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THE RELATIONAL TURN, THE THERAPEUTIC ALLIANCE, AND PSYCHOTHERAPY RESEARCH

STRANGE BEDFELLOWS OR POSTMODERN MARRIAGE?

I AM GRATEFUL to Jay Greenberg for asking me to write about the influence of the relational turn on my work, and extremely pleased to have an opportunity to honor Stephen Mitchell's memory in this fashion. I had the good fortune of being in clinical supervision with Steve and of collaborating on a project with him shortly before he died. I had been deeply influenced by his writing for many years, and the experience of beginning to develop a relationship with him is one that I will always cherish. One of the qualities I most admired in Steve was his openness to different perspectives and his ability to play with seemingly irreconcilable visions of reality in a way that pointed toward a larger whole.

My central focus in this article is on the way in which relational psychoanalysis has influenced my thinking as a psychotherapy researcher and as a clinical theorist who writes both for analysts and for clinicians of other orientations. The divide that separates the world of psychoanalysis from the worlds of both mainstream psychotherapy research and other therapeutic traditions is, in many respects, a large one. At the same time, there is a critical need for psychoanalysts to become more actively involved in a dialogue with these different cultures. While the rumors of Freud's death may be exaggerated, the declining fortunes of psychoanalysis in recent years make this type of dialogue increasingly important. As I have argued elsewhere, the type of insularity that has been characteristic of the psychoanalytic tradition does not, to put it mildly, serve it well these days (Safran, 2001; Safran & Aron, 2001). The growing demand by the health care system and by the public in general for some form of accountability, and associated developments such as the American Psychological Association Task Force on Psychological Intervention Guidelines (1995) or the American Psychiatric Association Steering Committee

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on Practice Guidelines (1996), make it increasingly important for analysts to be active participants in the conversations that are shaping the future of both practice and training in the mental health field.

I was a psychotherapy researcher long before I became a psychoanalyst, and I also had the experience of receiving training in a variety of other therapeutic traditions before beginning formal psychoanalytic training. I have never felt comfortable identifying myself exclusively with any one therapeutic tradition and my writing has tended to reflect a predilection for positioning myself on the boundaries between orientations. The Zen teacher Shunru Suzuki used to say, if you give a cow or sheep a large enough meadow, it won't stray too far—an aphorism that I return to in due course. I am not sure whether I feel more comfortable thinking of myself as a cow or a sheep, but for me, relational psychoanalysis has become such a meadow. The profound sense of pluralism and commitment to the importance of dialogue that is central to the relational tradition and that Steve embodied have provided me with an experience of being at home that eluded me for many years earlier in my career.

I turn now to speaking about my research program on the topic of ruptures in the therapeutic alliance and the influence that the relational turn has come to have on my thinking in this area. Any attempt to define what an alliance rupture is presupposes that we know how to conceptualize the therapeutic alliance in the first place, or that the alliance is a meaningful concept—both controversial assumptions. For now, however, I offer a pragmatic, working definition. Alliance ruptures are periods of tension or breakdown in collaboration or communication between patient and therapist. These periods vary in intensity from relatively minor tensions, of which one or both of the participants may be only vaguely aware, to major breakdowns in understanding and communication that if not addressed, may lead to premature termination or treatment failure. Alliance ruptures vary in duration and form. For example, in some cases it is obvious that there is tension or disagreement between patient and therapist and this tension is resolved within a session or two. In other cases, a pseudoalliance or an alliance between the therapist and the patient's false self becomes established, and an entire treatment can take place without the patient being touched in a real way (Balint, 1968; Winnicott, 1965).

I first began doing research on the topic of ruptures in the alliance in the late 1980s (e.g., Safran, 1989; Safran, Crocker, McMain & Murray, 1990). A number of factors influencing my decision to do research in this

area. At the time, the concept of the therapeutic alliance was becoming increasingly topical among psychotherapy researchers, and there was an accumulating body of evidence indicating that the therapeutic alliance is one of the better predictors of outcome across a range of different therapeutic modalities. These findings, together with the failure of psychotherapy research to demonstrate that any one form of psychotherapy is consistently more effective than others, were taken by many to support a "common factors" or "nonspecific factors" model of change. This model stipulates that therapeutic change takes place as a result of factors that cut across all forms of therapy rather than factors or principles that are *specific* or distinctive to specific treatments. Examples of common factors are faith in the therapist, the feeling of being understood, and the expectation that change will take place. Thus, for example, the common-factors position is that patients in psychoanalysis change, not because of the specific, insight-promoting effects of interpretations, but because of nonspecific effects of the analytic relationship common to any therapeutic relationship.

This way of looking at things, while useful up to a point, assumes a false dichotomy between specific and nonspecific factors. Consistent with Mitchell's (1988) argument that one must always take into account the relational meaning of an intervention, I argued that there is always an interdependence between technical and relational factors (Safran et al., 1990). The problem with the common-factors model is that it prematurely forecloses inquiry into one of the most important questions confronting clinical theorists and researchers: How does the complex interactive matrix (to use Greenberg's, 1995 term) of therapist, patient, and technical variables unfold over time in ways that either promote or hinder change. My hope was that by focusing systematically and intensively on those moments in the therapeutic process when developments in the interactive matrix lead to problems in the alliance, it would be possible to shed some light on how these so-called nonspecific factors in treatment operate, and to develop a more refined understanding of how ruptures in the alliance can be successfully negotiated when they take place.

