Psychotherapy Research
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/tpsr20

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Theory, research, and practice
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Published online: 05 Nov 2013.

To cite this article: Charles Gelso (2014) A tripartite model of the therapeutic relationship: Theory, research, and practice, Psychotherapy Research, 24:2, 117-131, DOI: 10.1080/10503307.2013.845920

To link to this article: http://dx.doi.org/10.1080/10503307.2013.845920

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HONORARY PAPER

A tripartite model of the therapeutic relationship: Theory, research, and practice

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(Received 1 May 2013; revised 7 September 2013; accepted 13 September 2013)

Abstract

The development and empirical examination of a tripartite model of the therapeutic relationship over nearly three decades are described. The model asserts that all therapeutic relationships, to varying degrees, consist of a real relationship, a working alliance, and a transference-countertransference configuration. Research testing propositions about how each of these components is related to treatment process and outcome, and to each other, is presented. Many propositions have been supported, but some have been disconfirmed. Although the tripartite, or perhaps a quadripartite, model appears to be empirically and theoretically viable, continued research and theoretical development will serve to refine the model further. The development and testing of additional models that unpack the global concept of the therapeutic relationship would also be useful.

Keywords: tripartite model; therapeutic relationship; real relationship; working alliance; transference; countertransference

Over the past three decades, I have been involved in the development and empirical examination of a conceptualization of the therapeutic relationship that I believe has considerable applicability to psychotherapies of all theoretical persuasions (Gelso, 2011; Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998; Gelso & Samstag, 2008). This work was originally stimulated by the clinical theories presented by the classical psychoanalyst Ralph Greenson (1967). Based on my practice of psychodynamic psychotherapy, Greenson’s conceptions about the therapeutic relationship made a great deal of sense to me. However, some of these conceptions were quite fragmentary, few were defined in a way that allowed for empirical study, and, for Greenson, the conceptions had to do with classical psychoanalysis and, secondarily, psychoanalytic psychotherapy. Thus, considerable refinement (including clear definition of the key constructs) and elaboration were needed for the theory to have greater scientific merit. Also needed was an examination of how the theory might be extrapolated to psychotherapies beyond psychoanalysis.

In brief, the tripartite model that has evolved over the years posits that all psychotherapy relationships, regardless of the therapist’s theoretical orientation, consist of three interlocking elements: A real relationship, a working alliance, and a transference configuration (consisting of patient transference and therapist countertransference). Although each of these components was rooted in psychoanalytic theory, each is theorized to be important across diverse theoretical perspectives. In this tripartite model, all of these elements are theorized to be present from the first moment of contact between therapist and patient, and sometimes even before contact in the form of the patient’s or therapist’s fantasies of the therapist or the patient-to-be. The elements or components are both interrelated and separate, and each influences the others, as well as the process and outcome of treatment. During the psychotherapy hour, and indeed within most communications between patient and therapist about their relationship, each component is present. However, at certain times one component may be most salient, with the others receding into the
background. At other times, another element will become figure, and the others ground.

In the present article, I provide an update of both this theory of the therapeutic relationship, and the empirical work that has addressed key aspects of the theory. Particular emphasis is given to how the theoretical propositions have been tested, what we have found, and fruitful future directions for research. First, I discuss the overall therapeutic relationship, and follow with an examination of each key component, its definition, how it unfolds, and how it relates to treatment success. I then explore how the components relate to one another. Because the theory of the tripartite model posits that the key constructs relate to treatment success and to each other in particular ways across theoretical orientations, I focus particularly on research findings that cut across theories and do not pertain exclusively to psychoanalytic treatments.

It should be noted at the outset that I shall not be reviewing the external correlates of each component, i.e., the nomological network of associations of each component with other constructs. Such a review is beyond the scope of this paper. Suffice it to say that for each of the components of the therapeutic relationship, empirical studies have been and continue to be done on therapist, patient, and treatment factors that correlate with, contribute to, and result from that component. Such research is an important part of understanding the separate elements of the tripartite model and their connection to treatment success and failure.

The Therapeutic Relationship: Definition and Effect

When Jean Carter and I began work on a tripartite model (Gelso & Carter, 1985), we were surprised at how few attempts there were to define “the relationship.” This seemed so discrepant from good science. It appeared that the concept of relationship was most often conflated with three of Rogers’s necessary and sufficient conditions, which are therapist factors and certainly do not define a relationship between patient and therapist. In more recent times, the working alliance has often been used as a proxy for or operationalization of the relationship, even though leading investigators of the working alliance do not believe this to be a good idea (e.g., Horvath, 2009). I have argued that the overall relationship must be more than the working alliance (Gelso, 2009; Gelso & Samstag, 2008), and the use of alliance to capture the totality of the therapeutic relationship hugely oversimplifies matters.

Carter and I (Gelso & Carter, 1985) defined the relationship as “the feelings and attitudes that the counseling participants have toward one another, and the manner in which these are expressed” (p. 159). Although this conception is quite general, it has seemed to be a viable working definition and has been used in subsequent work on the therapeutic relationship (e.g., Norcross, 2002, 2011). The phrase, “the manner in which these are expressed,” requires some clarification. For the relationship to have meaning, it must be expressed in some way, although these ways may be remarkably subtle and nonverbal. Without such expression, there can be no relationship.

In exploring the therapeutic relationship and its definition, it soon became apparent that the relationship needed to be differentiated from psychotherapy techniques and procedures, and the theoretically prescribed roles in which the therapist and patient engage. These techniques and roles may be seen as actions of the therapist that are tied to his or her theory of the psychotherapy hour and of how to facilitate movement and change. They may reflect the therapeutic relationship, but they do not define it, and they are not the relationship itself. In practice, however, the technical (theoretically prescribed roles and techniques) and relational parts constantly interact and influence one another. There is a profound synergy between the two (see Norcross & Lambert, 2011). For example, how the therapist feels toward the patient and vice versa has a profound effect on what techniques are used, and especially how they are used. Thus, to exemplify further, the nature, depth, frequency, length, and especially the emotional tone of a psychoanalytic therapist’s interpretations will be deeply, if subtly, influenced by the therapeutic relationship. The patient’s responses to these interpretations, likewise, will be affected by the therapeutic relationship.

