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RELATIONAL TURN AND PSYCHOTHERAPY RESEARCH

Abstract. Psychoanalytic authors have traditionally been skeptical of nomothetic studies, in which group averages obscure the uniqueness of individual cases. Several relational psychoanalytic authors have expressed more pronounced skepticism, affirming, for example, that given the uniqueness of each therapist-patient dyad, systematic empirical research is particularly problematic. In this article we highlight the potential synergy between relational thinking and today's psychotherapy research, by exploring some of the ways in which the work of relational authors has influenced relational psychotherapy research, shifting the focus of study from validation of the models of treatment to the study of the clinical variables such as: countertransference, therapist empathy, self-disclosure, rupture and resolution in therapeutic alliance, intersubjective negotiation, and the patient-therapist attachment relationship. In conclusion, the aim of this article is to facilitate the dialogue between relational psychoanalysis and the field of psychotherapy research, by exploring ways in which these two different worlds can reciprocally stimulate and enrich one another.

Keywords: psychoanalysis, psychotherapy research, relational turn, attachment, therapeutic alliance, intersubjective negotiation

Relational psychoanalysis and systematic empirical research have had a rather contentious relationship. Various factors have contributed to the tensions. Psychoanalytic authors have traditionally been skeptical of nomothetic studies, where the uniqueness of individual cases can be

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seen as smoothed out by averages. In fact, psychoanalysis from its inception has relied on a logic of "discovery" based on individual cases and a logic of "justification" whereby new cases contribute to a deepening of knowledge with more nuances or modifications. In relational psychoanalysis, this skepticism is even more pronounced for several authors. Irwin Hoffman (e.g., 2009) has been a vigorous proponent of the idea that in relational psychoanalysis it is particularly misleading to apply ideas and methods from empirical research to enhance knowledge or to assess treatment results. Given that relational psychoanalysis is based on a social constructivist philosophical ground, the idea that the perspectives on life created within a particular therapist–patient dyad should be comparable in a statistical sense, with knowledge gained in other unique patient–therapist relationships, may seem nonsensical. In this view, the development of meaningful knowledge takes place between two individuals in their unique relationship, and only such knowledge is useful in the clinician's growth as a therapist or in evaluating treatment.

This position has, however, been sharply debated by authors who argue for the need of a larger place for empirical research in the development of psychoanalytic perspectives (Eagle & Wolitzky, 2011; Fonagy, 2013; Safran, 2012). One major argument has been that patients seek treatment because they suffer, and it would be unethical to reject the empirical study of the reliability and effect of the proposed solution (i.e., therapy) on this suffering. Other arguments are that the development of knowledge always becomes enriched by different perspectives, and the present-day societal demands for evidence-based treatments must be addressed squarely by psychoanalysis. The history of psychoanalysis is replete with examples of conservative and orthodox bastions being challenged by new ideas that have emerged in the contemporary cultural and political surroundings (Frank, 2013; Lingiardi & De Bei, 2011a; Safran, 2013).

It is perhaps paradoxical that relational psychoanalysis has been particularly receptive to other scientific disciplines since its beginnings, including disciplines such as evolutionary theory (Slavin & Kriegman, 1992) and sociology (Altman, 1995). Better known is the movement's adoption of concepts from infant research (Beebe & Lachmann, 2002), attachment research (Bromberg, 2006; Lichtenberg, Lachmann, & Fosshage, 1996; Mitchell, 2000), and—more recently—neuroscience (Schore, 2005, 2007, 2012). However, relational analysts have not been as receptive when it comes to using findings from empirical psychotherapy research in their

everyday clinical work. This wariness has been attacked by critics (Bornstein, 2001; Josephs, 2001; Masling, 2003; Silverman, 2000), who interpret it as yet another refusal on the part of contemporary psychoanalysts to develop a scientific foundation based on empirical data in order to provide support for the validity, legitimacy, or efficacy of psychoanalysis.

As an example of this skepticism about empirical studies, Stephen Mitchell (1993), with his proverbial sense of irony, maintained that relational authors are "particularly vulnerable to a clinical state... that I have come to think of as the 'Grünbaum syndrome.'"

> I have come down with it several times myself. It begins with some exposure to the contemporary philosopher Adolf Grünbaum.... What follows is several days of guilty anguish for not having involved oneself in analytic research. There may be outbreaks of efforts to remember how analysis of variance works, perhaps even pulling a 30-year-old statistic text off the shelf and quickly putting it back. There may be sleep disturbance and distractions from work. However, it invariably passes in a day or so, and the patient is able to return to a fully productive life. (p. 206)

The relational tradition's distancing from empirical research stems from genuine epistemological concerns. The reasons for this "disinterest" lie at the hermeneutic heart of the relational paradigm itself. In Mitchell's (1997) words:

> Now there are many psychoanalytic schools, each with claims to an exclusive possession of objective truth.... Among those who have struggled directly with the implications of this [psychoanalytic] proliferation, there have been essentially three strategies (cutting across theoretical traditions): an appeal to empiricism, an appeal to phenomenology, and the hermeneutic/constructivism approach. The first strategy looks outside the analytic process itself for a firmer soil in which to ground psychoanalytic theory; the second strategy tends to diminish the importance of analyst's theory in the analytic process. The third strategy continues to grant an important role to the analyst's knowledge but calls for a rethinking of the very nature of that knowledge. (pp. 45–48)

The relational approach has adopted this third position, where the question of clinical knowledge is essential, but it is grounded on the uniqueness of mutual coconstruction, not on the reproducibility of empirical data. Mitchell and most other relational analysts do not dispute

the possibility of subjecting psychoanalytic theory and practice to some kind of empirical validation. They do question the nature and degree of the analyst's claim to "truth" in the clinical situation. The fact that the conceptualization of the patient's situation is construed in a dyadic interplay makes it difficult or even meaningless for the therapist to consider the relevance of those constant variables that are usually studied in psychotherapy research such as therapeutic methods, therapist skills, or patient diagnosis.

Most empirical studies are based on the idea that many factors can be investigated apart from the specific relational context, or at least that these factors are similar enough to make average comparisons meaningful. Psychotherapy researchers would also claim that just as in the study of personality, the idiographic approach is compatible with the nomothetic one in psychotherapy research (Lingiardi & McWilliams, 2015). In all sciences using data from human activities and interactions, variation between people is taken for granted. Surgeons operate in personal ways, and teachers have their idiosyncratic ways of stimulating learning. This does not prevent researchers from gaining knowledge about different methods, provided that the differences between the practitioners within one group are smaller than the differences between the groups.

