Alliance as Structure: The Evidence for Making Collaboration Explicit

Foundational Reading for Clinicians

By Sarah Ozol Shore, MS, www.sarahozolshore.com, sarah@sarahshore.com September 2026

Abstract

Therapeutic alliance is among the most replicated predictors of outcome in psychotherapy research, yet the construct is defined in most clinical training almost entirely in relational terms: warmth, trust, and connection. This paper revisits Bordin's tripartite model of alliance, which names bond alongside two structural components, goal consensus and task collaboration, that receive comparatively little attention in practice. Drawing on meta-analytic evidence on goal consensus and collaboration, on the demonstrated effectiveness of collecting client feedback, and on research showing that training clinicians in the explicit skills of alliance rupture and repair produces an outcome effect substantially larger than the alliance-outcome correlation itself, this paper argues that the portion of alliance responsible for improved outcome is not a relational disposition but a structure that can be made explicit, taught, and practiced. Implications for how alliance is conceptualized and trained are discussed.

1. Introduction: What Alliance Research Already Shows

Therapeutic alliance is among the most consistently replicated predictors of outcome in psychotherapy research, holding across theoretical orientation, treatment modality, and assessor perspective. In Flückiger, Del Re, Wampold, and Horvath's 2018 meta-analytic synthesis of 295 independent studies encompassing more than 30,000 patients, the alliance-outcome association across face-to-face treatment was r = .278, a relationship that has held stable across four decades of accumulated research. Yet the construct producing this finding is, in most clinical training and most clinical writing, defined almost entirely in relational terms: warmth, trust, connection, and the sense that a client feels seen and supported. Edward Bordin's 1979 tripartite formulation, still the most widely used definition in the field, names bond alongside two components that receive far less attention in practice: agreement on the goals of treatment and collaboration on the tasks used to reach them.

2. Why Bond Is Not the Whole Construct

The distinction between bond and the two explicit, structural components of Bordin's model is not merely conceptual. It has been tested directly. Tryon and Winograd's synthesis of the goal consensus and collaboration literature, conducted for the American Psychological Association's Interdivisional Task Force on Evidence-Based Therapy Relationships, found that treatment outcomes improve both when a therapist and client explicitly agree on what

they are working toward and when they actively cooperate on the steps used to get there. The Task Force's 2018 summary, led by Norcross and Lambert, rated goal consensus and collaboration as probably effective elements of the therapeutic relationship, a category distinct from bond-oriented qualities such as positive regard, and rated the practice of systematically collecting client feedback as demonstrably effective in its own right. These findings locate measurable clinical value in the explicit, structural half of the alliance construct, independent of whatever warmth or trust a therapist and client happen to develop.

3. What Clinical Training Leaves Out

This distinction rarely survives contact with clinical training. Most training in alliance development addresses the bond dimension almost exclusively: how to convey empathy, how to establish rapport, how to remain present with a client's affect. The task and goal dimensions, when addressed at all, are often treated as implicit byproducts of good rapport rather than as skills requiring their own deliberate construction. A clinician may be highly skilled at conveying warmth and trust while never having explicitly named, with a given client, what each of them is responsible for bringing to treatment, how disagreement will be handled, or how the two of them will know together whether the current direction remains useful. The client experiences connection. Neither party necessarily holds a shared, explicit understanding of the clinical structure they are operating within.

4. What Changes When You're Trained to Do This Explicitly

The clearest evidence that this distinction matters clinically, not only conceptually, comes from research on alliance rupture and its repair. Ruptures, defined as episodes of tension or breakdown in the collaborative relationship between therapist and client, are understood in this literature as a normal and frequent feature of psychotherapy rather than a sign of clinical failure. Eubanks, Muran, and Safran's 2018 meta-analytic synthesis examined two separate questions. The first asked whether resolving a rupture, once it occurs, predicts better treatment outcome. It does, modestly, with a correlation of $r = .24$ across three studies. The second asked a different question: does training clinicians in the explicit skills of recognizing and repairing alliance ruptures improve treatment outcome. Across eight studies, the pre-post effect size was $r = .65$, more than double the baseline alliance-outcome correlation reported across the broader literature. The clinicians in these studies were not simply becoming warmer or more attuned. They were being trained in a specific, teachable structure: recognizing markers of withdrawal or confrontation, distinguishing disagreement from resistance, and using a defined process to renegotiate the working relationship when it strains.

5. What This Means for Your Practice

Considered together, these findings suggest that the portion of alliance most responsible for improved outcome is not a disposition a therapist either has or lacks. It is a structure that

can be made explicit, taught, and practiced, in the same way any other clinical skill is taught and practiced. The relational qualities that dominate most discussions of alliance, warmth, trust, and felt safety, remain necessary. They appear to be insufficient on their own. What the research on goal consensus, collaboration, feedback, and rupture repair converges on is a more specific and more actionable claim: the moment a therapist and client make their respective responsibilities, their disagreement, and their shared sense of direction explicit, rather than trusting those things to emerge from good rapport, is the moment the alliance begins to function as a clinical structure in its own right rather than a byproduct of the relationship.

Whether alliance matters has been settled for four decades. What remains largely unaddressed in clinical training is what it would take to build an alliance that functions as an explicit, calibrated structure with each client, rather than trusting that structure to emerge on its own.

References (APA 7)

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Sarah Ozol Shore, MS
Clinical Trainer