Because of the deep synergy between therapeutic technique and the relationship, it is important that their connection be empirically examined. Still, as indicated, the therapeutic relationship is different from techniques and treatments, and accounts for process and outcome variance in and of itself. For example, based on their synthesis of existing research, Norcross and Lambert (2011) conclude that about 20% of the total outcome variance is a result of the therapeutic relationship alone. Similarly, when Bhatia and Gelso (2013) examined 249 therapists’ perceptions of elements of the tripartite model and of the quality/outcome of a given session, they found that the relationship accounted for 27% of the variance in session outcome. Even after taking into account inflation due to monomethod bias and to the use of session rather than treatment outcome as the criterion, this is a very sizeable chunk of variance, representing a very large effect size.
Because of the enormous amount of empirical evidence amassed over the decades, it is clear that the global therapeutic relationship has a substantial impact on the treatment. It is now important that we open the package of the relationship and understand its contents (Gelso, 2009; Horvath, 2009). The tripartite model is one potentially useful view of what is inside this package.

Key Components of the Tripartite Model: Definitions, Roles, and Effects

The Real Relationship: The Foundation

I begin by discussing the real relationship because it may be the most fundamental of the relationship components. All relationships, all sessions, and perhaps even all relational responses in therapy have a real relationship element; and in this sense the real relationship is universal. In more recent work, my collaborators and I (e.g., Gelso, 2011; Gelso et al., 2005; Gelso & Samstag, 2008) have defined the real relationship as the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other. Thus, as Greenson (1967) suggested, there are two key elements of the real relationship: Genuineness and realism or realistic perceptions of the other. We have further refined the real relationship construct to take into account both how much genuineness and realism exist (termed magnitude) and the extent to which the realism and genuineness are positive vs. negative (termed valence). Regarding valence, it is important to note that one can be genuine and realistically perceive the other negatively. Sometimes, for example, a patient can perceive a therapist realistically, be genuine, and not like him or her! When we combine realism and genuineness with “how much” (magnitude) and “how positive vs. negative” (valence), the result may be seen as an index of the strength of the real relationship, with greater magnitude and more positivity in valence being indicative of a stronger real relationship.

The real relationship concept has been around perhaps from the beginnings of the talking cure. Indeed, Freud (1937/1964) stated that “Not every good relation between an analyst and his subject during and after analysis was to be regarded as transference; there were also the friendly relations which were based on reality and which proved to be viable” (p. 222). The topic of a real relationship was also taken up by many analysts over the early decades of the twentieth century (see Gelso’s 2011 review). Still, this has been a highly controversial construct, and is seen as problematic by some humanists and relational analysts who have particular trouble with the concept of “real.” These therapists challenge whether anything can be considered real beyond the participants’ co-constructions; they raise the question of who is the arbiter of what is real; and they worry about how to measure what is real. These arguments are important, and I have sought to address them in some detail (Gelso, 2009, 2011). I have taken the viewpoint that although there is great co-construction between therapist and patient, there are indeed realities of each that are to be understood and that can be measured, albeit highly imperfectly. As for who is the arbiter of what is real, it seems to me that everyone’s perspective is valuable, and no one perspective owns the market on truth.

Partly because of these thorny theoretical, philosophical, and political questions, the real relationship received the least empirical attention of the components of the therapeutic relationship. However, following the development of psychometrically sound and convenient measures from therapists’ (Gelso et al., 2005) and clients’ (Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010) perspectives, research has begun to appear. In keeping with propositions offered by Gelso and Carter (1994), the evidence clearly points to a meaningful relation between the real relationship and both session outcome (Bhatia & Gelso, 2013; Eugster & Wampold, 1996; Gelso et al., 2005) and treatment progress and outcome (Ain & Gelso, 2008, 2011; Fuertes et al., 2007; Gelso et al., 2012; LoCoco, Gullo, Prestano, & Gelso, 2011; Marmarosh et al., 2009; Owen, Tao, Leach, & Rodolf, 2011). Both patients’ and therapists’ perceptions contribute to outcome, although not both perspectives in every study. In addition, in every comparison made so far, when the relationship and its sister concept, the working alliance, have been examined together, the real relationship contributed to session and treatment outcome variance above and beyond the contribution of the working alliance (Bhatia & Gelso, 2013; Fuertes et al, 2007; Lo Coco et al., 2011; Marmarosh et al., 2009).

We know next to nothing empirically about how therapists can strengthen their real relationships with clients. However, the definition itself of the real relationship can help direct the therapist. The definition itself suggests that the therapist be genuinely and accurately (i.e., accurately). The concept of therapist genuineness is one of the trickiest around. Genuineness or authenticity implies that the therapist be open and honest, or, as Carl Rogers said, genuineness implies that the client can see all the way through the therapist. However, nearly all
therapists would perhaps agree that we cannot simply tell the patient whatever we have in mind. What we do tell must be guided by some theory or awareness of what can be valuable, or, at a minimum, not destructive to the patient.

Generally, there does appear to be a positive relationship between how much therapists disclose to their patients and both therapists’ and patients’ perceptions of the strength of the real relationship (Ain & Gelso, 2008, 2011). Using retrospective reports of former patients ($n = 94$; Ain & Gelso, 2008) and current reports of psychotherapy dyads ($n = 61$; Ain & Gelso, 2011), it appears that amount of therapist self-disclosure accounts for 9–10% of the variance in perceived therapist genuineness within the real relationship. This implies that although the therapist’s openness or self-disclosure certainly matters in terms of perceptions of his or her genuineness, variables other than self-disclosure must also be at work. I have theorized that patients’ perceptions of therapists’ genuineness within the real relationship are importantly determined by qualities such as therapists’ nonverbal behavior, the congruence between what therapists say and their nonverbal expressions, consistency in what is said to the patient, and therapists’ clarification of why they will not disclose certain material (Gelso, 2011, pp. 158–159). These qualities seem more important that the amount of self-disclosure in affecting perceived therapist genuineness. However, this is a topic that is clearly in need of empirical efforts.

Unfolding of the real relationship. Gelso and Carter (1994) posited that “As the therapy progresses, the real relationship deepens” (p. 304) and that “during the latter stages of most therapies, the real relationship is more prominent than ever” (p. 304). Although research on the unfolding of the real relationship is still in its infancy, the two studies that have addressed these propositions are supportive (Fuertes, Gelso, Owen, & Chen, in press; Gelso et al., 2012). In keeping with Gelso and Carter’s propositions, in both studies of brief therapies, the real relationship started off strong from both clients’ and therapists’ perspectives, and it further strengthened as treatment progressed, especially for the cases in which outcomes were more successful.