The main criticism that has been raised to the application of "scientific procedures" to relational psychoanalysis is that the logic and methods of psychotherapy research lead to purported knowledge about principles that should be followed in order to guide therapeutic action, which tends to promote a "normative field" in which the importance of relational understanding and knowledge is not easily recognized. Many of the criticisms raised by Hoffman (2009) follow this approach, and point out the risk of falling into a "prescriptive, authoritarian objectivism" (p. 1045) and overestimating the external validity of empirical data. Moreover, the relational approach is constituted by a clinical and theoretical "sensibility" involving reflection on the clinical process, and not by clearly defined—or even worse—"manualized" theory or technique (Ghent, 1992).

In our opinion, there is a strong need to accept the discomfort of this clinical and theoretical "tension" and to bridge the gap between relational practice and empirical research. Our position is that, even if the clinical experience provides relational knowledge for therapeutic work, it is not the only knowledge that can be gained about therapeutic processes and outcomes (Lingiardi & De Bei, 2011b).

The Empirical Perspective: The "Outcome Problem" and Process Research in Relational Psychoanalysis

In the research design used to establish evidence-based treatments, the first and most important question is whether a certain therapy works in terms of "outcome" (e.g., a better life for the patient, fewer symptoms, more knowledge about one's life history, wider range of affect tolerance, increased ability for relating intimately). Although some authors have argued that psychoanalytic therapy does not have a curative aim, this could be seen as a philosophical rather than a clinical view. Few people enter any kind of therapy without wanting to change something in their lives. Thus, the question of whether therapy leads to any changes is important not only for research searching for so-called empirical evidence, but for all therapists, patients, and third parties involved (e.g., families, treating physicians, health-care agencies). In a sense, it is important to "measure outcome."

How to do it is quite another question. The movement for "empirically supported treatments" (EST; originally called "empirically validated treatments") has, under the auspices of Division 12 (Clinical Psychology) of the American Psychological Association (APA), created a framework for evaluating the efficacy and effectiveness of psychological treatments, which favors randomization designs, manual-based treatments with adherence controls, strict inclusion and exclusion criteria based on diagnostic categories, and outcome measures that are tied to psychiatric diagnoses (Wampold, 2013). The debate about this movement has been fierce (Levy, Ablon, & Kaechel, 2012; Norcross, Levant, & Beutler, 2005; Wampold, 2001; Wampold & Imel, 2015; Westen, Morrison, & Thompson-Brenner, 2004). Many authors have argued that the EST requirements favor cognitive-behavioral therapies (CBT) by, for instance, demanding adherence ratings based on treatment manuals and by neglecting the importance of the individual therapist's competence in creating a therapeutic relationship with the patient. Despite these controversies, the EST movement has had a large influence on training and deliverance of psychotherapy in several countries (United States, England, Sweden), because state authorities and insurance companies base their decisions on lists of which treatments are considered to be ESTs.

The psychoanalytic world, in general, has met this challenge in several ways (see, e.g., APA, 2013). Some authors have denied or belittled the

importance of studying treatments with randomized designs. But several psychoanalytic researchers have accepted the research model and made important contributions to the knowledge about the effectiveness of psychoanalytic treatments (Barber, Muran, McCarthy, & Keefe, 2013; De Maat et al., 2013; Leichsenring, 2009; Leichsenring, Klein, & Salzer, 2014; Leichsenring & Leibing, 2007). Although the number of studies that have analyzed results from therapies that are explicitly designated as "relational" is quite small, there are some studies of other psychoanalytic approaches that can help us understand how empirical research could promote psychoanalytic knowledge. The examples presented below should be read carefully, and not be interpreted as evidence of the encounter between relational psychoanalysis and empirical research. They are based on a one-person perspective, where the therapist "delivers" interpretations, but their value lies in the potential contribution to an increased understanding of the scientific study of clinical exchange (Lingiardi, Gazzillo, & Waldron, 2010; Lingiardi, Shedler, & Gazzillo, 2006; Waldron, Gazzillo, Genova, & Lingiardi, 2013).

Clarkin, Levy, Lenzenweger, and Kernberg (2007) conducted a randomized trial in which transference-focused psychotherapy (TFP) was compared with dialectical behavior therapy (DBT) and supportive treatment for borderline patients. The results indicated that all three treatments were similarly effective for symptom reduction. A secondary analysis (Levy et al., 2006) showed that one-third of the patients who received TFP had changed their attachment patterns from insecure to secure attachment patterns. They had also increased their reflective functioning (RF) ability substantially. No such changes were found for the patients in the two other treatments. These results indicate that psychodynamic therapy focused on the therapeutic relationship, in this case for borderline patients, may bring about specific changes that may be important for the stability in symptom change and life satisfaction over time.

Barbara Milrod and her colleagues in New York (Milrod et al., 2000, 2007) have studied the effects of psychodynamic therapy on panic disorder symptoms. They compared a manualized variant of psychodynamic therapy with applied relaxation. The results showed that the dynamic treatment was superior in reducing self-reported panic symptoms. An important finding in this study was that mentalization about the

symptoms,[1] measured as symptom-specific reflective functioning, increased in the dynamic therapy but decreased in applied relaxation (Rudden, Milrod, Target, Ackerman, & Graf, 2006). The results might indicate that dynamic therapy can have specific effects on the patient's ability to understand the intrapsychic and relational nature of the symptoms (see also Diamond et al., 2014).

A third example of an outcome study that may be of interest to relational therapists is the randomized study of psychodynamic therapy, performed in Oslo under the leadership of Per Høglend (Høglend et al., 2006, 2008). In this study, called the FEST study (First Experimental Study of Transference interpretations), psychodynamic therapy during one year, with and without transference interpretations, was compared. The main result was that patients with initially lower levels of capacity for object relations made substantially better use of the therapy with transference interpretations, whereas patients with initially higher levels of object relations capacity achieved similar outcomes with therapy containing transference interpretations and therapy that did not have this focus. Thus, somewhat counterintuitively, those patients who seemed to have less capacity to form intimate relationships took advantage of this possibility in the therapeutic relationship, whereas those who had been able to establish mature relationships had as much help from therapy without transference work.

