Therapeutic Alliance: A Concept for the Childbearing Season

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ABSTRACT

This analysis was conducted to describe the concept of therapeutic alliance and its appropriateness for health-care provider-client interactions during the childbearing season. The concept has been defined in other disciplines. A universal definition suggested a merging of efforts directed toward health. A simple and concise definition evolved, which is applicable to the childbearing season as well as to health-care encounters across the life span. This definition states: Therapeutic alliance is a process within a health-care provider-client interaction that is initiated by an identified need for positive client health-care behaviors, whereby both parties work together toward this goal with consideration of the client's current health status and developmental stage within the life span.

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As a concept, therapeutic alliance captures the essence of many interactions between clients and health-care providers. Schwartz-Barcott and Kim (1993) list therapeutic alliance in the client-nurse domain under the category "concepts reflecting the character of an interaction" (p. 128). A dictionary definition of the word "therapeutic" refers to notions of healing; the word "alliance" implies an agreement, union, or merging of efforts (Sokolowski, 2001). When the two words are used together, therapeutic specifies the nature of the alliance and sets boundaries that limit its application.

Therapeutic alliance has not been widely promoted in the childbirth education literature or in midwifery scholarship. Instead, the literature is replete with references to provider-client collaboration and educator-client relationships. Although there is mention of therapeutic alliance and therapeutic relationships in the nursing literature, a need still exists for further development and elaboration of the concept as it relates to maternal-newborn nursing. The use of case studies and exemplars would highlight therapeutic alliance in the childbearing season and expand the application of the concept to examine a wider range of clinical practice situations.

Therapeutic alliance emerged as a concept from the psychiatric and psychoanalytic literature. Madden's (1990) work brought some clarity to the concept in the nursing literature, with a particular focus on community health nursing. Yet, a void in the maternal-newborn nursing literature prompted me to conduct a concept analysis to clarify the meaning of therapeutic alliance and examine its relevance in the context of the childbearing season. I utilized the hybrid model of concept development (Schwartz-Barcott & Kim, 1993) in my endeavor.

THE HYBRID MODEL

The hybrid model of concept development (Schwartz-Barcott & Kim, 1986, 1993) was created in response to a void in the literature regarding the selection, development, and application of concepts and theoretical frameworks in clinical nursing situations. The model focuses on analysis and refinement of individual concepts and ensures the following:

> *1) concepts selected for analysis are integral to nursing practice; 2) literature reviewed is broad enough to capture commonalities and extremes in conceptualization and usage across disciplines; 3) the focus of analysis is a definition and measurement of the concept; and 4) analysis from the literature review is integrated with empirical data collected in clinical practice.* (Schwartz-Barcott & Kim, 1993, p. 108)

The hybrid model has three phases: a theoretical phase, a fieldwork phase, and a final analytical phase. The theoretical phase is concerned with concept selection, literature review, consideration of meaning and measurement, and choosing a working definition of the concept (Schwartz-Barcott & Kim, 1993). The fieldwork phase involves setting the stage, negotiating entry, selecting cases, and collecting and analyzing data. The final analytical phase combines the initial theoretical analysis with knowledge gleaned from observations during fieldwork.

THEORETICAL PHASE: LITERATURE REVIEW

A literature review identified ways in which previous authors have used the concept of therapeutic alliance within psychiatry, nursing, and midwifery. Originally, the concept emerged from the psychiatric literature and was described by Freud (1912, 1913) in his attempts to clarify the treatment relationships. The term ''therapeutic alliance'' was first used by Zetzel (1956) in the psychoanalytic literature. It was defined as a working relationship between patient and analyst.

Replete in the literature are terms that are closely related to therapeutic alliance, such as ''helping alliances'' (Luborsky, 1976) and ''working alliances'' (Greenson, 1968). Intrinsic phenomena associated with the establishment of therapeutic alliance were identified (Dickes, 1975; Frank, 1971; Langs, 1975). There was consensus that the work of therapy cannot be constructive without a therapeutic alliance and that both therapist and client can facilitate or undermine the alliance. Research from three major psychotherapy centers—the Penn Psychotherapy Project (Luborsky et al., 1980; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982), the Vanderbilt Project (Moras & Strupp, 1982), and the Toronto Center for the Study of Neuroses (Marziali, 1984; Marziali, Marmar, & Krupnick, 1981)—described therapeutic alliance as a process concept that includes both patient and therapist variables.