The Working Alliance: The Catalyst

If the real relationship is the foundation of the overall relationship, the working alliance is what most directly allows the work of psychotherapy to get done. Greenson (1967) noted that the real relationship is a part of all human encounters, whereas the working alliance is an artifact of psychotherapy in the sense that the only reason for its existence is to allow a piece of work to be done. Furthermore, Greenson theorized the alliance to emerge from the real relationship, and while the alliance is infused by transference (see next section), it is mostly composed of realistic perceptions. Gelso and Carter (1994) have defined the working alliance as “the alignment or joining together of the reasonable self or ego of the client and the therapist’s analyzing or ‘therapizing’ side for the purpose of the work” (p. 297). This joining together of the patient and therapist reasonable sides “allows each to observe, understand, and do the work of psychotherapy in the face of the many emotional obstacles and resistances that impinge on virtually all therapies” (Gelso, 2011, p. 8). When the joining together occurs, the well-known conditions for an effective alliance posited by Bordin (1979) may be realized: The therapist and patient experience a working bond, they agree (implicitly or explicitly) on the goals of therapy and believe these to be attainable, and they agree on the tasks that will help attain those goals. In this conceptualization, it can be seen that the focus is on the working aspect of the alliance. This is in contrast to other notions, such as therapeutic alliance, that seem more to address the overall relationship, although ambiguously. Focusing on the working alliance allows it to be differentiated from other components, which are not directly linked to a working collaboration.

A voluminous amount of research has been done on the working alliance over the past three decades or so. In keeping with theoretical assertions (Gelso & Carter, 1985; Gelso & Hayes (1998), recent meta-analyses of 190 independent alliance-outcome ratings (Horvath, Del Re, Flukiger, & Symonds, 2011) indicate a moderate and stable median correlation coefficient of .28. This relationship seems to hold for a wide range of treatments, thus supporting the idea that the alliance is a pantheoretical concept. Based on their exhaustive review, Horvath and his collaborators concluded that the development of a sound or “good enough” alliance early in therapy is vital for therapy success and that the alliance matters in all forms of therapy. The fact the working alliance seems to matter across diverse treatments would appear to disconfirm Gelso and Carter’s (1994) assertion that the early working alliance would be particularly important in briefer therapies. However, not enough has been done on alliance development in long-term therapies to draw firm conclusions.

Unfolding of the working alliance—tear and repair. One of the most exciting and valuable directions that working alliance research has taken pertains to how the alliance develops over the course
of therapy. Researchers have sought to determine whether there are characteristic patterns that unfold in terms of the magnitude or strength of the working alliance. This work dovetails with conceptions of alliance ruptures or strains, and the notion of tear and repair, perhaps first underscored by Bordin (1980, 1994), and vigorously explored theoretically and empirically by Safran and Muran and their collaborators (e.g., Safran & Muran, 1996, 2000; Safran, Muran & Eubanks-Carter, 2011; Samstag, Muran & Safran, 2004). The concept of rupture in the alliance may be defined as “a tension or breakdown in the collaborative relationship between patient and therapist” (Safran et al., 2011, p. 224) The basic idea of tear and repair (also termed rupture-repair) is that due in part to the patient’s characteristic underlying relational conflicts, and in part to what may be termed the therapist’s empathic failures, the patient will encounter difficulties in the working alliance. These will become especially significant as the therapist seeks to work with the underlying conflicts and “rubs against” the patient’s defenses. Fundamentally, this may be seen as a useful, if not necessary, part of successful therapy, for as the therapist works with the patient to understand the rupture, it becomes repaired. The repair, and the understanding that allowed for repair, move the therapy forward. Thus, the process of rupture and repair ultimately benefits the therapy.

Related to the concept of rupture and repair, Gelso and Carter (1994) posited a pattern in successful therapy in which an initially strong alliance would give way to diminishing alliance as the therapist begins probing the patient’s conflicts, including how they may be exhibited in the therapeutic relationship. Then, in successful treatments, these difficulties become resolved and the alliance again becomes strong. By contrast, in less successful treatments, this high-low-high pattern, or what may be termed a rupture-repair cycle, does not occur. In such instances, the therapist may fail to understand and explore his/her empathic failures or the patient’s core issues, or the patient’s defenses may thwart such exploration.

What does the empirical evidence say about rupture and repair, and the high-low-high pattern of alliance development? Regarding rupture-repair, although little research has addressed this question, based on a meta-analysis of three studies Safran et al. (2011) found a moderate relation between the existence of rupture-repair sequences and treatment outcome. It should be noted that this does not mean that the mere existence of ruptures helps, but that the existence of ruptures that are repaired benefits outcome. This important finding leads to the question of whether we might train therapists to facilitate

the repair of ruptures. Here, too, Safran and his collaborators point to promising findings. A review of seven studies examining theoretically diverse treatments indicates that training in the repair of ruptures appears to have at least a modest effect on treatment success.

As for the related question about high-low-high patterns in successful cases, the evidence is rather mixed. However, after an extensive review, Horvath et al. (2011) conclude that some change or fluctuation in the alliance is indicative of more favorable outcomes than are stable or linear alliance patterns, provided that the overall quality of alliance does not decline or end up low. It may be that rather than a single high-low-high pattern as theorized by Gelso and Carter (1994), in effective treatments there are at least one and possibly more high-low-high patterns (Stiles et al., 2004), indicative of rupture-repair sequences. This would make sense especially as treatments become longer term, where a single high-low-high pattern would not appear to make good sense clinically. Research and theory on the areas of rupture-repair and alliance curves are likely to grow and continue to yield fruitful findings.