It may be instructive to scrutinize the limitations of these studies from a relational perspective. Some are intrinsic to the logic of systematic empirical studies, such as the fact that average ratings are used, generalizations are made to groups of patients (and therapists), and patients are randomized to treatment alternatives, where adherence to a specific intervention method is monitored. It is important to recognize that despite the dominance of the randomized clinical trial paradigm (with its implicit assumption of linear causation), many prominent psychotherapy researchers recognize that all forms of psychotherapy (not just relational

[1] Mentalization about the symptoms refers to the patient's reflection regarding his or her difficulties. The Panic-Specific Reflective Functioning Scale (PSRF), focusing on the symptom-specific mentalization, proposes to assess: a) the difficulty "knowing" about conflicts specifically connected with the symptoms, while having unimpaired awareness of other aspects of one's internal emotional experience; and b) a self-awareness of the person's psychological contributions to his or her symptoms.

psychoanalysis) operate through nonlinear and recursive processes. (e.g., Krause & Lutz, 2009; Stiles, 2009).

Quantitative studies about groups of patient–therapist dyads can only provide knowledge about groups, whereas the knowledge about the individual patient comes in the personal meeting in the psychotherapist's room. But it would be unreasonable to pit them against each other. The situation with regard to attempts to study outcome of psychodynamic therapy (or any therapy) is certainly complex, and it is regrettable that some authors are prone to use oversimplified arguments in a situation where scientific discretion is required (e.g., Greenberg, quoted in Crumbley, 2011). At the same time, it is clear that many research designs, in particular EST, pose requirements that are problematic for most psychoanalysts, relational or classical, as well as for many psychotherapy researchers. If, on one side, the EST movement emphasizes a reminder to methodological rigor, on the other side it tends to ignore the "real" patients and the basic real conditions of all forms of therapies (Norcross et al., 2005; Westen et al., 2004).

Nowadays, many researchers find it more fruitful to focus on *factors* that promote change in therapy rather than to try to evaluate the effects of particular, well-defined treatments or treatment packages. For many, particularly dynamic and humanistic researchers, studies of treatment effects mean one must give up the ethos of genuine curiosity about how therapy works. Put against the wall, however, the researcher and the clinician may be forced to accept outcome research. In many countries, research projects do not get funded if they do not include randomized comparisons between treatment models. Rather than giving up the fight for research funding, many researchers choose to conduct randomized trials and then include important questions about factors that promote change in the design. In fact, in a growing number of countries (e.g., the UK, United States, Scandinavian countries, and, to a lesser degree, Italy) state authorities or insurance companies require that treatments they support or promote should be "evidence-based." The question for psychodynamic therapists in these countries is sometimes whether they and their training institutes will survive. Therapists may be conscious of the complexities of how psychotherapy works, but it is in fact understandable that politicians, health administrators, and the general public ask whether a particular form of therapy works for a certain clinical problem or not.

In parallel with the complicated discussion of outcome research, studies have looked at process factors in psychotherapy, in particular the therapeutic relationship and the personality characteristics of the therapist and, more recently, of the patient. This research area has been considered and explored in the work of the APA Division 29 (APA, 2013) and the two volumes by Norcross (2002, 2011), in which the focus is on *psychotherapy relationships that work* rather than on treatment techniques. Much of this research has considerable affinity with contemporary relational thought, as by Clara Hill and Sara Knox (2009). Issues such as countertransference, therapist empathy, self-disclosure, patient–therapist attachment, and ruptures and reparations in the relationship are all key elements in contemporary psychotherapy research. Here, there are many points of contact between psychotherapy research and the relational approach. We will first present two areas of research in which results from empirical studies might enrich clinical relational practice. Then, we will discuss principal issues, possibilities, and obstacles of this attempt to create a bridge between empirical research and relational psychoanalysis.

The First Point of Contact: Studies on Therapeutic Alliance

Therapeutic Relationship as a Unifying Theme

The concept of therapeutic alliance can be traced back to the original Freudian distinction of the transference in its "irreprehensible" positive form versus the therapeutically challenging "erotic" and "negative" forms (Freud, 1912/1958, pp. 528–529). The "irreprehensible" positive transference was understood as an instrument for cooperation, and was later to be called "the alliance," whereas erotic and negative transferences ought to be analyzed. The alliance concept has been downplayed (or openly critiqued) by authors who use the transference construct to explain every dynamic in the relationship, whereas others have embraced it as a structural dimension of the therapeutic relationship. Among the founders of the concept of therapeutic alliance are three psychoanalysts: Richard Sterba (1934); Elizabeth Zetzel (1958, p. 357: "the analyst enters the analytic process as a real person and not just as a transfer object"); and Ralph Greenson (1965), who differentiates among the working alliance, transference, and the real relationship.

It is worth recalling that psychoanalysis in the United States in the 1960s and 1970s, at the height of its popularity, nurtured great faith in

the possibility of extending the analytic treatment method to patients with severe pathologies. In these attempts, techniques that deviated from the traditional analytic stance, sometimes based on ego psychology, were sometimes used. It was in this climate that the usefulness of the concept of the therapeutic alliance was emphasized, largely for recognizing the reality that interpretations had a limited effect on patients who lacked the necessary preconditions to absorb or process it. For those patients who responded to the analytic method, there existed an underlying, unspoken agreement on the aims and methods of treatment with the therapist. This subtext was missing in the relationship with more problematic patients. In such cases, the analyst needed to prepare the ground (i.e., an alliance) on which the actual analytic process could rest.

It is paradoxical that the birth of the relational movement generated a loss of interest in the alliance construct (to be explained below; see also Colli & Lingiardi, 2009; Lingiardi, Filippucci, & Baiocco, 2005; Safran & Muran, 1995, 1996, 1998, 2000, 2006).

At the same time, researchers started to define and explore the treatment alliance from an empirical perspective. Beginning in the early 1970s, numerous studies were conducted to gather empirical evidence of the role of alliance as a critical variable in the therapeutic process. Thanks to this research, therapeutic alliance became recognized as the most important therapeutic factor common to all forms of psychotherapy.

At the beginning, researchers concentrated on exploring the relationship between alliance and therapeutic outcome in a variety of contexts: different types of treatments, different populations and diagnostic categories, the effects of gender, and various factors related to the therapist (e.g., training level and experience; see Horvath, 2005; Horvath, Del Re, Flückiger, & Symonds, 2011). Also studied was the relationship between outcome and alliance as assessed from contrasting perspectives (e.g., that of the patient, therapist, or observer), and the strength of the link between outcome and alliance in different phases of treatment (Horvath & Bedi, 2002; D. J. Martin, Garske, & Davis, 2000; Owen & Hilsenroth, 2011). In particular, there is some evidence that a good alliance predicts a positive outcome from the first session (Falkenström, Granström, & Holmqvist, 2013), but at the same time, there is ample clinical evidence that signs of a poor therapeutic alliance in the early stages of therapy do not necessarily correspond to poor outcome. This suggests that the usefulness of the construct as a predictor must not be related to the negative quality

of the alliance per se, but rather to the ability of patient and therapist to "work" on the alliance and repair its impasses (Lingiardi, 2013).