Another factor influencing my decision to do research on alliance ruptures was the recent emergence of a new development in psychotherapy research referred to as the *events paradigm*. This research paradigm, which was pioneered by an important mentor of mine, Leslie Greenberg, in collaboration with Laura Rice (Greenberg, 1986; Rice & Greenberg, 1984), is an approach to investigating the mechanisms of change in psy-

chotherapy. It is based on the assumption that the reason traditional psychotherapy outcome research (referred to as "horse race" research by its critics) fails to find differences in the effectiveness of different approaches, and more importantly, fails to come up with findings that are meaningful to clinicians, is that the unit of analysis is too global. The *events paradigm* stipulates that rather than attempting to demonstrate that one therapy is more effective than another, we should be studying specific moments in therapy, or events that are critical to change. The idea is that rather than attempting to confirm what we already know, we should be attempting to discover what leads to important turning points in therapy or what the process is through which important turning points take place. It seemed to me that the therapeutic alliance rupture was a particularly worthwhile event to study because (1) refining our understanding of how do deal with alliance ruptures should, in theory, help us to work with those patients who are refractory to change, (2) this type of investigation can potentially provide a window into the way in which technical and relational factors interact and into an important mechanism of change, and (3) alliance ruptures are relevant to clinicians of all orientations (Safran, 1993b).

A Brief History and Critique of the Alliance Concept

The concept of the therapeutic alliance has a long history in psychoanalysis, beginning with Freud's early discussion of the importance of making a "collaborator" of the patient (Breuer & Freud, 1893–1895) and subsequent introduction of the notion of the unobjectionable positive transference (Freud, 1912b). Key figures within the psychoanalytic tradition who contributed to the further development of the alliance concept included Sterba (1934), Zetzel (1956), and Greenson (1967), all of whom stressed the importance of providing relational conditions that facilitate the development of trust in the patient. There are differences in the various ways in which these theorists conceptualized the alliance construct, which we need not go into here. There are, however, two important commonalties worth mentioning. The first is that there is a general tendency to distinguish between the more rational, nonneurotic aspects of the patient's psyche that make the alliance possible, and the more transferential aspects of the patient's attitude. Sterba, for example, theorized that the alliance takes place through a process in which the patient splits off an observing aspect of his or her ego through identification with the observing capacities of the analyst.

A second commonality is that all of these theorists thought of the alliance as necessary but not sufficient for change. They believed that the core mechanism of change was insight, and the most important intervention was interpretation, because only interpretation would allow patients to recognize their own unconscious conflicts. The popularity of the alliance concept, especially in the fifties and sixties, was consistent with the movement toward widening the scope of psychoanalysis at that time. There was an interest in broadening the range of patients who could benefit from psychoanalysis. This was accomplished by emphasizing the importance of the development of trust, thereby permitting greater technical flexibility for the analyst and legitimizing a departure from the traditional classical prescriptions of abstinence and neutrality.

Although the concept of the alliance has had an important impact within psychoanalytic circles, especially in North America, it has always been controversial. One of the central criticisms is that by distinguishing between the transferential versus the real aspects of the analytic relationship, there is a danger of leaving important aspects of the relationship unanalyzed or of not taking into account the all-encompassing conflictual nature of the patient's motivation (e.g., Brenner, 1979).

Another criticism is that the alliance concept can lead to a confusing of conformity on the patient's part with therapeutic progress. Lacan (1973), for example, argued that the emphasis on rational collaboration between patient and analyst was consistent with what he saw as the pathological North American emphasis on adaptation and conformity. From a Lacanian perspective, the type of identification with the analyst that Sterba considered important perpetuates an already existing confusion between the desire of the self and the desire of the other. It thus contributes to the patient's self-alienation.

Within classical psychoanalytic theory, the concept of the alliance still continues to play a meaningful, if controversial, role, as evidenced by the appearance of two recent books on the topic (Levy, 2000; Meissner, 1996). Within the type of relational psychoanalytic thinking that is on the ascendance, however, the topic of the alliance tends to be marginalized. Some papers occasionally allude to the alliance in passing, but it is clearly on the margins of contemporary theoretical discourse. As far as I am aware, no one has explicitly critiqued or rejected the alliance concept

from a relational perspective. It has been more a matter of losing interest in it than anything else. I believe that there are a number of reasons for this loss of interest. First, relational thinking tends to emphasize that the human encounter is at the heart of the change process. There is thus no need to rely on a concept such as the alliance, which reminds one of the importance of the fundamentally human nature of the analytic relationship. Second, relational thinking tends to emphasize the importance of technical flexibility, innovation, and spontaneity on the analyst's part. There is thus no need to legitimize the analyst's departure from an idealized stance of abstinence and neutrality through the concept of the therapeutic alliance (Safran & Muran, 2000). Third, relational thinking emphasizes that all interventions must be understood in terms of their relational meaning. There is thus less need to invoke the alliance concept as way of understanding those situations in which, as the saying goes, "the operation is a success, but the patient dies." Fourth, from a contemporary constructivist-hermeneutic perspective, the idea that one can distinguish between transferential and reality-based aspects of the analytic relationship is epistemologically naïve. Moreover, this type of naïve realism tends to reinforce the power imbalance in the therapeutic relationship, because typically it is the analyst who is assumed to be the arbiter of reality.

Reconceptualizing the Alliance from a Relational Perspective

Andrea has been seeing me in treatment for three years. She is an extremely attractive, professional woman in her early forties who has been divorced for six years. She initially consulted me because of her difficulty in establishing a satisfying long-term relationship with a man, and because of feeling stuck in her career. She has a characteristic pattern of becoming involved with men who are emotionally unavailable, and of having casual sexual relationships, which while satisfying at one level, leave her feeling exploited and empty at another. Her father is a rather passive, emotionally unavailable man, while her mother is more dominant and expressive, but ultimately self-centered and narcissistic.

The men Andrea typically becomes involved with tend to be dominant, charming, and emotionally expressive, but ultimately unavailable and often narcissistic and exploitative. In addition, they are typically large, brawny men, who she describes as "manly." She perceives such men as having the capacity to look after her and protect her. Andrea's conflicts at work

center around her difficulty in motivating herself to advance professionally and a conflictual relationship with her boss—a man who is apparently overly demanding, unappreciative, self-centered, and either unwilling or unable to provide the type of guidance and mentorship that she desperately wants from him.