The Penn Psychotherapy Project specified two forms of alliance: Type 1 is based on the client's perception of the therapist as being warm, helpful, and supportive; Type 2 is based on a sense of working together in a joint struggle against whatever is impeding the client (Frieswyk et al., 1986). Similarly, the Menninger Treatment Interventions Project viewed therapeutic alliance as a patient's collaboration in the tasks involved in the treatment process (Frieswyk et al., 1986).

The Vanderbilt Project identified major impediments to the development of a therapeutic alliance and specified treatment strategies. Gomes-Schwartz (1978) suggested that there are varying definitions of effective ingredients in psychotherapy. For example, client-centered therapy emphasizes the curative powers of a positive human relationship, while psychodynamic theory suggests that a good relationship is not sufficient to induce an enduring personality change. According to Strupp and Binder (1984), the three key elements that determine change are the quality of the client-therapist relationship, reconstructive learning experiences mediated by the therapist, and client willingness to engage in therapeutic interactions. Foreman and Marmar (1985) proposed the following definition of therapeutic alliance, which can be translated from the context of patient and therapist to health-care provider or childbirth educator: ''Therapeutic alliance is the observable ability of the therapist and patient to work together in a realistic collaborative relationship based on mutual respect, liking, trust, and commitment to the work of treatment'' (p. 922).

Recent studies link adult attachment patterns to differences in client and therapist behaviors, to differences in the quality of a therapeutic alliance, and to differences in outcomes (Daniel, 2006). The foundation of this research can be traced to Bowlby's (1969, 1988) attachment theory. Bowlby considered therapeutic alliance to be the establishment of a secure base that is dependent on the interaction between the help-seeker and help-giver. Maccoby and Masters (1970) suggested that fear,

anxiety, illness, and fatigue increase attachment behavior. They indicated that a bond is more likely to form between a victim and an individual who provides comfort at a time of distress. Howard, Turner, Olkin, and Mohr (2006) hypothesized that a therapeutic alliance is vital in the earliest phase of treatment and that a strong alliance is more predictive of a successful outcome.

The nursing literature is replete with studies focusing on therapeutic relationships, partnerships, joint decision making, negotiation, and nurse-client collaboration. Roberts (1982) suggested that increased collaboration facilitates more effective health-care practices and outcomes. Recommendations included nurse flexibility and "a meeting of the minds"—with shared knowledge, feelings, and beliefs. Moughton (1982) focused on the role of the patient as a partner in the health-care process, with therapeutic alliance as an essential element in planning care. Edel (1985) suggested that a therapeutic alliance capitalizes on a patient's autonomy and individuality. In this way, the patient is an active participant who works with the nurse to search and explore possible reasons for noncompliance. Deering (1987) added the elements of caring and nurturance to the mixture of ingredients comprising a therapeutic alliance. Lastly, Madden (1990) used the hybrid model (Schwartz-Barcott & Kim, 1986, 1993) as a research methodology for a concept analysis of therapeutic alliance in a community health setting. Madden's (1990) definition of therapeutic alliance states the following:

> *Therapeutic alliance is a process that emerges within a provider-client interaction in which both client and provider are: 1) actively working toward the goal of developing client health behaviors chosen for consistency with the client's current health status and lifestyle; 2) focusing on mutual negotiation to determine activities to be carried out toward that goal; and 3) using a supportive and equitable relationship to facilitate that goal.* (p. 85)

Madden's (1990) definition specified therapeutic alliance to be a process, yet the stages of the process were never elaborated. A process has a beginning, middle, and end. Therefore, a description of what initiates the process, what keeps it going, and what causes it to end is warranted.

The nursing, midwifery, and childbirth education literature all addressed the need for positive, trusting, respectful, supportive, and educational therapeutic relationships between health-care providers and clients. Along these lines, McCrea and Crute (1991) explored midwives' understanding of the factors affecting the development of therapeutic relationships with clients. Four main issues were identified: the nature and value of the midwives' role, recognition of authority and autonomy in the practicing role, emotional involvement with clients, and maintaining personal integrity. When the midwives were successful in managing the aforementioned issues, the relationship was therapeutic and special for clients. Conversely, mismanagement of these issues led to dilemmas that inhibited the development of positive, meaningful relationships.