Psychotherapy research recently entered a new phase, producing more and more in-depth studies of the clinical dynamics involved in the therapeutic alliance (Hilsenroth, Cromer, & Ackerman, 2012; Horvath, 2006; Safran & Muran, 2006; Safran, Muran, & Shaker, 2014). This new line of research was prompted by an increased recognition of the beneficial effects "created" by the therapist, a reconsideration of the concept of alliance, and the formulation of the concept of *collaborative interaction* (Colli & Lingiardi, 2009; Ponsi, 2000). In essence, the idea is that the therapist and the patient both contribute to the formation of an effective therapeutic collaboration and that researchers studying the processes involved in this collaboration must disentangle the various components of the alliance and identify other "relationship variables," such as the real relationship (Gelso, 2009), transference (Bradley, Heim, & Westen, 2005), countertransference (Betan, Heim, Zittel, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Tanzilli, Colli, Del Corno, & Lingiardi, 2015), empathy (Elliott, Bohart, Watson, & Greenberg, 2011), the therapist's interventions (Jones & Price, 1998; Lingiardi, Colli, Gentile, & Tanzilli, 2011), the state of mind regarding attachment (Diamond, Clarkin, et al., 2003; Diamond, Stovall-McClough, Clarkin, & Levy, 2003), and the individual characteristics of the participants (see Ackerman & Hilsenroth, 2001, 2003; Taber, Leibert, & Agaskar, 2011).

This work has led to the idea that alliance cannot be seen as a *one-size-fits-all* package. On the contrary, the nature of the alliance varies depending on the individual patient and therapist, a reality that has generated the proliferation of expressions such as "matching patients to therapies" (Roth & Fonagy, 2004) and "tailoring psychotherapies and therapists to patients" (Horwitz et al., 1996; Lambert, 2004).

A static vision of alliance (as something like a trait variable of each therapy) has been replaced by a dynamic conception of something that is constructed over the course of treatment through processes of rupture and reparation of the relationship (Colli & Lingiardi, 2009; Safran & Kraus, 2014; Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011). As a consequence of this, the notion that alliance is a factor capable of explaining change *by itself* has lost its hold. Today, alliance is recognized as a generic, nonspecific construct (but not a "panacea"), studied through its interaction with other specific and nonspecific factors. Even more important, it is no longer considered as a mere precondition for treatment,

but also as a mechanism of change. In fact, achieving collaboration can be a therapeutic objective in and of itself (especially in treatment of psychoses and other severe personality disturbances).

So, what direction has research on the therapeutic relationship taken in recent years? First, the concept of alliance has gained widespread acceptance (Hilsenroth et al., 2012; Horvath et al., 2011; Norcross, 2011). This is partly in response to the equivocal results of studies comparing the efficacy of different psychotherapies and to the contradictory results of research on the impact of specific factors on outcome (Wampold & Imel, 2015). However, the sweeping success of the alliance construct cannot be explained purely on the basis of empirical evidence. A correlation of approximately .25 (thus "explaining" about 6% of variance in results) does not indicate a particularly wide effect. Other factors seem to account for more, such as the therapist's trust in the method and expectancy of success (Norcross et al., 2005) and the therapist's characteristics (Imel, Hubbard, Rutter, & Simon, 2013).

So one might ask: "Why then is the therapeutic alliance so popular among psychotherapy researchers?" (Safran & Muran, 2006, p. 286). One reason could be that the concept captures an aspect of therapy that is experienced as part of the mutual work. At the same time, as a large number of empirical studies on the therapy process have focused on the treatment alliance, a relational paradigm shift that has occurred in many psychodynamically oriented psychotherapeutic traditions. This "relational turn" has favored, among other things, an interest in therapists' experiences and actions, the mutual understanding of their interventions, and the influence of gender, all of which may also be studied as key variables influencing the efficacy of an intervention.

Although the emergence of the relational paradigm has resulted in a greater emphasis on the relationship dimension, relational authors have paradoxically seldom used the construct of therapeutic alliance explicitly. To understand this lacuna, it should be recalled that the concept of "therapeutic alliance" was first conceived within the realm of ego psychology, whereas other theoretical approaches—especially the British object relations model, but also the U.S. Freudian structural model—dismissed it as useless (Wallerstein, 1995). Ego psychology, however, needed to incorporate the issue of the relationship in its sphere, and the concept of alliance provided an effective way to do so.

In relational psychoanalysis, the concept of relationship rather than alliance has been used. This inclusive concept does not make the distinction between transference and alliance, which is basic to the development of the alliance research. Thus, Stephen Mitchell (1997, p. 49) wrote, "when interpretation fails, it is because there is no working relationship." In other words, the therapy is missing "the platform that makes interpretive leverage possible, a place for the analyst to rest her weight when making interpretations."

The relational tradition has less interest in the alliance concept because, in this perspective, the relationship is always in focus. The use of the concept "relationship" encompasses both veridical and distorted perspectives on the interaction, or rather, refuses to make the distinction. Once the whole analytic situation was viewed from a bipersonal point of view, and the quality and regulation of the analytic relationship took center stage in the theory and technique, the need for a construct such as "alliance"—the same need that had seemed so critical when relational aspects were underappreciated—more or less disappeared.

Nevertheless, the concept of alliance did not fade entirely from the writing of relational authors. It must be admitted that once the entire analytic situation was viewed from a relational (or bipersonal) perspective, the concept of alliance was subsumed into that of relationship, losing its usefulness as a discrete category. Nonetheless, the need remained for concepts to identify a breakdown in the relationship, like ruptures and impasses.

Impasses and Ruptures: When the Therapeutic Relationship Becomes the Focus of the Clinical Work

Reenvisioned from this perspective, it is clear that the problem of *ruptures* appears frequently in relational writings, albeit by different names or expressions: "pulling yourself up by your bootstraps" (Mitchell, 1997); "non-negotiable" subjects (Pizer, 2004), and "strong or weak dissociation" from the experience, making an experiential "fusion of horizons" between patient and analyst impossible (Stern, 2003). Stolorow and Atwood (1992) warn of intersubjective "conjunctions" and "disjunctions, that is, "excessive" syntony or differences in aspects of patient and analyst subjectivities that can induce a blind spot in the relationship. According to Jessica Benjamin (1995, 2002), an impasse coincides with a rupture in intersubjectivity, a fixation in forced complementarity between "doer/done to." Reflecting on particularly painful relational deadlocks, Jody Messler

Davies (2000) wonders "Whose Bad Objects Are We Anyway?" Emmanuel Ghent (1990), who explores the patient–analyst relationship in terms of a distinction between *submission* and *surrender*, sees submission as a distorted expression of the true self, which eventually provokes a rupture in the relationship.