In our very first session of work together, Andrea had demanded a formulation of her problem and systematic treatment plan from me. She wanted to know what our work together would look like, how I conceptualized the goals of treatment, and how we would proceed toward them. Feeling flustered, pressured, and incapable of producing what she was asking for on the spot, I had managed to articulate some of these feelings to her, and to suggest that the intensity of her need might be interfering with the development of an organic process between us that would eventually lead to what she really needed. She seemed to find this exchange helpful. It made sense to her and seemed to provide her with a useful way of beginning to understand what might be going wrong in some of her other relationships.

Since this session we have settled into a pattern of work together in which extended periods of relative harmony in our relationship, during which Andrea seems to find our work together helpful, are punctuated periodically by sessions in which she once again demands something more substantial from me and accuses me of being withholding. At these times, Andrea typically asks me to be more active and directive. She wants me to take more responsibility for determining how we will spend our sessions, to give her more advice, to give her more feedback, and so on. Or she may ask me to tell her how I conceptualize her problems, and to spell out how I think change will take place. At these times I attempt to explore the meaning of these requests for her and to understand what is being enacted between us and how each of us is contributing to the interaction. I also experiment with modifying my stance with her. In general I think I am more active and directive with Andrea than I am with many patients, although I have no doubt that I can become quite withholding and withdrawn when I am feeling pressured by her and resentful. This too is something that we talk about. So far we have managed to negotiate each of these crisis periods in our relationship productively and we continue to work together.

From a relational perspective, the type of clinical process I have described above would, of course, be conceptualized as an ongoing transference-countertransference enactment. But it also provides a good illus-

tration of the type of therapeutic alliance ruptures that are the focus of our research program. As in Andrea's case, alliance ruptures are often characterized by tension around the goals and tasks (i.e., how patient and therapist work toward those goals) of treatment. And this tension is often an expression of deeper transference-countertransference concerns. I return to these themes in a moment.

When I first began doing research on therapeutic alliance ruptures I was not concerned with the theoretical controversies surrounding the concept of the alliance in the psychoanalytic literature. Psychotherapy researchers had by and large come to accept the value of the concept and the emphasis was on demonstrating that the quality of the alliance is a good predictor of treatment outcome. My interest was in moving beyond this emphasis on prediction to what I saw as the more important question of how strained or ruptured alliances can be repaired. Over time, however, I became increasingly concerned with the question of whether it makes sense to retain the concept of the alliance, given the various theoretical problems that I have mentioned. I also became interested in the question of whether there is a way of reformulating the concept of the alliance in terms that are meaningful from a relational perspective. These concerns came to a head while I was in the process of writing *Negotiating the Therapeutic Alliance* with my colleague, Chris Muran (Safran & Muran, 2000). An important goal of ours in this book was to synthesize the results of our research program with developments emerging out of relational psychoanalysis, in an attempt to provide a systematic framework for negotiating therapeutic impasses.

One of our difficulties in writing the book was that we were attempting to address three different audiences at the same time: the psychoanalytic community, the psychotherapy research community, and a rather large and diverse group of therapists adhering to different orientations, who are not psychoanalytically oriented, but who might potentially be interested in recent developments in psychoanalytic theory. It was thus a challenge to find ways of conceptualizing things in a fashion that would be meaningful to all three cultures. As I became more interested in thinking and writing about things in a way that was more congenial to a relational worldview I seriously considered jettisoning the concept of the therapeutic alliance. Ultimately, however, I made the decision to retain the concept, or at least a reformulated version of it (Safran & Muran, 2000). There were two primary reasons for this.

First, even though the concept of the alliance does not play a central role in relational theory, it continues to play a role in clinical discussions at an informal level. I believe that the reason for this is that despite the fact that there are problems with the various available conceptualizations of the alliance, we all nevertheless have an implicit understanding that some type of collaborative bond between patient and analyst is necessary in order permit the treatment to move forward in a productive fashion, and we implicitly distinguish between alliances that are more or less fragile or robust.

Second, although the concept of the alliance does not play the central role in psychoanalytic theory that it once did, it has become an important theoretical construct in many other theoretical orientations, in large part due to its centrality in the psychotherapy research literature. Retaining the concept of the alliance in psychoanalytic theory thus facilitates dialogue between psychoanalysis and other approaches and between the psychoanalytic and research communities.

In order to salvage the alliance concept it seemed critical to me to reconceptualize it in terms that make sense from the perspective of contemporary relational theory. I found an important foundation for this type of reconceptualization in the perspective of Edward Bordin, a psychoanalytically oriented researcher who played a seminal role in stimulating an interest in the therapeutic alliance by psychotherapy researchers. Bordin (1979) theorized that there are three dimensions to the alliance: the degree to which patient and therapist agree about treatment goals, the degree to which they agree about the tasks of treatment, and the quality of the bond between patient and therapist (i.e., the extent to which the patient feels trusting, understood, has faith in the therapist, and so on).

Different forms of treatment (and different therapists) value different treatment goals. Abend (2001), for example, considering the topic of goals, argues that the goal of psychoanalysis is to develop greater freedom of choice. Greenberg (2001) argues that the goal is to develop greater self-knowledge. Contrasting sharply with both of these goals is the behavioral emphasis on reducing or eliminating symptoms.

The tasks of therapy consist of the specific activities or processes that the patient needs to engage in to benefit from treatment. It is important to emphasize that these tasks are not necessarily concrete or behavioral, but are often more subtle in nature. For example, free association can be conceptualized as a therapeutic task. So can reflecting on the nature of one's own participation in the analytic relationship.

The goal, task, and bond dimensions of the alliance influence one

another in an ongoing fashion. For example, an initial agreement between patient and therapist about therapeutic tasks and goals will tend to enhance the quality of the bond. Conversely, when there is tension around tasks and goals, as is often the case with Andrea and me, the existence of an adequate bond will help patient and therapist to negotiate an agreement.