The Transference-Countertransference Configuration: Conflict and Projection

Transference

Many see this construct, transference, as Freud’s greatest discovery related to psychological treatment. Although the notion of transference has been central to psychoanalytic theories of the treatment hour, great controversies exist within psychoanalysis around how it should be defined, ranging from rather restrictive classical definition to what is referred to as a totalistic definition, which is inclusive but also ambiguous. The former restricts transference to reactions to the analyst originating in the patient’s original Oedipus complex, whereas the latter includes all of the patient’s reactions to the therapist. This all-inclusive definition makes transference equivalent to patients’ reactions to therapists, which also makes the term, transference, into theoretical excess baggage. In my work, I have sought to integrate classical conceptions with more current relational/self-psychological notions. We (Gelso & Hayes, 1998; Gelso & Bhatia, 2012) have defined transference as the patient’s experience and perceptions of the therapist that are shaped by the patient’s own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to and in earlier significant relationships.
Within the tripartite model, transference is viewed as a universal, as occurring in all psychotherapies and all relationships. In keeping with this view (and referring to countertransference as well as transference), Judith Schaeffer (2007), who received her doctoral training in CBT, offers the decisive view that:

there is no question that all therapists and clients transfer functions and roles they or others played in the past onto each other. There is no question that nonanalytic therapists must identify transference and countertransference as soon as possible. There is no question that they must diagnose them accurately and give serious consideration to interpreting them to appropriate clients so that, rather than be controlled by them, they can control them and benefit from the major contribution they can make to variables responsible for positive outcomes .... Otherwise, the double-edged swords of transference and countertransference will cut their way through what is working and enable variables responsible for negative outcome to gain a stronghold, (p. xi).

However, because the concept of transference is so indelibly rooted in psychoanalysis, some nonanalytic theoreticians have doubted its existence in therapies other than psychodynamic ones, and some have viewed it as an artifact of psychoanalytic treatment. What does the empirical evidence say about the occurrence of transference in nonanalytic as well as analytic treatments? Gelso and Bhatia (2012) reviewed 16 qualitative and quantitative studies that examined transference in either nonanalytic therapies or in samples of therapists with diverse theoretical orientations. They concluded that the findings:

support the assertion that transference indeed happens in nonanalytic therapies, and it does not seem to happen much less than in analytic therapies. The content of transference is also essentially the same in nonanalytic and analytic therapy, and transference does not appear to be an artifact of the analytic therapist. That is, it is not simply created by the therapist's belief in its existence. Lastly, transference is likely to show itself, perhaps increasingly [as treatment progresses], whether or not the therapist attends to it. (p. 387)

These findings, although based on a small number of studies, are consistent with experimental results from the social psychological laboratory. In an extensive program of research by Andersen and her collaborators (see Andersen & Pryzybilski, 2012), strong evidence has accumulated for the existence of transference “throughout interpersonal life in everyday perception and behavior. Prior relationships can and do play out in present ones” (p. 381). These findings, conceptualized by Andersen from a social-cognitive perspective, are consistent with, but greatly extend, Freud’s early assertions about transference in everyday life (Freud, 1912/1953).

The evidence that transference seems to exist across diverse therapies begs the question of its impact on those treatments. The evidence is mixed on whether the mere existence of transference, whether negatively or positively valenced, is related to session or treatment outcome. For example, in samples with diverse therapist theoretical orientations (Bhatia & Gelso, 2013; Gelso et al., 2005), as well as psychodynamic therapists (Markin, McCarthy, & Barber, 2013), the amount of therapist-rated negative transference has been found to be associated with therapist-perceived session smoothness, and overall session outcome. The greater the amount of negative transference, the rockier and less smooth the sessions and the weaker the ratings of session outcomes. Gelso, Hill, and Kivlighan (1991), using theoretically diverse therapists, did not find a relation of negative transference to session outcome.

Regarding treatment outcome, Marmarosh et al. (2009), using a theoretically diverse sample of therapists, found that negative transference was also predictive of less symptom change at the end of brief therapy. Gelso, Kivlighan, Wine, Jones, & Friedman (2007) found that negative transference, especially in the final quarter of brief therapy, differentiated more from less successful cases. The less successful cases exhibited a dramatic increase in negative transference, whereas the more successful cases showed a drop in transference during the final quarter. It should be noted that in only one of these studies was positive transference related to session or treatment outcome. Markin et al. (2013) studied psychodynamically based therapy done by seasoned therapists, and found that positive transference actually positively related to deep and successful sessions. Interestingly, the Markin et al. study was the only one in which ratings of positive transference and session outcome were done by external raters.

When putting the above findings together, it may be very tentatively concluded that there are main effects of transference on session and treatment outcome, but these effects are likely to be modest. What may be more significant is that, whatever the main effects are, they appear to be qualified by interaction effects. As hypothesized by Gelso and Hayes (1998), therapist-rated negative transference can be for better or worse, depending on how emotionally insightful the therapist sees the patient being. Greater amounts of early negative transference are especially indicative of good session and treatment outcomes when the client is rated as highly emotionally insightful, whereas when the client is rated as having low emotional insight, high negative transference has a markedly negative association with...
outcome, as indicated in two studies from our laboratory (Gelso et al., 1991, 1997). Recently, a third study partially replicated this finding with a large sample of theoretically diverse therapists, where session depth was the criterion (Bhatia & Gelso, 2013). These findings, which include therapists of widely varying orientations, are consistent with Graff and Luborsky’s (1977) investigation of more and less successful psychoanalyses. They found that in the successful cases, transference came increasingly under the control of analysand insight, even as transference itself increased from the beginning to the end of psychoanalysis.

In addition to the interaction of transference and insight as just described, recent evidence suggests that the effects of transference on treatment success may partly depend on how the transference is handled. Thus, Hogland and his colleagues (Johansson et al., 2010) find that transference interpretations tend to lead to insight, which in turn is associated with positive outcomes. These studies focus on psychodynamically based treatments, and it will be useful to see if they can be extended to other orientations (see Levy & Scala, 2012).

The transference work emanating from our research laboratory at the University of Maryland is almost exclusively based on therapists’ reports. Although this is an important reference group, therapists naturally have their own slants and biases, and it is critical to test the relation of transference to outcome from the vantage points of outside raters. The Markin et al. (2013) study is unique in its use of trained raters, and more research of this kind will be useful. Although the unconscious nature of transference raises questions about the meaning of patients’ perceptions of transference, it may still be useful to examine the patient’s perspective.