Some of these concepts, and the established importance of working on the problems in the quality of alliance, are in line with findings from infant research. For instance, Edward Tronick's (2008) well-known studies on mother–child attunement demonstrated that healthy development was not linked so much to perfect attunement—indeed, mothers and their children seem to lack attunement in approximately 70% of their interactions—as to the capacity of the dyad to repair the lack of attunement (see also Beebe & Lachmann, 2002, 2013).

But what does research data reveal about the ability of patients and therapists to recognize and articulate a rupture in the relationship? First of all, it is worth recalling that patients do not always have the ability (or desire) to verbalize their discomfort or their disagreement with the therapist over a goal or goals of the therapy. As Rennie (1994) showed, there are a number of factors behind this deference, including 1) fear of criticizing the therapist; 2) a need to meet perceived expectations; 3) acceptance of their own limits; 4) fear of hurting the therapist's self-esteem; and 5) fear of appearing ungrateful.

A further problem (for clinicians) concerns the proper way to act or "react" when they become aware of a patient's negative feelings about the therapy or the therapist. Indeed, some old research suggests that the mere awareness by the therapist of a patient's negative feelings about the therapy can compromise the results of the treatment (Fuller & Hill, 1985; J. Martin, Martin, Meyer, & Slemon, 1986, 1987). There are various ways of interpreting this finding. One possible explanation is that therapists respond to a perceived alliance rupture by adhering more resolutely to their particular treatment model rather than by responding flexibly. As an alternative, therapists may respond defensively to the patient's negative feelings and express negative feelings themselves. These two possibilities are not mutually exclusive. Research on psychodynamic therapies, in fact, noted that an increase in transference interpretations in response to signs of alliance rupture correlates with a less successful outcome (Høglend et al., 2008).

On the other hand, alliance increases when therapists not only manage to recognize a rupture or stalemate in the alliance but also respond

without going on the defensive, participating in a straightforward manner towards a resolution and adjusting their attitude or behavior accordingly (Foreman & Marmar, 1985). Lansford (1986), for example, found that patients rated alliance more positively after patient and therapist both demonstrated their willingness to acknowledge and repair a rupture in the alliance. The relative success or failure of this process was also predictive of treatment outcome. Rhodes, Hill, Thompson, and Elliott (1994) found that an impasse was generally resolved when patients were willing to articulate their negative feelings and therapists put their energies into the reparation process. In the absence of these dynamics, the patient was more likely to terminate treatment against the therapist's recommendations.

An ever-growing number of studies suggest that effective management of ruptures in the alliance not only reduces the dropout rate, but may actually represent a decisive aspect in the entire change process. The focus on the *process* of rupture–repair work has been particularly developed in Safran and Muran's research group (Safran & Muran, 1996, 1998, 2000; Safran et al., 2011; Safran, Muran, Samstag, & Stevens, 2002). They utilized a method based on task analytic investigation (Greenberg & Pinsof, 1986) to integrate quantitative and qualitative analyses of processes involved in the performance of crucial events during the session (e.g., alliance ruptures). In this way, the authors were able to construct a descriptive model of alliance rupture and reparation and validate it with empirical evidence (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1998).

This research program allowed Safran's group to distinguish two major alliance rupture modes manifested by patients: *withdrawal* (with indirect forms of resistant communication) and *confrontation* (with more direct, explicit communication about perceived problems). These two modes reflect distinct behaviors adopted by the patient as strategies to deal with the tension between self-definition and relatedness to the other. The first rupture mode—withdrawal—involves vague, indirect rupture markers, whereas the confrontation mode involves a more unequivocal expression of conflict with the therapist.

Although patients tend towards one mode or the other, it is also common for the same subject to present both modes over the course of therapy, or even for the therapeutic impasse to be aggravated by the simultaneous presence of both rupture styles (Muran et al., 2009). On the basis of these research results, Safran and Muran formulated the

Brief Relational Psychoanalytic Treatment, an intervention model whose effectiveness is being validated empirically (Muran, 2002; Safran, 2002; Safran, Muran, Samstag, & Winston, 2005). Their research program has led to the development of training methods to enhance therapists' abilities to detect and work constructively with alliance ruptures and negative therapeutic process (Safran & Kraus, 2014; Safran, Muran, Demaria, Boutwell, Eubanks-Carter & Winston, 2014). They developed, manualized, and evaluated the efficacy of an alliance-focused treatment known as brief relational therapy (BRT; Safran, 2002; Safran, Muran, Samstag & Winston, 2005). Based primarily on principles emerging from contemporary relational thinking as well as their research program, BRT strategies have been integrated into other therapeutic modalities through alliance-focused training (AFT; Safran, Muran, & Shaker, 2014). The approach emphasizes the relational and contextual nature of ruptures, based on the assumption that "the significance of each technical factor can only be understood in the relational context in which it is applied." This highlights the "interdependence of technical and relational factors in psychotherapy" (Safran, 2001, p. 166). Although Safran and Muran emphasize the importance of acknowledging the therapist's failures and mistakes, their model has been criticized for focusing on the role of the patient in ruptures and thus diminishing the intersubjective nature of the therapeutic relationship (Aron, 2001). The team does, however, deserve much credit for calling clinicians' attention to these occurrences and for providing useful guidelines that still allow for contextual interpretations.

Also of note is the research on psychoanalytic therapies carried out with the Analytic Process Scales (Waldron, Scharf, Crouse, et al., 2004; Waldron, Scharf, Hurst, Firestein, & Burton, 2004). Six psychoanalytic therapies have been studied in this way—three conducted in the United States by analysts of the ego psychology school and three others conducted in Italy by relational analysts. Results demonstrate that one of the most powerful healing factors in these therapies is the circular relationship between therapists' "good" interventions (e.g., communications that are suitable in their type, content, expressive form, timing) and the productivity of patients' responses (i.e., responses that indicate closer contact with their emotions, greater awareness of their own psychic contents and a deeper engagement in the therapeutic relationship).