This is where contemporary relational thinking has had an important impact on my own extension of Bordin's perspective (Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2001, 2002). Increasingly I have come to think of the concept of negotiation as providing an important bridge between Bordin's conceptualization of the alliance, my own research program on alliance ruptures, and relational psychoanalytic thinking. In particular I am indebted to Mitchell (1993), Pizer (1998), and Benjamin (1988) who, in their own ways, all emphasize the centrality of negotiation in the analytic process.

Therapeutic tasks and goals provide an important part of the substance of the negotiation that inevitably takes place in any therapy. This negotiation is always taking place—sometimes explicitly, but often implicitly. When things are running smoothly, the negotiation may take place out of awareness. For example, the therapist may decide, without thinking, not to use a particular intervention because he or she has a sense that the patient will not find it helpful; or the patient may give the analyst the benefit of the doubt and try on an interpretation for size. But when things break down, and there is an overt rupture in the therapeutic alliance, this process of negotiation becomes foregrounded. Over and above the immediate benefit of negotiating the type of alliance that permits the patient and therapist to collaborate constructively on specific therapeutic tasks or goals, the process of negotiation in and of itself lies at the heart of the therapeutic process.

Learning to negotiate the needs of the self versus the needs of others is both a critical developmental task and an ongoing challenge of human existence (Safran, 1993a). Elsewhere (Safran & Muran, 2000; Safran, 2002a) I have argued that this ongoing challenge can also be conceptualized as a tension between two basic human needs: the need for agency or self-definition and the need for relatedness (Aron, 1996; Bakan, 1966; Greenberg, 1991). These two needs are inevitably in conflict with one another, yet at the same time exist in dialectical relationship with each other. True autonomy (as opposed to counterdependency) can only be achieved in the context of relatedness (i.e., a secure base) and true relatedness (as opposed to symbiosis) can only take place when the individual has achieved some degree of self-definition or independence. Many of the problems that people bring into treatment are influenced by difficulties they have in negotiating the tension between the needs for agency and relatedness in a constructive fashion.

For patients, the development of a relationship with the therapist inevitably involves negotiation both interpersonally and intrapsychically. At the interpersonal level it involves the ongoing negotiation between the subjectivities of patient and therapist at both conscious and unconscious levels. And at the intrapsychic level it involves the ongoing negotiation between the patient's needs for agency and relatedness. This ongoing process of negotiation can have an important impact on the patient's fundamental sense of the extent to which he or she lives in a potentially negotiable world or needs to compromise his or her own sense of integrity in order to hold onto relationships (Benjamin, 1990; Mitchell, 1993; Pizer, 1998; Safran, 1993a; Safran & Muran, 2000). As Andrea's case illustrates, the tasks and goals of treatment are often important arenas for this type of negotiation.

It should be emphasized that this process does not entail an attempt to achieve a surface consensus, but rather a genuine confrontation between individuals with conflicting views, needs, or agendas. Both patient and therapist struggle to sort out how much they can accommodate to the other's views about treatment tasks and goals, without compromising themselves in some important way. This conceptualization is thus less vulnerable to the previously mentioned criticism, which equates the alliance with compliance.

From my perspective, this conceptualization of the alliance provides a number of additional advantages over traditional conceptualizations. First, it avoids the thorny issue of distinguishing between transferential and real aspects of the relationship. The meaning of various tasks and goals for patients is always determined both by previous relational experiences and by the emergent aspects of the therapeutic relationship. For example, for Andrea, my willingness to work with her to establish tasks to be completed at work between our sessions seems to signify my willingness to guide her and nurture her in a way her parents never have. I assume there is also something about the evolving matrix of our relationship (including my feelings about her and my feelings about offering her the kind of guidance she asks for) that plays a role in coloring her experience of my actions. Obviously, for another patient in the context of a

different therapeutic dyad, the assignment of such tasks might be experienced as controlling or manipulative. For therapists, the meaning of different tasks and goals will be shaped both by their own previous relational experiences and their allegiance to the values of the professional community they identify with (Aron, 1999). Thus for example, for a given analyst, not acting on the desire to make transference interpretations with a patient who does not find them helpful may be experienced as an assault on his professional identity.

Second, the current conceptualization highlights the interdependence of technical and relational factors. Consistent with contemporary relational thinking (e.g., Aron, 1996; Mitchell, 1988) it implies that the meaning of any intervention can only be understood in the relational context in which it occurs. Any intervention may have a positive or negative impact on the quality of the bond between therapist and patient, depending on its idiosyncratic meaning to the patient (and therapist), and any intervention may be experienced as more or less facilitative depending on the nature of the preexisting bond. Third, it acknowledges the possibility of change taking place in many ways. Traditional conceptualizations of the alliance tend to assume that the goal of treatment is insight and that the intervention of choice is interpretation. In contrast, the present conceptualization emphasizes that there are a range of different possible therapeutic tasks and goals, rather than assuming a monolithic model of change. It is thus consistent with a type of theoretical pluralism characteristic of contemporary relational thinking.

Finally, it has a more dynamic and mutual quality to it than traditional conceptualizations of the alliance. Although theorists such as Sterba, Zetzel, and Greenson emphasized the importance of the analyst acting in a supportive fashion in order to facilitate the development of the alliance, ultimately they assumed that the patient will identify with the analyst and adapt to his or her conceptualization of the tasks or goals of treatment (i.e., the use of interpretation in order to gain insight). In contrast, the present conceptualization emphasizes the importance of mutual agreement about treatment tasks and goals and highlights the critical role of ongoing negotiation and mutual accommodation.