**The unfolding of transference.** We know little about the unfolding of transference over the course of differing psychotherapies. Beach and Power (1996) coded and rated implicit and explicit transference statements in 40 sessions each of CBT and psychodynamic therapies. They found that in both treatments, explicit transference references increased in later versus earlier sessions, despite the fact that CBT therapists seldom responded to patients’ transference references. Still, consistent with Gelso and Hayes’s (1998) proposition, more transference was evidenced in the psychodynamic treatments.

There is also some evidence that transference unfolds very differently for more and less successful cases, and perhaps for varying theoretical orientations. Graff and Luborsky (1977), for example, examined the unfolding of transference over the course of a small number of psychoanalyses. They found that in successful analyses, analyst-rated transference increased linearly throughout the work, whereas in less successful cases, transference remained stable throughout. This finding was replicated by Patton, Kivlghan, and Multzon (1997), who found that in 20 sessions of psychoanalytic counseling, the more successful cases exhibited an increasing pattern of transference across sessions. This is a markedly different pattern than that uncovered by Gelso et al. (1997) in their study of brief, theoretically heterogeneous therapy with a 12-session duration limit. These investigators found that in more successful cases, therapist-reported transference (especially negative transference) rose from the first through the third quarter of treatment, and then sharply declined in the final quarter. For less successful cases, however, transference started out at a slightly higher level and rose continuously through the four quarters of treatment.

The striking difference in the unfolding of transference in the three studies may be due to the fact that the Graff and Luborsky (1977) and Patton et al. (1997) studies were on psychoanalytic interventions, whereas the Gelso et al. (1997) investigation was on brief, theoretically diverse therapy. In connecting these findings to those discussed in the last section concerning insight, it may be that in psychoanalytic treatments that place a premium on the emergence of transference, transference tends to increase throughout successful treatments but is increasingly accompanied by patient insight, whereas in successful theoretically diverse treatments, in which transference is not necessarily viewed as a key to success, patients’ insight is accompanied by a reduction in negative transference. In such treatments, a linear increase in negative transference is a sign that the patient is not, in fact, gaining insight into the relationship.

**The Double Helix of Countertransference**

Like transference, the construct of countertransference has been surrounded by considerable controversy and debate around definitions. Also like transference, the definition of countertransference over the years has ranged from the classical definition (i.e., the therapist’s transference to the patient’s transference) to the totalistic definition, which includes all therapist reactions. In an effort to provide a definition of countertransference that integrated these two, as well as others, Gelso and Hayes (2007) defined countertransference as “the therapist’s internal and external reactions that are shaped by the therapist’s past and present emotional conflicts and vulnerabilities” (p. 25). This definition views the therapist’s issues as fundamental, even though it...
may be the patient’s behaviors that serve as the trigger. Indeed, some patients seem to excel at stirring conflictual reactions in therapists; but still, in my work with Jeff Hayes, we have favored the view that in order to consider the therapist’s reaction as countertransference, these reactions would have to be a reflection of the therapist’s unresolved issues stirred up by the patient or the therapeutic frame (the psychotherapy situation itself). We have taken the position that therapist reactions that seem fully expected based on the patient’s behavior (e.g., feeling angry with an abusive patient) are best not viewed as countertransference because viewing them as such muddies the definitional waters, moving closer to the totalistic definition. As I have indicated, I do not consider that totalistic definition tenable as a scientific construct because it then has essentially no boundaries, and begs the question of why even use the term countertransference rather than the more parsimonious term, therapist reactions.

Because it is usually something about the patient that serves as the trigger that interacts with some vulnerability or unresolved conflict within the therapist to cause countertransference, Gelso and Hayes developed the concept of the countertransference interaction hypothesis to explain countertransference reactions. Although some patient behaviors are more likely than others to trigger countertransference, and some therapists are more vulnerable than others, research suggests that just what serves as a trigger for which unresolved conflicts to materialize into countertransference reactions is a highly individualized matter (Gelso & Hayes, 2007). Such a hypothesis is best studied in terms of complex moderation and perhaps mediation models, which move us closer to answering the question of which patient behaviors create what countertransference reactions in which therapists.

In a certain sense, countertransference has had a shakier history in psychoanalysis than has transference. For many of the early years, it was viewed as something to be done away with, and the good analyst, who had been effectively analyzed, would not have countertransference reactions. Perhaps because of this negative view, countertransference moved to the psychoanalytic underground. Toward the latter part of the twentieth century, however, the construct was revived, and has been the topic of much theoretical discussion and research. The extrapolation of the concept of countertransference to nonanalytic theories has been more readily acceptable than it has for transference, as there does appear to be general agreement that countertransference is an important construct across theoretical systems. There also appears to be general agreement that countertransference can be for better or worse, depending on how the therapist works with his or her internal reactions. The idea that countertransference can be a hindrance or an aid is what moved Epstein and Feiner (1988) to propose that the potentially helpful and harmful elements “have been intertwined, like a double helix, throughout the historical development of psychoanalytic conceptions of countertransference” (p. 282).

This double helix metaphor has been fundamental to my work on countertransference with Jeff Hayes and others (e.g., Gelso & Hayes, 2007). For example, we have proposed that the effect of countertransference depends on how the therapist is able to understand and manage his or her internal reactions to the patient. If countertransference is poorly understood and managed, it will tend to spill into the session and become manifested behaviorally. In such cases it is a hindrance to one degree or another. However, if it is effectively managed, countertransference can be used by the therapist to aid his or her understanding of the patient and the patient’s impact on others. We have theorized that there are five major, interrelated constituents of countertransference management: (1) the therapist’s self-insight during sessions, both emotional and intellectual insight; (2) how well the therapist is emotionally integrated in the session, including having firm but permeable boundaries between him/herself and the patient; (3) the therapist’s empathic ability during sessions; (4) the therapist’s skill in managing and modulating the anxiety that is experienced in the sessions; and (5) how effectively the therapist is able to conceptualize the dynamics of the patient and the treatment hour, from whatever theoretical position s/he prefers.

Of the five constituents, reviewers have at times questioned the singular focus on only one affect, anxiety, in constituent 4. The singling out of anxiety in this theory is based on the view that anxiety is the most fundamental emotional state against which defenses are developed. Thus, the many affects that reflect countertransference are considered to be triggered by the therapist’s anxiety and are generally defenses against anxiety.