According to these studies, no particular interventions (encouragement to elaborate, clarification, interpretation, supportive or challenging types

of interventions) have special therapeutic value, nor does it seem plausible that interventions focusing on specific issues (e.g., transference, self-esteem, emotional and sexual life, aggressiveness, or developmental themes) are truly effective if not delivered "in the right way and at the right time" (Waldron, Gazzillo, & Stukenberg, 2015). Instead, what can propel the analysis forward, research suggests, are interventions in which the therapist is clearly attuned with the patient's prior communications. In turn, the productivity of these communications facilitates the therapist's ability to communicate well, establishing what we have called "the virtuous circle of a good analysis" (Gazzillo & Lingiardi, 2007). Later, the results of these studies were cited by the Boston Change Process Study Group (2010) as empirical evidence to substantiate their change model (see also Lingiardi et al., 2010).

Finally, research in progress (Gazzillo et al., 2014) on the role of both technical and relational factors in psychoanalyses and psychoanalytic psychotherapies, seems to support the idea that analyses that produce good outcomes (i.e., that produce symptomatic remissions and strengthen personalities' health) are systematically characterized both by higher levels of "classical" interventions such as clarifications and interpretations and by a more "relational" attitude (i.e., an analyst who is more straightforward, warmer, more empathic, and attuned; see Waldron, Gazzillo, Genova, & Lingiardi, 2013). Moreover, it seems that a vital quality of effective analysis is the degree of emotional engagement of both therapist and patient in the analytic process (Waldron et al., 2015).

To Sum Up: What Do We Know Today About Therapeutic Relationship/Alliance?

As mentioned above, the creation of a task force by the Division 29 of the APA, devoted to studying the role of relationship factors in psychotherapy, puts on an empirical level what relational therapists had always been convinced of on the clinical level, i.e., the curative dimension of the relationship. But even more important is the central idea that the relationship is a fundamental component of the therapeutic endeavor *in conjunction with* a series of other interpersonal aspects (e.g., therapist and patient characteristics, the type of patient–therapist attachment). Rather than treating the therapeutic relationship as a single concept, it should be seen as a *means through which different aspects of the therapeutic process operate in different moments of the therapy* (Roth & Fonagy, 2004), including the effects of the quality of the therapeutic alliance.

Results reported by Castonguay, Constantino, and Holtforth (2006) help identify important features of the therapeutic relationship/alliance from an empirically informed clinical point of view:

1. In general, the alliance is a construct that correlates with the observed therapeutic outcome (Horvath, 2005). The literature demonstrates that the quality of this alliance correlates positively with certain patient characteristics (e.g., capacity for mentalization, expectations of change, quality of object relations) and negatively with others (avoidance, interpersonal difficulties, depressive thoughts, etc.; ee Constantino, Castonguay, & Shut, 2002).
2. Likewise, certain therapist behaviors and attributes correlate negatively with the quality of the alliance (e.g., rigidity, excessive criticism, inappropriate self-disclosure; see Ackerman & Hilsenroth, 2001, 2003). Here again, research highlights the clinician's skill in managing and negotiating the relationship (Castonguay et al., 1996; Piper et al., 1999). It is likely, however, that the therapist's characteristics do not exert a direct negative influence on the quality of the relationship so much as an indirect one on the quality of the alliance. Faced with a rupture or impasse in the alliance, a risk is that therapists may react by adhering more rigidly to their particular technique or treatment model, undermining their chances of repairing a rupture and exacerbating an impasse.
3. Some data suggest that the quality of the alliance is a particularly good predictor of outcome when measured in the early phases of treatment. On the other hand, a weak initial alliance can be predictive of dropout (see Constantino et al., 2002). These findings signal to the clinician the usefulness of monitoring the relationship from the first encounter. Rather than assuming that initial problems of collaboration or early signs of disengagement will automatically decrease with time, therapists should start fostering the alliance from the first minute of therapy and be prepared to address alliance ruptures at their first sign of emergence" (Castonguay et al., 2006, p. 273).
4. Today we know that certain types of interventions (e.g., inappropriate use of silence, inappropriate self-disclosure, rigidity, criticism, insistent use of transference interpretation) can cause or exacerbate difficulties and ruptures in the alliance (Ackerman & Hilsenroth,

2001; Coady & Marziali, 1994; Jones & Price, 1998; Marmar, Gaston, Gallagher, & Thompson, 1989; Piper et al., 1999). This relationship, however, is quite complex. For instance, Ligiéro and Gelso (2002) found that when such interventions involve countertransference behaviors,[2] the level of therapeutic collaboration deteriorates. Furthermore, should the therapist begin to view the quality of the alliance negatively (e.g., because of distrust, confusion about goals), the first to suffer is the quality of the therapist's interventions, and only thereafter—indirectly—the quality of alliance with the patient. In short, these observations suggest the need to study characteristics of interventions in relation to the more "stable" therapist variables (e.g., state of mind concerning attachment; Rubino, Barker, Roth, & Fearon, 2000).

5. Finally, the question remains of how to train therapists to direct their energies most effectively towards constructing a positive alliance. Horvath (2005) reported that fewer than half of the training programs designed with this objective managed to achieve a positive relationship between training and quality of the alliance as assessed by the patient or an external observer. His research also revealed that external observers are able to identify certain therapist *characteristics* (e.g., flexibility, interest, or warmth) much more reliably than they can identify therapist *activities* associated with having or improving a positive alliance. These findings indicate the need for greater precision in identifying the interactive elements between therapist and patient that correlate with alliance. At the same time, clinical methods should be developed that successfully identify and manage therapists' counterproductive reactions to their patients in order to create more efficacious relationships (Safran & Muran, 2000).

Though this concise review is necessarily incomplete, it does suggest that relational variables have come to assume a more central role

[2] It is important to differentiate countertransference feelings from countertransference behaviors. Internal reactions experienced by the therapist can be acknowledged by him or her, and depending on their source, can prove useful in understanding the client and therefore enhance therapy. On the other hand, these reactions can be expressed as countertransference behavior and, if not handled in an appropriate manner, are likely affect treatment in an adverse way. Such behaviors, no matter what the source, would be detrimental to the therapy process (Ligiéro & Gelso, 2002, p. 4).

in the field of psychotherapy research over the last 20 years. In other words, research on alliance has demonstrated that the therapeutic relationship cannot be understood simply as one of the treatment variables that influence outcomes (Hatcher & Barends, 2006). On the contrary, the therapeutic relationship is an active and dynamic aspect, perhaps the most essential, of all therapeutic operations in the treatment process and shaped by the mutual influence of both patient and therapist.

Many of the issues at the heart of relational psychoanalysis include aspects that are highly compatible with the research on relationship as a therapeutic factor. There is no question that these relational concerns coincided both with the more generalized interest in the therapeutic relationship and with the centrality of rupture and reparation processes in clinical work.