Psychotherapy Process Research: Modelling Change

Having sketched out some relevant theoretical considerations, I now provide a brief summary of some aspects of our research program. For the last decade or so my colleagues and I have been using a psychotherapy research strategy associated with the *events paradigm*, called *task analysis* (Greenberg, 1986; Rice & Greenberg, 1984; Safran, Greenberg & Rice, 1988) to develop a better understanding of the way in which alliance ruptures are resolved (e.g., Safran, 1993a,b; Safran et al., 1990; Safran & Muran, 1996; Safran, Muran & Samstag, 1994; Safran et al., 2001, 2002). Task analysis is designed to model the processes involved in successfully negotiating specific therapeutic tasks. For our purposes we established alliance rupture repair as the task of interest and set about identifying patterns that tend to be associated with successful resolution. Psychotherapy process can be seen as a sequence of recurring states that take place in identifiable patterns. By identifying these states and outlining patterns of transition between them, it is possible to develop a model that can sensitize clinicians to these patterns. The goal of this type of research is not to generate rigidly prescriptive models, but rather to aid clinicians in the development of pattern-recognition abilities that can facilitate the intervention process. A key feature of the task-analysis paradigm is that there is a continuous process of cycling back and forth between theory and empirical observation, with theory-generating hypotheses to be tested and observation helping to refine theory (Greenberg, 1986; Safran, Greenberg & Rice, 1988). In this respect, theoretical developments emerging from relational psychoanalysis have come to play an increasingly important role over time in the refinement of our resolution model.

I here outline a highly simplified version of the model that has emerged from our research. The model consists of five states, each state consisting of a distinctive patient-therapist interactional pattern. These five states are as follows: (1) enacting the alliance rupture, (2) attending to the rupture and initiating the disembedding process, (3) exploration of the patient's experience, (4) exploration of the avoidance, and (5) emergence of the underlying wish. Although the rupture resolution process typically involves a progression from the first state (attending to the rupture) to the last state (emergence of the underlying wish), there tends to be considerable cycling back and forth between the states over time. It is thus a nonlinear process. I also want to emphasize that the resolution process always unfolds in the context of a complex and shifting transference-countertransference matrix in which the patient and therapist cycle back and forth between greater and lesser degrees of embeddedness in the particular relational configuration out of which the alliance rupture emerges.

In the first state (*enacting the alliance rupture*) the patient and thera-

pist are embedded in a relational configuration that gives rise to the rupture. Although the therapist may have some degree or awareness that there is a rupture or impasse, he or she has not yet begun the process of reflecting on the nature of his or her own participation in the current relational configuration. There are two primary types of ruptures we have identified: *withdrawal ruptures* and *confrontation ruptures*. In withdrawal ruptures the patient deals with tension in the therapeutic relationship by withdrawing or partially disengaging from the therapist, some aspect of his or her own experience or the therapeutic process. In confrontation ruptures the patient directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapeutic process. Many ruptures contain both withdrawal and confrontation features, but the distinction between the two types and the associated rupture resolution processes nevertheless appears to be meaningful. Patients who characteristically present with withdrawal ruptures tend to have difficulty directly expressing their needs for agency. Patients for whom confrontation ruptures are more common tend to have difficulty expressing their needs for relatedness. Thus, working through alliance ruptures, in addition to establishing the necessary foundation for a particular therapeutic task or goal, also provides an opportunity for patients to learn to negotiate the needs for agency versus relatedness in a constructive fashion.

In the second state (*attending to the rupture and initiating the disembedding process*), the therapist begins to explicitly focus on what is being enacted in the therapeutic relationship in the here and now. He or she also begins to reflect on the nature of his or her own participation and to initiate the disembedding process. Some form of metacommunication, in which the therapist attempts to step outside of the enactment by commenting on it and in some cases explicitly acknowledging his or her own contribution, is often helpful. I also want to reiterate that although the disembedding process is first initiated in this state, it continues throughout the rupture resolution process.

In the third state (*exploration of the patient's experience*) the patient begins to explore and express feelings about the alliance rupture. In the case of withdrawal ruptures, patients typically begin to express their negative feelings or their wish for support or nurturance, but in a qualified or indirect fashion. In the case of confrontation ruptures, these feelings are typically expressed in a blaming or demanding fashion. Many of my sessions with Andrea provide a good illustration of this type of blaming

and demanding. I have found Ghent's (1992) distinction between need versus neediness particularly useful for purposes of understanding what is taking place here. When an individual has had a developmental history in which the needs for nurturance and love are responded to with neglect or punishment, he or she becomes critical of these needs and to various degrees dissociates them. Instead of the underlying need, the individual expresses neediness, that is, a "manipulative, at times vengeful demandingness, which is, in large measure, an expression of rage at lifelong deprivation of one form or another" (p.142).

In the fourth state (*exploration of the avoidance*), the therapist and patient explore the defensive processes interfering with the acknowledgment and expression of underlying wishes and needs. The process typically alternates back and forth between the *exploration of the avoidance* and the *exploration of the patient's experience*. The *exploration of the avoidance* helps to free up the *exploration of the experience* when it becomes blocked, and the *exploration of experience* inevitably leads to more anxiety, more defensive activity, and the need for further *exploration of the avoidance*. There are two primary types of defensive processes here. The first consists of fears and expectations of the therapist's response (e.g., abandonment, retaliation, collapse) to one's underlying needs. The second consists of internalized negative judgments about one's own wishes or needs.

In the fifth state (*emergence of the underlying wish*) the patient expresses wishes or needs emerging in the context of the therapeutic relationship that are being defended against. In the case of withdrawal ruptures these typically take the form of self-assertion (e.g., the expression of anger at the therapist because of his or her failings or limitations). In the case of confrontation ruptures these typically take the form of needs or wishes of a more vulnerable nature, such as the wish for nurturance or guidance. When patients express their underlying wishes it is important for therapists to respond to them in an empathic and validating fashion. It is important not to view these feelings as derivatives of instincts that must be tamed or renounced, but rather as normal human yearnings for nurturance and support. In some cases it can be important for therapists to gratify the patient's wish. For example, I believe that it has been helpful for me to accommodate to Andrea's wishes, within limits, by being more active and directive than I am with many patients. It is here that the ongoing process of negotiation discussed earlier becomes paramount. The therapist's intuitive sense of what feels "right" plays a critical

role in determining whether to gratify the patient's wish or not. And as Mitchell (1993) points out, the way in which the patient's wish registers in the countertransference is codetermined both by the quality of the wish that is expressed by the patient and by the analyst's unique character, values, and interests.

