes in therapist-rated alliance on therapist-rated outcome in the alliance-focused treatment than in the CBT condition (Zilcha-Mano, Muran, et al., 2016).

Future Directions

Aside from testing the full proposed model, several additional directions for future studies should be considered. Although over 30 alliance measures exist, studies disentangling within- and between-alliance effects used the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) almost exclusively, and most of them did not differentiate between the bond, agreement on tasks, and agreement on goals aspects of the WAI (for an exception, see Hoffart et al., 2013). Because in the past decades, many studies on the alliance–outcome association measured the alliance at only one time point in the treatment, it may be necessary to examine whether the available measures and each of their subscales are sensitive to weekly changes in alliance. It may also be necessary to adapt existing measures to improve their sensitivity to change, for example, reframe the items to refer to changes in alliance since the previous session (e.g., a WAI item may be rephrased as follows: "Compared to last session, my confidence in my therapist's ability to help me is higher/same/lower," DeRubeis, personal communication, 2015). Future studies should determine which questions measuring alliance are more sensitive to changes across treatment: those that reflect tasks associated with a specific type of treatment or those focusing on the bond, without referring to any aspect of the work. They should also determine whether changes of one type or another are more closely related to various types of outcome (e.g., changes in wellbeing vs. symptomatic change). Especially, it is important to examine whether corrective experiences—wherein patients become more capable of regarding the therapist as

a caring person with genuine concern for their welfare—manifest in state-like changes in the bond factor and contribute to better quality of interpersonal relationships.

The potential contributions of disentangling the within-patient and between-patients components should also be examined in the context of other frameworks for understanding the patient–therapist relationship, such as Gelso's tripartite model, which conceptualized the patient–therapist relationship as including the real relationship, a working alliance, and a transference–countertransference configuration (Gelso, 2014), as well as Wampold's model, which states that after the initial therapeutic bond is formed, the relationship involves three healing aspects: the real relationship, the creation of expectations, and participation in healthy actions (Wampold & Budge, 2012). Although this article emphasizes corrective experiences and other changes in the state-like component of alliance as therapeutic in themselves, other perspectives in the literature stress additional factors (Wampold & Budge, 2012).

Although the present article has focused mainly on patients' trait-like characteristics, therapists also have a general capability of forming alliance. Deviations from this general capability may occur between different patients the therapist is treating, as well as at different stages of treatments (the therapist state-like component of the alliance; e.g., Baldwin & Imel, 2013; Baldwin et al., 2007; Wampold & Imel, 2015). It stands to reason that therapists' trait-like characteristics also affect state-like changes in alliance during treatment. The literature supports such an argument, with the real characteristics of the therapist inevitably affecting patient reactions and perceptions of the therapist (Crits-Christoph, Cooper, & Luborsky, 1988; Gelso, 2014) and outcome (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). Future studies should evaluate the ability of trait-like characteristics of the therapist to predict state-like changes in alliance, as reported by the patient, therapist, and external observers. They should include adequate numbers of therapists and of patients assigned to each (Crits-Christoph et al., 2011; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012) to examine the effect on outcome of each component belonging to both patient and therapist, as well as potential moderators.

This article has demonstrated the potential contributions of the exciting statistical analysis methods making their first appearance in psychotherapy research. Use of these statistical methods is still limited, however, focusing mainly on individual treatments for depression (for group treatment, see Tasca & Lampard, 2012), from specific treatment orientations, and adopting the point of view of the patients. In addition, in some instances, the distinction between state-like and trait-like changes may be artificial, as trait-like characteristics are also the product of a specific interpersonal context (Mitchell, 1995). Finally, little is known about the specific trait-like and state-like subcomponents that most strongly affect outcome. Several trait-like subcomponents (e.g., object relation, interpsychic and intrapsychic characteristics, tendency to feel understood in treatment, Luyten & Blatt, 2013) and state-like subcomponents (e.g., bond vs. agreement, Ulvenes et al., 2012; responsiveness, Silberschatz, 2015) have been proposed as being most dominant in predicting outcome, but their systematic review awaits more data to be collected, using advanced analytical methods, and especially the disentanglement of within- and between-patients and therapists effects. Thus, more exciting work awaits us yet, differentiating between treatment modalities (e.g., Ulvenes et al., 2012) and exploring new perspectives on the complexity of therapeutic change.

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