A Second Point of Contact: The Centrality of Attachment Dynamics

Attachment theory is another area in which psychotherapy research and the relational model show several affinities. Bowlby's theory has taken on an increasingly important role within the relational paradigm, both as a new concept of motivation and as a metaphor serving to organize the clinical relationship and providing a fresh perspective on the major clinical constructs (see, e.g., De Bei & Dazzi, 2014; Mitchell, 2000; Wallin, 2007). A similar situation holds for psychotherapy research. For instance, in the systemization of the importance of relationship variables in psychotherapy, attachment patterns and styles (in both therapist and patient) has emerged as a variable with a distinct impact on therapeutic outcome (Norcross, 2011). In other words, both the clinical literature of the relational movement (and others; see Slade, 2008) and the empirical research literature have recognized attachment as a variable capable of influencing the outcome of treatment (Daniel, 2006; Obegi & Berant, 2009).

Attachment may influence treatment outcome in two ways. First, the attachment patterns of the patient (and therapist) may influence the extent to which they can establish a viable and fruitful therapeutic alliance and find ways of cooperating towards a positive treatment result. This influence is often called moderating, as it may moderate treatment results according to the participants' initial predispositions. An example could be that a patient with an ambivalent/anxious attachment pattern may create

an intense, somewhat clinging relationship that might be the subject for mutual exploration.

Attachment is also an aspect of the therapeutic relationship. By studying attachment dynamics in the clinician–patient relationship and their effect on the psychotherapy process, researchers have attempted to investigate precisely *how* this variable affects the outcome of psychotherapy (Farber & Metzger, 2009; Mallinckrodt, 2010; Obegi & Berant, 2009; Talia et al., 2014). In brief, it can be said that research applying results from adult attachment studies to the clinical relationship has shed light on the relationship between patients' attachment status and a number of variables, including 1) the dynamics of transference–countertransference (Eagle, 2013; Fonagy, 1991; Gunderson, 1996; Holmes, 1995, 1996, 2010; Liotti, 2007; Szajnberg & Crittenden, 1997); 2) the quality and nature of the therapeutic alliance (Dozier, Cue, & Barnett, 1994; Dozier & Tyrrell, 1998; Eagle, 2003; Parish & Eagle, 2003; Söderberg et al., 2014); 3) the narrative patterns of the therapeutic dialogue (Fonagy, 2001; Slade, 2008); and 4) the nature of symptoms reported by the patient, the patient's capacity to make use of the treatment, and the therapeutic outcome (Fonagy et al., 1996; Korfmacher, Adam, Ogawa, & Egeland, 1997; Tyrrell, Dozier, Teague, & Fallot, 1999).

These studies highlight the relationship between attachment constructs and clinical variables. Concepts such as alliance, transference, and countertransference are gradually being reinterpreted in light of attachment theory and empirical research, as seen, for example, in the book edited by Obegi and Berant (2009). A series of other studies are relevant in this field. For example, Eames and Roth (2000) observed that secure patients tended to form effective alliances whereas patients with an avoidant attachment experienced more problems in the relationship. However, patients with a preoccupied or avoidant style evaluated the alliance more positively over time, which seems to indicate that patients with problematic relationships need more time to establish a therapeutic bond.

Another interesting finding discussed by Eames and Roth (2000) is that subjects with a preoccupied attachment report a greater number of ruptures than patients with an avoidant attachment style do. This variance suggests that patients with relational difficulties with intimacy and fear of abandonment (preoccupied) may still make the effort to establish greater intimacy with the therapist; avoidant patients, on the other hand, may go on the defensive, denying the existence of relational problems or

establishing a superficial relationship limited by their reluctance to relate on a more personal, authentic level.

Another study investigating the impact of attachment style on the development of alliance was conducted by Mallinckrodt, Gantt, and Coble (1995). Their principal finding was that both the secure and the fearful attachment styles correlate with several aspects of alliance. For example, patients with a secure style, who perceive the therapist as responsive, accepting, and caring, reported a stronger alliance. The researchers found no correlation, however, between preoccupied patients and overall assessment of alliance. Thus, it is likely that, in their effort to avoid rejection, preoccupied patients submit to the therapist as a means of appeasing him or her, but without becoming involved in the (more threatening) task of identifying and openly discussing their personal problems (e.g., agreeing on the tasks and goals of the treatment).

In a subsequent study, Mallinckrodt, Porter, and Kivlighan (2005) examined the relationship among adult attachment styles, patient–therapist attachment, and alliance. Results showed that patients with a secure attachment style demonstrated greater openness to exploration during the therapy sessions and they had a secure attachment with the therapist. Although Mallinckrodt et al.'s study did not involve outcome assessment, the results certainly point to a model in which a secure attachment relationship with the therapist facilitates a sense of security during the sessions, which in turn encourages a positive outcome.

Marmarosh et al. (2014) investigated the hypothesis that complementary attachments are best for achieving a secure base in psychotherapy. Using a combined sample of 46 therapy dyads from a community mental-health clinic and university counseling center, the client- and therapist-perceived therapy alliance, attachment anxiety, and attachment avoidance were examined at the beginning of therapy. The findings partially support the notion that different attachment configurations between the therapist and client facilitate greater alliance, but this was the case only with regards to the dimension of attachment anxiety.

Diamond, Clarkin et al. (2003) and Diamond, Stovall-McClough, et al. (2003) analyzed the state of mind regarding attachment and the therapeutic relationship and the level of reflective function and personality organization in a group of 10 subjects with borderline organization being treated with transference focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 1999). First, in the vast majority of cases, the state of mind regarding the therapeutic relationship (patient-therapist-adult-attachment

interview; PT-AAI) correlated with one or more aspects of the state of mind regarding parents, as assessed with the adult attachment interview (AAI) in the 4th and 12th months of psychotherapy. Second, all patients demonstrated an increase in security according to the AAI. This increase, however, did not correlate with structural changes in defense mechanisms, identity diffusion, or reality testing, although these changes did correlate with the quality of object relations. Finally, Diamond, Stovall-McClough, et al.'s (2003) research produced intriguing and somewhat counterintuitive results concerning the reflective function scale. Not only did the level of reflective function demonstrated by therapists vary from one patient to another, but also that "in order for the patient to develop the capacity to understand self and other in terms of mental states, patient's and therapist's RF must be complementary, neither too discrepant nor too parallel" (p. 253).