Whether or not the therapist is able to or chooses to gratify the patient's underlying wish, it is important to empathize with the associated feelings. It may, for example, be important for the patient to acknowledge her desire for the therapist to magically transform her and for the therapist to empathize with this desire rather than to invalidate it as immature. Or a therapist may not grant the patient's request to extend the session length, but may nevertheless empathize with the desire and the pain associated with having it unfulfilled. In such cases, empathizing with the underlying yearning and the pain associated with having the wish go unmet helps the patient to begin to experience his or her needs as valid and legitimate, while at the same time beginning to accept the limitations of the other and to relinquish the pursuit of an idealized and unattainable goal (Safran, 1993a, 1999). It is in the crucible of this dialectic of desire and frustration that the capacity for intersubjectivity is forged. For Andrea, the question of whether she can come to experience me as nurturing despite my limitations, yet at the same time not deny her desire for more, is a central and ongoing one.

A limitation of the type of schematic model I have outlined above, of course, is that it can sound mechanistic and tends to leave out the complex and subtle affective interplay between patients and therapists that breathes life and meaning into the entire process. Therapeutic alliance ruptures arouse intense and disturbing feelings of need, anger, impotence, self-indictment, and despair in both patients and therapists, and the most profound and important therapeutic task consists of harnessing and working constructively with these feelings. When, for example, therapists are the object of intense aggression, they can become paralyzed by their own internal conflicts concerning their own aggressive feelings, and this can make it difficult for them to reflect more fully on what is taking place in the interaction. Under such circumstances there can be a collapsing of *internal space*. The type of inner work that therapists need to engage in to facilitate a reopening of this internal space and that allows them to work through difficult alliance ruptures has become a topic of increasing interest of mine in recent years (e.g., Safran & Muran, 2000) and one that I return to later.

Psychotherapy Outcome Research

In a pilot project funded by the National Institute for Mental Health, Chris Muran and I have developed and manualized a treatment approach specifically designed to be used for purposes of negotiating or resolving ruptures in the therapeutic alliance (Safran, 2002a,b; Safran & Muran, 2000). The approach is referred to as Brief Relational Psychoanalytic Treatment (BRT). In order to facilitate the research process, it is designed to be conducted in a brief, time-limited format (e.g., thirty sessions), although it is not intrinsically a short-term model. BRT is based primarily on principles emerging from relational psychoanalysis, but it is intended to be used by therapists of all orientations. An important feature of this approach is that the principles and intervention strategies are articulated in specific and clear-cut fashion. It is thus considered to be a *manualized* treatment, in the sense that clear guidelines are spelt out to specify what therapists should be doing and for determining whether they are doing what they should be doing.

It is probably important to say something about psychotherapy treatment manuals at this juncture, since the term may be unfamiliar and probably off-putting to some psychoanalysts. From the perspective of mainstream psychotherapy outcome research it is considered critical for there to be clearly spelled-out guidelines indicating what the treatments being studied should look like in practice. These guidelines or manuals allow researchers to be confident that all therapists conducting the same treatment are actually doing the same thing.

The mid to late 1980s were marked by considerable enthusiasm among psychotherapy researchers about the role that treatment manuals could potentially play in facilitating the training of therapists (e.g., Luborksy & DeRubeis, 1984). Many felt that the precise specification of treatment principles and techniques characteristic of treatment manuals, by identifying critical therapeutic skills in an unambiguous fashion, should be able to translate into improvements in clinical practice. Although there continues to be enthusiasm about the value of treatment manuals by researchers, many have become less sanguine about their potential. Critics argue that treatment manuals artificially constrain clinical practice and reduce treatment flexibility and therapist creativity (e.g., Strupp, 2001). Nevertheless, the use of a treatment manual and the evaluation of therapists' adherence to that manual still remain necessary criteria of rigorous psychotherapy outcome research.

In addition, the development of clear-cut treatment guidelines makes it possible to train a broad range of clinicians who have not necessarily received extensive psychoanalytic training or who may not even be psychoanalytically oriented. This facilitates the training of a wide range of therapists adhering to different orientations and professional backgrounds. It also allows other researchers to evaluate the effectiveness of the approach in different contexts, and renders some of the important developments emerging from relational psychoanalysis available to a wider audience of clinicians.

The task we set for ourselves in developing a treatment manual was to strike a balance between the need to specify principles and strategies of intervention in a clear-cut fashion and the need to facilitate the development of improvisational skill and personal responsiveness in therapists (Safran & Muran, 2000). One way we attempt to accomplish this is by complementing concrete guidelines of a more technical nature, with considerable emphasis on conveying the essence or the spirit of the approach. In addition, we place considerable emphasis on spelling out training procedures for increasing therapists' ability to *reflect-in-action*, that is, the ability to respond flexibly to the emerging situation rather than imposing theory on it (Schon, 1983). We also outline procedures for training therapists to work with their own internal processes and to harness and work constructively with their own countertransference reactions.

Below, I outline some of the central features of the BRT. This list does not provide an exhaustive description, but I hope it will give readers some idea of the "relational flavor" of the approach, especially when contrasted with other short-term psychoanalytically oriented approaches. The key principles of BRT are as follows: (1) it assumes a two-person psychology and a constructivist epistemology, (2) treatment is conceptualized as an ongoing cycle of enacting, disembedding, and understanding, (3) it involves an intensive focus on the here and now of the therapeutic relationship, and an ongoing collaborative exploration of both patients' and therapists' contributions to it, (4) it assumes that the relational meaning of interventions is critical, (5) it make extensive use of countertransference disclosure and therapeutic metacommunication (i.e. stepping outside the current enactment by commenting on it), in order to elucidate and disembed from the relational configuration that is being enacted between therapist and patient, and (6) it emphasizes the importance of allowing case formulations to emerge gradually over time as therapists begin to develop some understanding of the nature of their own participation in the interactive matrix. This contrasts sharply with short-term approaches that emphasize the importance of developing accurate case formulations early in treatment, and assume that therapists can be sufficiently disembedded to do so (Safran, 2002a).