What does the empirical evidence have to say about the existence of countertransference across theoretical orientations? And what are the effects of countertransference and its management? Regarding the existence of countertransference, as proposed by Gelso and Hayes (1998), qualitative studies in which therapists’ viewpoints have been intensively studied strongly support the idea that countertransference reactions are very common, even in successful cases and when therapy is done by recognized experts of varying persuasions. For example, Hayes et al. (1998) found that eight expert therapists identified
countertransference in fully 80% of their total of 127 sessions of brief therapy (one patient per therapist), even when the above-described integrative definition of countertransference was used. (Because that definition requires that the reaction be based on an unresolved conflict or vulnerability in the therapist, it is more conservative that the totalistic definition.) It should be noted, however, that in a number of studies, actual countertransference behavior within sessions is typically infrequent. That is, while there is generally some countertransference in most sessions in the form of the therapist’s conflict-based feelings, there usually is not a lot countertransference that is acted out behaviorally (see review by Gelso & Hayes, 2007).

As for the effects of countertransference, a meta-analysis of 10 quantitative studies (Hayes, Gelso, & Hummel, 2011) indicates a modest negative relationship to treatment outcome, although the relationship is stronger when outcome measures are more distal (e.g., ratings or measures of outcome) than proximal (e.g., experiencing level in sessions). Thus, it appears that although countertransference is typically low, when it does exist it tends to adversely affect the treatment. In an important recent study, Markin et al. (2013) found that in psychodynamic therapy, positively valenced countertransference behavior, in particular, predicted smooth but superficial sessions.

Can the negative impact of countertransference be minimized by good countertransference management? The answer appears to be affirmative. The Hayes et al. (2011) meta-analysis of 11 quantitative studies indicates a modest but inverse relationship between countertransference management and countertransference. This relationship was stronger when supervisors rated countertransference rather than when therapists rated their own countertransference. The association was also stronger when countertransference was assessed by a measure specifically devised to assess this construct.

Finally, countertransference management was found to be positively related to treatment outcome, with a large effect size (Hayes et al., 2011). Thus, it appears that countertransference tends to hinder treatment, but can be diminished by good countertransference management abilities, and that these management skills also lead to positive outcomes. These connections of countertransference, countertransference management, and treatment outcome are consistent with what we have theorized (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998, 2007).

The unfolding of countertransference. Although we have theorized about how the real relationship, the working alliance, and transference unfold over the course of treatment, no such predictions have been made for countertransference. Given how countertransference has been conceptualized, we would not expect any particular unfolding process. The therapist’s job is to monitor his/her internal reactions, understand them in relation to his/her unresolved conflicts and the patient’s material and person, and prevent them from intruding negatively into the therapeutic relationship. The one study from our program pertaining to countertransference over the course of treatment suggests that in a sample of six cases of brief theoretically heterogeneous therapies, therapists in the less successful cases significantly increased in their self-reported countertransference behavior during the second quarter of treatment (Fuertes et al., in press). The causal direction of countertransference behavior and outcome is unclear, and from a clinical perspective it seems likely that this is an instance of circular causality—increases in negative countertransference may adversely affect outcome, and a therapy that is not going well is likely, for a range of reasons, to stimulate negative countertransference behavior in therapists.

The Interrelationships Among the Components

As I earlier noted, the components of the therapeutic relationship are theorized to overlap with and influence each other, sometimes in straightforward ways, and other times in more complicated ways. Some empirical work has been done on these interrelations, and this will be briefly summarized along with theoretical expectations.

The Real Relationship and the Working Alliance

Greenson (1967) theorized that the working alliance emerges from the real relationship. Whether or not this is true, theoretically the two constructs ought to be moderately to strongly related to one another, and Gelso and Carter (1994) suggested that each component influences the other throughout treatment. At the same time, these “sister constructs” are also theoretically separable in that one (the real relationship) pertains to the person-to-person relationship that invariably exists any time two persons get together, whereas the other (the working alliance) represents the working collaboration between therapist and patient. The ways in which these constructs may be separated were brought home to me personally in two different experiences as a patient in psychotherapy. In the first experience, I had a very sound working connection with my therapist, but felt little sense of personal connection, as if we were not
from the same “tribe.” In the second experience, I felt both a working bond and a personal relationship. The first therapy experience was helpful, but the second was more helpful and more far-reaching.

Thus, theoretically we would expect considerable overlap but also separateness (Gelso & Carter, 1994; Gelso & Hayes, 1998). Research to date generally supports this proposition, especially when it is therapists who are doing the rating. Thus, the therapists’ ratings of the working alliance and the real relationship typically are found to be moderately correlated, but each add uniquely to the prediction of session and treatment outcome (Bhatia & Gelso, 2013; Fuertes et al., 2007; Gelso et al., 2005; LoCoco et al., 2011; Marmarosh et al., 2009).

When it is clients who are doing the rating, working alliance and real relationship are highly related (Fuertes et al., 2007; Kelley et al., 2010; LoCoco et al., 2011; Marmarosh et al., 2009; Owen et al., 2011). The magnitude of this relationship (usually r of .70–.80) may seem to suggest that in clients’ minds these constructs are one and the same. However, when Kelley et al. (2010) inspected the correlation of real relationship to separate aspects of working alliance, they found that the relationship was substantially stronger for the Bond subscale than the Agreement on Goals and Tasks subscales. Inspection of the Bond subscale of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) used in our studies revealed that three of the Bond items tap personal feelings between therapist and patient, and only one item taps the work collaboration. Thus, the Bond subscale of the WAI appears to be a mixture of items assessing the personal relationship and the work collaboration, which naturally would inflate the correlation of working alliance and real relationship. It seems significant that despite this high degree of overlap in clients’ rating of the working alliance and the real relationship, some research has suggested that client ratings of real relationship predict treatment progress and outcome above and beyond the variance accounted for by working alliance (Fuertes et al., 2007; Marmarosh et al., 2009; LoCoco et al., 2011).

In sum, research supports the theorized close relationship of working alliance and real relationship, while at the same time also pointing to their separateness. Finally, in the only study on the topic, Gullo, LoCoco, and Gelso (2012) found that correlations of both therapist- and client-rated working alliance and real relationship appear stronger as brief therapy progresses. Thus, it may be theorized that as therapy progresses and the relationship deepens, the work collaboration and personal connection move toward blending together.