Mentalization is a key concept in attachment research. Introduced in the psychoanalytic research tradition by Peter Fonagy and colleagues (Fonagy, Target, Steele, & Steele, 1998), it has captured the interest of therapists and researchers who try to understand the way that people come to understand their own and other's minds. Mentalization, usually measured as capacity for reflective functioning, has been used both as a predicting factor in psychotherapy and as a measure of treatment outcome. Attempts to understand how therapists may enhance mentalization by their interventions have been particularly interesting (Bateman & Fonagy, 2006, 2013; Bernbach, 2002; Karlsson & Kermott, 2006).

Another interesting study was carried out by Westen and colleagues (Bradley et al., 2005). Studying transference patterns in the treatment of patients with personality disorders, they determined that the patient's relationship with the therapist—as perceived by the clinician—can be described along five major dimensions: secure/engaged, avoidant/counterdependent, anxious/preoccupied, angry/entitled, and sexualized. The "overlap" of these transference factors with adult attachment styles identified with the AAI lends support to a vision of the therapeutic relationship as an intimate, asymmetrical relationship, emotionally charged, care-oriented, and capable of activating patterns of thought, emotion, affect regulation, etc. related to attachment. Thus, "although the distinction between working alliance and transference may be heuristically useful, the patient's response in both cases is based on a combination of prior expectations and current situational primes" (Bradley et al., 2005, p. 347).

On this subject, Westen and Gabbard (2000) wrote:

> From a connectionist perspective, the act of presenting for treatment evokes a set of highly specific wishes, fears, affects, and cognitive constructions, including expectations about helping relationships, doctors, confiding intimate material, confiding shameful material, and so on. Every early contact the patient has with the analyst—the initial referral, the first telephone contact, the way the analyst greets the patient in the waiting room—will be processed in light of these wishes, fears, and expectations. Features of the analyst such as age, gender, appearance, manner, dialect, clothing, and office furnishings will trigger conscious and unconscious associations. These features will dominate the patient's reactions early in treatment because they are initially more salient than anything else about the analytic relationship. No matter how anonymous and nonintrusive the analyst attempts to be, he or she can create nothing resembling a "blank screen" for the patient's transference projections, because no situation is free from interpretation of the situation in light of prior experiences. (p. 123)

To sum up and combine these two research themes, the results of contemporary psychotherapy research seem to support a reinterpretation of the concept of alliance as a secure base (Obegi, 2008). This way of viewing alliance is justified by the predictive capacity of the attachment construct, insofar as it is a variable that mediates between the quality of the relationship and outcome (Meyer & Pilkonis, 2002), and by the fact that it accounts for personality character parameters of both participants in the relationship. Thus, both directly and indirectly, attachment research validates the clinical work of relational psychoanalysts and psychotherapists, as well as their efforts to redefine the principal concepts of psychoanalytic practice.

Conclusions

According to the relational approach, technical and relational aspects of treatment are inseparable, i.e., all interventions are relational acts and the therapeutic relationship is the crucible of change. This idea is often in opposition to research paradigms that emphasize studies on the efficacy and effectiveness of therapeutic methods and packages (Hatcher & Barends, 2006). Although no researcher or treatment method proponent would deny the role of the relationship between therapist and patient for outcome, there has been a clear divide between researchers

and clinicians who focus on the effects of a method on outcome, and others who try to disentangle the nuances of the therapeutic relationship and how this is associated with treatment outcome. In many current psychotherapy research studies, both these perspectives are accorded interest. Thus, factors that are in focus for relational therapists, such as empathy, warmth, therapist self-disclosure, transference, countertransference, and, most important, ruptures and reparations in the therapeutic alliance, are also studied empirically in psychotherapy research. The issue to be discussed here is whether these two traditions, the clinical and the scientifically empirical, may enrich each other—as we believe—or whether their epistemological bases are too different to make it possible to establish a dialogue between them, as we often hear from some fellow analysts.

Researchers' awareness of the need to contextualize technical factors within the therapeutic relationship has altered their interpretation of the therapist's role. Not being a "constant," the therapist (with his or her personality, relational patterns, and behaviors) is recognized as an important variable accounting for a significant portion of differences in therapeutic results. In relational terms, this seems to imply that researchers have embraced the idea that much of what transpires in the therapeutic relationship is inevitably "coconstructed" by patient and analyst.

Another relational idea, that "intersubjective negotiation" of ruptures in the therapeutic relationship is essential to the success of the psychotherapy, also has its counterpart in empirical research. Among relational authors, a basic idea is that the patient's progress largely depends on the therapist's capacity to provide a new relational experience through which the patient can gradually learn to negotiate his or her needs creatively and constructively. In the words of Philip Bromberg (2006, p. 76), the patient must learn "the sensation that life can still be the same and that relational ruptures can be repaired without losing the reassuring continuity of the attachment bond."

These new trends in empirical research may do much to stimulate relational authors and therapists to reflect on the possibilities of using results from clinical research in their work. When attempting to make empirical research useful for relational therapists, several issues should be addressed. The first is to identify change mechanisms described in the relational literature in order to build hypotheses to be tested. A second issue is to reflect on methods to measure and describe these mechanisms. A number of different methods have been tried, sometimes in a way that

has not been so well associated with theoretical underpinnings. As a third task, researchers may design studies that aim to capture change processes.

The differences between results from empirical studies and clinical experience in actual therapy should not, however, be underestimated. No findings of recurrent patterns and statistical associations will ever change the challenges in the unique encounter between two persons in the therapy room. Nor would we want them to. Vital relational therapy is based on the struggle to make sense of the patient's life history and the mutual striving to understand the shared experience in the therapy room. The very kernel of relational work is the suspense of previously acquired knowledge, focusing instead on the current relational situation.

But at the same time, relational therapy has emphasized the contextual frame. Therapy is not made in the void, but rather in a gendered, political, socioeconomic, and ideological context. One important contextual factor is, for many therapists, contemporary research. Instead of being naïve or less cognizant of research findings, therapists ought to inform themselves about them.

The therapist who believes that "the main factor influencing the therapy outcome is the alliance" might be more stimulated in her or his work from recent findings about the dynamic ways in which the alliance is established, disturbed, ruptured, and rebuilt.

The mother who informs herself about research on attachment and affective attunement does not lose her spontaneity and curiosity about her child, and the therapist who knows more about process and outcome results continues to strive with the complexities in the relationship with the patient, but potentially with more ideas to enrich the therapeutic work.

To summarize, several research projects and initiatives have contributed to making empirical results more useful to relational practice. It is hoped that this work may generate a scientific community that will work to establish better dialogue between psychotherapies and research methods, and thus to bring the various epistemologies into contact in what is, in effect, a classically relational act.

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