In a small sample pilot study, designed to evaluate the effectiveness of BRT as a treatment strategy for dealing with therapeutic alliance ruptures, we monitored patients who were receiving either short-term psychodynamic therapy (with a more traditional one-person psychological focus) or short-term cognitive therapy over the first few sessions of treatment, and identified those with whom therapists were having difficulty establishing an alliance. We then offered these patients the option of being transferred to another therapist in another treatment condition. If they elected to be transferred, we randomly assigned them either to BRT or to a control condition (cognitive therapy, if they began in the psychodynamic treatment, or traditional psychodynamic treatment, if they began in the cognitive treatment). As we had predicted, we found that patients who had been transferred to BRT improved more than those transferred to either of the other two treatments (Safran, Muran, Samstag & Winston, 2002).

In a related study with a larger sample (Muran, Safran, Samstag & Winston, 2002), we conducted a more conventional psychotherapy outcome study that compared BRT to traditional short-term psychodynamic therapy and short-term cognitive therapy in a group of patients who had received mixed personality disorder diagnoses. Our first finding was that when we simply looked at treatment outcome, the three treatments were equally effective. As I indicated previously, this type of therapeutic equivalence is a common finding in psychotherapy research. When, however, we compared the three treatments using a more stringent measure of clinically meaningful change, both BRT and the cognitive treatment were found to be more effective than the more traditional psychodynamic treatment. A third finding was that there were fewer dropouts in the BRT treatment than in the other treatments. This suggests that while BRT is no more effective than cognitive therapy for those who completed treatment, more patients were likely to complete BRT than either the traditional pychodynamic treatment or the cognitive treatment. A second set of analyses confirmed that patients who dropped out of treatment had poorer alliances than those who completed treatment did. Taken as a whole, these findings point to the unique benefits of BRT as a treatment for dealing with problems in the therapeutic alliance. The research also

provides an illustration of the way in which relational developments in psychoanalysis can contribute toward the practice of psychotherapy more broadly conceived.

The Therapist's Inner Work

On the morning of the particular session that I am about to describe I had gone to work feeling vaguely under the weather because of a cold I was developing and also worn out and rather fragile because of a painful conflict I was in the midst of with a close friend of mine. Andrea was my first patient of the day, and as she walked into my office that morning I found myself silently praying that this would not be one of our difficult sessions. She began the session by telling me that a friend of hers, who is a therapist, had suggested a therapy group for her to join and that she had made an appointment to interview with the therapist who runs the group. I began to feel myself tensing up. Earlier in treatment, Andrea had asked me what I thought about the possibility of her joining a therapy group, and at that time we had explored the meaning of her considering this possibility in terms of our relationship. Part of what had emerged for Andrea from this exploration was a sense that participating in a therapy group might help her to feel that some of her needs were being taken care of elsewhere, thus making her feelings of frustration with our relationship more tolerable. We had explored the similarity between what was going on for her here, and her tendency to become romantically involved with more than one man at the same time. Ultimately Andrea had decided not to join a group, but to see what it would be like to attempt to work things out between the two of us without the emotional buffer that the group would provide.

Now she was not only introducing the possibility of the group again, she had already scheduled an interview with the therapist. I was feeling surprised and a little angry. My impression was that things had been going well between us. If Andrea was upset about something that had happened between us, why had she not spoken about it with me? How could she decide to interview for a group without even raising the topic again with me? I tried to stay calm and to think of something useful to say. "I guess I'm kind of surprised," I found myself saying.

"Surprised?" Andrea repeated with an icy edge to her voice.

I heard myself stammering, "Well, I guess it seems kind of out of the blue. I mean, I know that we had talked about you joining a group at one point, but I thought that that idea was on the back burner, and that you were relatively happy with the way things were going between us."

"How could you be surprised? How could you not know how frustrated I am?" replied Andrea. "Haven't I told you before?"

"Well, yes," I sputtered. "What do I have to do to get through to you?"

Andrea interrupted. "You refuse to respond to my needs."

"That's not really fair," I thought, but before I could begin to mount a case for myself in my own mind, Andrea spoke again.

"Anyways, if I start the group, I'll have to stop our work together. I won't be able to afford both."

Now I was paralyzed with intense and conflicting emotions. "How could she do this?" I thought. "After all we've been through together. All the times that I've tolerated her accusations of being cold and withholding, and tried to respond in an open, nondefensive fashion. The various ways in which I *have* accommodated to her needs. She thinks I'm cold and withholding. I wonder how she'd feel if she were working with a classical analyst?"

"But maybe she *is* picking up on something about you," another voice in my head whispered. "She's not the first person to accuse you of being cold and withholding." For a moment I began to slide into a state of self-disparagement, but then quickly rallied to defend myself against my internal accuser. "The hell with it," I thought. "I've been good to her. I may not be perfect, but I've really struggled to the best of my ability to help her." As I stepped back for a moment from my own internal drama, I watched my mind playing with various psychoanalytic concepts in an attempt to help me to regain a sense of control. "Projective identification. Enactment. Maybe she needs me to show my feelings in a way that her emotionally unavailable father was never able to. Maybe she needs to see me upset." At the same time, I felt mildly critical of my attempt to distance myself from my immediate experience by using concepts and formulations, and was slightly amused at myself.

Eventually Andrea and I worked our way through this rupture as we had every time previously. Rather than focus on the details of how we did this, however, I want to keep the focus on my inner experience. I want to highlight my experience of internal paralysis and my difficulty sitting with and processing the range of conflicting feelings I was experiencing: shock, anger, righteous indignation, self-loathing, impotence, and so on.

Over time I have become increasingly intrigued with the question of

how therapists are able to work constructively with their own inner experience in a way that allows them to work through alliance ruptures. What exactly is the nature of the state of mind that permits therapists to relate to the feelings of rage, impotence, self-loathing, and despair that emerge during difficult therapeutic impasses, without defining themselves by these feelings and without dissociating them? How do we enter into this state of mind and how can we begin to talk about the relevant internal processes in a meaningful fashion?