The Real Relationship and the Transference Configuration

Initially Gelso and Carter (1985, 1994) viewed the transference configuration and the real relationship as being mutually exclusive. They could not exist simultaneously, and as transference was worked through, the real relationship took its place. This viewpoint has not been supported empirically, and the theory has been modified. More recently, I have suggested that the transference configuration and the real relationship exist side by side, and at any given time both may be present, even in the same expression (Gelso, 2009, 2011). This view is reminiscent of Greenson’s (1967) comment that there are real relationship elements in all transferences, and transference in all real relationships. A clinical example from a long-term therapy may help clarify how transference and the real relationship may co-exist simultaneously:

In my first session following a rather serious surgery, my patient, John, expressed concern by asking “How are you doing buddy?” I replied honestly, “I am doing well, thanks.” As I began to pursue how some of his expression of concern was transferrentially related to the material with which we had been dealing, John replied, “Well, that may be so, but I also was just concerned about you as a person.” (Gelso, 2009)

On the basis of our work over several years and especially in recent months, I knew John’s expression reflected his need to please others for fear that if he did not, he would be cast aside or even damaged. At the same time, we had worked together a long time, and genuinely cared about each other. His expression of concern was genuine and realistic, and transferential at the same time.

If this theorized relation of transference and the real relationship were valid, we would expect a small to moderate negative relationship between the two. That in fact is what has been empirically documented, but only for negative transference and when it is the therapist who is rating both transference and real relationship (Gelso et al., 2005; Marmarosh et al., 2009; Bhatia & Gelso, 2013). For positive transference, the correlations tend to be in the same direction, but usually are nonsignificant and have very small effect sizes. This may be because therapists have a hard time differentiating positive transference from a strong real relationship, and the tendency to see the two as similar may cancel out the expected negative relationship of transference and the real relationship. Also, when therapists rate transference, but clients rate the real relationship, the relation between the two constructs tends to dissipate.
In sum, the theoretical proposition that transference and the real relationship exist on separate dimensions and can thus co-exist at the same time and in the same expression is supported. Still, as expected when negative transference is high, there is a tendency for the real relationship to be weakened, at least when therapists are the evaluators of both constructs.

Regarding countertransference and real relationship, we would also propose that a reciprocal and negative relation would exist between the two, such that therapists’ acted out countertransference would weaken the real relationship, and a weakened real relationship would stimulate countertransference. Thus, there ought to be a negative correlation between the two. This negative relation ought not to be very strong because most therapists are probably effective at managing their countertransference, even after it has been manifested in the session (Gelso & Hayes, 2007). In the two studies from our research program, this theoretical assertion has been partially supported. Palma and Gelso (2013), for example, found that both therapist-trainees’ and their clinical supervisors’ ratings of the strength of the relationship between the therapists’ negative countertransference behaviors and in addition, therapist-trainees’ ratings of the relationship correlated negatively with the amount of countertransference behavior rated by supervisors. Thus, when therapy supervisors saw more negative countertransference behavior in sessions conducted by their trainees, both the supervisors and the trainees perceived the real relationship as weakened; and when supervisors perceived more positive countertransference, trainees rated the real relationship as weaker.

Similarly, Bhatia and Gelso (2013) studied the reports of experienced therapists and found that these therapists’ ratings of the amount of negative countertransference in a given session were inversely related to the strength of the real relationship they had with a particular patient. These relationships did not hold up for positive countertransference, and, similar to the case with positive transference, it may be that therapists have a hard time differentiating positive countertransference from positive feelings with the real relationship. For example, countertransference behaviors like “befriending the patient” may be seen by some as the same as being helpfully supportive. At this point, though, it appears likely that negative countertransference (e.g., being rejecting or hostile toward the patient) affects the real relationship and vice versa. Because there is evidence that positive countertransference as rated by external judges who were well trained to recognize positive countertransference tends to have a damaging effect on sessions (Markin et al., 2013), it may be that there is an association of positive countertransference to the real relationship, but it is not detectable when therapists rate their own countertransference.

The Transference Configuration and the Working Alliance

Gelso and Carter (1994) theorized that transference influences the working alliance, with positive transference at times serving to strengthen it and negative transference serving to weaken it. They also suggested that, in turn, the working alliance influences transference, mostly through creating conditions that allow patients to understand and work through transference. It follows from these propositions that negative transference ought to be negatively related to the working alliance. On the other hand, it follows that positive transference would be unrelated to the working alliance because although at times it might benefit the alliance, at other times it does not. For example, Greenson (1967) noted that transference of any sort is a treacherous ally, one that cannot be counted upon. Thus, when the alliance is buffered by positive transference, as that transference gets resolved or otherwise weakens, the alliance will suffer. The sum of these points is that, on the whole, we would not expect a relationship of positive transference to working alliance.

Studies by Gelso et al. (2005), Marmarosh et al. (2009), and Bhatia and Gelso (2013) all support these propositions. In each of these studies, therapists’ perceptions of the amount of negative transference were negatively related to these therapists’ ratings of the strength of the working alliance (r’s ranging from −.25 to −.44). The correlations of therapist-rated positive transference and working alliance, however, were lower and generally non-significant (r’s from −.14 to .16). Interestingly, in the one study that examined the relationship of therapist-rated negative or positive transference with client-rated working alliance, significant relationships were not found. Thus, although the findings generally support the theory when it is therapists who do the ratings of transference and working alliance, they do not support the theory when the rating sources are crossed.

What about countertransference? In the first study that examined this question (Ligiero & Gelso, 2002), it was found that clinical supervisors’ ratings of their supervisees’ negative countertransference with given patients were significantly related to both supervisors’ and these therapist-trainees’ ratings of the working alliance the trainees formed with their patients. In this study, it was also found that
supervisor-rated positive countertransference was predictive of a weakened bond aspect of the working alliance. Bhatia and Gelso (2013) subsequently found that experienced therapists’ ratings of their own negative and positive countertransference were significantly and negatively related to their perceptions of the strength of their working alliance with a given patient. Thus, the evidence supports the hypothesized negative relationship between countertransference behavior and working alliance. Although this correlational research does not permit causal analysis, it seems likely that the relation of working alliance and countertransference is mutually causal, with each affecting the other to an important extent. Evidence such as this, as well as that cited earlier on the connection of the real relationship to countertransference, would appear to underscore the importance of therapists’ countertransference management ability in fostering effective treatment.

### Transference and Countertransference

Because transference and countertransference represent a similar, if not the same, underlying process (Gelso & Carter, 1994), they are viewed as a single component in the tripartite model. However, they are also different, and their difference is mainly due to the vastly different roles of the therapist and patient. The therapist’s job is primarily to focus on understanding and helping the patient, and secondarily on understanding his/her own reactions to the patient so that these are not acted out in the hour, but instead used to better understand the patient. Because of the similarities and differences between transference and countertransference, we might expect them to be interrelated, but modestly so.

Research to date does suggest that therapist countertransference reactions are related to certain patient characteristics that are at least similar to transference (e.g., Brody & Farber, 1996; Holmqvist, 1998; Martin, Buchheim, Berger, & Strauss, 2007; McIntyre & Schwartz, 1998; Rossberg, Katerud, Pedersen, & Friis, 2007). However, studies directly testing the relation between transference and countertransference are rare. In a sample of theoretically heterogeneous therapists, Bhatia and Gelso (2013) found that therapist-rated negative transference and the total amount of transference were significantly positively related to therapist-rated negative countertransference behavior, but the effect size was very small. In perhaps the most sophisticated study to date, Markin et al. (2013) conducted an HLM analysis of 44 patients in treatment with four experienced psychodynamic therapists and found that overt transference and countertransference behaviors, as rated by trained judges, were unrelated. However, they also found the negative transference behavior was related to negative affect in the therapist. Markin et al. suggest that this negative affect may well be an indication of internal countertransference, but that experienced therapists are trained to manage their internal reactions and not act them out with their patients.

Thus, the scant indirect and direct evidence suggests a modest relation of transference and countertransference, although the very limited amount of research does not allow for firm conclusions. The limited research notwithstanding, it does seem clear at this point that transference and countertransference are not strongly interrelated, despite the theoretical assertion that they reflect the same or a similar underlying process.

### Discussion

Although the basic structure of the tripartite model of the therapeutic relationship has been maintained over the years, specific modifications have occurred based on emerging theoretical understandings, clinical insights, and research findings. As indicated in this review, empirical efforts have supported many of the propositions originally offered by Gelso and Carter (1985, 1994), but some propositions have been disconfirmed. It does appear that the real relationship, the working alliance, and transference-countertransference relate to each other and to treatment process and outcome in theorized ways, although especially with regard to transference the effect may be moderated by additional variables. Thus, as so often is the case when theories are actually tested through controlled research, the empirically derived realities seem much more complicated than the theory would predict.

Where do we go from here regarding research and theory on the tripartite model? A fundamental question that has not yet been addressed in this paper is whether the tripartite model actually exists as such. Does a three-factor model actually fit the data? The aforementioned study by Bhatia and Gelso (2013) is the first to address this question. Practicing therapists (n = 249) completed commonly used measures of the real relationship, working alliance, transference, and countertransference with respect to the last session they had with a patient who had at least five sessions, and an exploratory factor analysis revealed the existence of four clean factors: Real relationship, working alliance, transference, and countertransference. Thus, although transference and countertransference may be combined into one factor for theoretical and stylistic reasons, the Bhatia and Gelso study raises the question of whether a quadripartite model may
represent a better fit, at least when it is therapists who rate all the constructs. Further factor analytic work would also be useful when measures are completed from patients' or external raters' perspectives, or from multiple perspectives.

As indicated throughout this paper, the large majority of studies on the four constructs of the model have utilized ratings made by therapists and/ or patients. Little use has been made of external raters, so this would be an important tactic in future studies. This is why the Markin et al. (2013) study is an important advance. The need for external raters is especially notable for studies on the real relationship and transference. It should be noted parenthetically that within psychoanalytically based treatments, there has been much research using trained raters, e.g., the important research program at the University of Pennsylvania (e.g., Crits-Christoph & Luborsky, 1998) on the core conflictual relationship theme as a measure of transference.

As noted earlier, research on the correlates of the four constructs I have described certainly exists and continues to be needed, especially in the areas of the real relationship, transference, and countertransference. What is the nomological network of associations with these constructs? Answers to this question will help us understand more fully the constructs, their interrelations, and connection to treatment process and outcome. An example of such research is the studies on how therapist and patient attachment relate to the real relationship (Fuertes et al., 2007; Marmarosh et al., 2009; Moore & Gelso, 2011; Palma & Gelso, 2013), countertransference (Ligiero & Gelso, 2002; Palma & Gelso, 2013), and the working alliance (Ligiero & Gelso, 2002; Marmarosh et al., 2009). These studies address the connection of a key relational variable (attachment) to the relationship variables within the tripartite model.

As research on the correlates of the four constructs of the model continues, it will be important to study moderators and mediators of the effects of real relationship, working alliance, transference, and countertransference on treatment process and outcome. Studies of moderation and mediation are indicators that the science in an area is becoming more advanced (Gelso & Palma, 2011), because such studies examine complex who, what, when, and where questions, e.g., for what client personalities or disorders is the real relationship most important in order to have successful outcomes? What therapist factors moderate the effect of countertransference behavior on session process and outcome? Under what conditions is negative transference helpful versus harmful to treatment? What variables mediate the differential role of working alliance and real relationship on outcome? This is of course just a tiny sample of the kinds of numerous moderation and mediation questions that may be addressed as we move forward in studies on elements of the tripartite model. Of course, for all of these questions, we need to be examining therapies of differing theoretical orientations, since the theory of the tripartite model claims that the key constructs are important across theories.

Although I have claimed that the tripartite model of the therapeutic relationship has broad relevance, there certainly are other models, even another tripartite model (Wampold & Budge, 2012). There are also interesting ideas about such models that could be more fully developed (see Horvath, 2009). Perhaps the key point is that we need to accelerate our development of sophisticated models of the therapeutic relationship that go beyond the global concept of “the relationship” and the equation of the total relationship with Rogerian therapist-offered conditions, the working alliance, or other singular constructs that do not address the interlocking constituents of this vital, complex aspect of psychotherapy. As indicated, we know that the package of the therapeutic relationship is a key part of psychological treatments, and we now need to fully scrutinize the contents.

Acknowledgments
I wish to express my gratitude to Jean A. Carter, Beatriz Palma, and Andres Rojas Perez for their helpful comments on an earlier draft of this article.

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