It has become customary in relational writing to speak in more personal and subjective terms about complex and difficult transference-countertransference enactments. At the same time, a limited amount of attention is devoted to explicating and illustrating the processes through which analysts can work with their own internal experience to negotiate their way from a state of mind in which no possibilities for constructive therapeutic work exist to one in which internal space reopens and new possibilities emerge.

One of the difficulties in talking about this type of inner work is that it is intrinsically more difficult to write about our own internal processes, both because of a reticence about revealing private material and because of the difficulty of reconstructing feelings and perceptions of a more subtle and fleeting nature. Writers such as Ogden and Jacobs provide interesting models of the way in which this type of writing can be done. Ogden (1994) tends to reconstruct his own fleeting-moment-to moment associations to his patient's material. Jacobs (1991) reflections are of a more personal nature. He focuses on personal memories, emotions, and self-states that in some way resonate with aspects of the patient's dynamics. Davies (2002) provides an intriguing glimpse of some of her own internal processes during a particularly difficult enactment with a patient. Taken together, these authors provide hints of a new, potentially fruitful type of narrative genre that could be further developed.

At a broad level the relevant state of mind seems to have something to do with self-acceptance, with the ability to allow and accept one's internal experience, whatever it is, rather than fighting against it. This state of mind seems to involve a process of "letting go" and surrendering to one's experience, while at the same time reflecting on it in a nonjudgmental fashion. To return to Suzuki's aphorism about the meadow, it involves cultivating the type of internal "spaciousness" that allows one's thoughts and feelings to emerge as they are, rather than attempting to rigidly control them because of a fear that they will "stray."

Increasingly I have come to believe that when an intervention helps to heal an alliance rupture, it does so, not because the therapist had found the right words, but because the words reflect the fact that the therapist has managed to enter into the right state of mind. As Nacht (1962) suggested, the way that patients experience an interpretation is inevitably colored by their unconscious perception of the analyst's attitude toward them. Moreover, I have come to believe that one of the primary functions of metacommunicating about the therapeutic relationship is to help the therapist enter into this state of mind, by putting into words that which feels unspeakable (Safran & Muran, 2000). This process is related to what Symington (1983) referred to as the analyst's act of freedom.

This emphasis on the therapist's inner work is influencing our current efforts in a number of ways. At the level of training we are experimenting with the use of mindfulness training, derived from the Buddhist tradition, for purposes of helping therapists to cultivate the kind of inner skill necessary to reopen internal space when it has collapsed (Safran & Muran, 2000). Mindfulness involves learning to direct one's attention in a nonjudgmental fashion in order to become aware of one's thoughts, feelings, fantasies, and actions as they emerge in the present moment. It involves cultivating an attitude of intense curiosity about one's inner experience as it unfolds. This type of attitude is entirely compatible with Freud's (1912a) recommendation that the analyst listen to material with "evenly hovering attention." While Freud, however, said little about how to achieve this type of listening stance, mindfulness practice involves the use of rigorous and systematic training procedures for purposes of cultivating this ability.

At an empirical level we are beginning to do research on the inner processes of the therapist. One doctoral student of mine recently completed a dissertation demonstrating that therapists who have internal representations of their fathers as hostile are more likely to express hostility toward their patients during alliance ruptures. Interestingly, their representations of their mothers were not as relevant (Nelson, 2002). Another found that therapists who had completed a one-year training program in Brief Relational Psychoanalytic Treatment were more comfortable making use of their countertransference experience and better able to *reflect-in-action* than therapists at the beginning of the training program (Peyton, 2001). We are currently conducting a study investigating whether therapists who are more open to and accepting of their internal experi-

ence as it emerges in the moment, are more successful at negotiating therapeutic alliance ruptures.

Conclusion

I recently had a telephone conversation with an old colleague of mine who does psychodynamically oriented research and who I had not seen in a few years. At one point, I asked him whether he would be attending the next American Psychological Association, Division 39 conference. "I'm not sure" he replied. "Listen. Before I say anything, how would you describe your orientation to psychoanalysis these days?" I felt like I was being asked my religious beliefs, and sensed that the wrong answer would run the risk of bringing the conversation to an abrupt halt. "Well," I said, noncommittally, and feeling vaguely like an apostate, "I guess I'm kind of eclectic." This was all the encouragement he needed. "Frankly," he said, "with all the relational stuff going on at Division 39 these days, I'm just not sure how much of that postmodern, constructivist crap I can stomach." He then proceeded to rail against what he saw as the mindless antiempiricism that characterizes the relational tradition.

His comment, although distinctive in its bluntness and characteristic of my old friend, was related to a question I am often asked: How can I reconcile being committed to a relational-constructivist worldview and continuing to do psychotherapy research? Are they not fundamentally incompatible? Doesn't the practice of psychotherapy research assume a type of realism and objectivity that is viewed as illusory from the perspective of a constructivist epistemology? (e.g., Wachtel, 2002; Warren, 2002). My answer to this question, in brief, is that the real implication of a constructivist epistemology is not that research is meaningless, but that we need to approach the whole topic of research with a certain degree of philosophical sophistication (see Safran, 2001; Safran, 2002b).

True, the social sciences, like all sciences, have an irreducibly social and interpretive character to them. Evidence is always interpreted through the eyes of the observer and is only one element in a rhetorical process through which people try to persuade one another of the validity of their positions. Moreover, the rules of evidence and standards for arbitrating between competing truth claims are socially constructed and modified over time. But all of this is part of an ongoing conversation, which has the potential to help participants see beyond their preconceptions. The real issue, I believe, is one of finding a middle ground position

between the extremes of objectivism on one hand and radical relativism on the other (Bernstein, 1983). My sense is that it is the ongoing struggle to find a middle ground on this issue, as on others, that lies at the heart of relational thinking. I certainly believe it was at the heart of Stephen Mitchell's.

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