Bluff and Holloway (1994) examined women's experiences of labor and birth with midwives. They found that the women in their study trusted their midwives and viewed them as experts in the birth process. The women desired a flexible relationship with the midwives and wanted to take an active part in labor and birth. A phenomenological study by Berg, Lundgren, Hermansson, and Wahlberg (1996) described the essential structure of women's experiences with midwives during labor as "presence," which included three themes: to be seen as an individual, to have a trusting relationship, and to be supported and guided on one's own terms. Similarly, midwives in a study by Kennedy, Shannon, Chuahorm, and Kravatz (2004) emphasized the importance of developing a relationship based on mutuality and the importance of creating an environment of care in which the choices of birthing women are honored. Hunter (2006) conducted an ethnographic study to explore the relationship of community-based midwives and clients. Data were collected using observation, interview, and focus groups. A model of midwife-woman relationships was proposed based on the concept of "reciprocity," with the goal being balanced exchanges with give and take on both sides.

Berg and Dahlberg (1998) examined women's experiences with a complicated birth. Women reported that they were able to deal more effectively with the complications when care providers recognized their individuality and treated them with acceptance and respect. An honest dialogue based on

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a supportive, trusting relationship helped the women manage an emergency situation.

Gibbins and Thomson (2001) described women's expectations during pregnancy and birth with their first child. The essence of the women's experiences centered on their feelings of being in control during labor and birth. Although many studies focus on a sense of control as a major contributing factor to a woman's satisfaction with her birth experience and subsequent well-being, not all studies conceptualize control in the same manner or distinguish between internal and external control. In light of this, Green and Baston (2003) conducted a study to determine how these senses of control relate to each other. They considered three control outcomes for laboring women: 1) feeling in control of what caregiving staff do to one; 2) feeling in control of one's own behavior; and 3) feeling in control during contractions. Participants were less likely to report being in control of caregiving staff (39.5%) than in control of their own behavior (61.0%). Approximately 20% of the sample felt in control in all three ways, while another 20% did not feel in control in any of them. Multiparous participants felt more in control than primiparous participants. Feeling in control of one's behavior and feeling in control during labor contractions were related to the amount of pain experienced and pain relief. All three of the control outcomes contributed independently to the women's satisfaction with their birth experience, with control of staff being the most significant.

Matthews and Callister (2006) conducted a study to gain an understanding of the perceptions of women about the maintenance of dignity during labor and birth. Three themes were identified: 1) nurses play a pivotal role in preserving women's dignity during childbirth; 2) women appreciate feeling valued and respected; and 3) dignity is enhanced by nursing care that gives laboring women their preferred level of control.

Hallgren, Kihlgren, and Olsson (2005) conducted a qualitative study in Sweden to describe the different ways midwives and laboring women relate to each other during labor. The study uncovered some aspects of support during childbirth not previously described. Three aspects of professional competence were disclosed: 1) a balance between respect for a couple's integrity, competence, and need for guidance; 2) a balance between the rhythm of the birth process and its supervision; and 3) making space for the miracle of a new human being's arrival into the world.

Birth stories often capture the pivotal life experience of giving birth and document the importance of listening to the voices of women. The storyteller as well as the listener benefit from richly descriptive narratives, which provide opportunities for connection to other women, integration of the experience into the framework of one's life, sharing of feelings, discussion of concerns, and identification of strengths gained from the childbearing season. Callister (2006) considered opportunities for women to share their birth stories with others as an important nursing intervention.

Using online birth stories, Bylund (2005) conducted a quantitative analysis of mothers' involvement in decision making during labor and birth. Fifty-seven percent of these birth stories discussed a decision that was made, and the most frequent decision focused on pain medication. The researcher concluded that having a midwife in attendance predicted a woman's involvement in decision making. The women's involvement in decision making correlated positively with the use of positive emotion words and negatively with the use of negative emotion words in the online birth stories.

McGrath (2007) explored the role of pain in childbirth and put forth numerous recommendations for assisting women to meet the challenges of labor and birth. She emphasized the psychological impact of birth, whether positive or negative, and the fact that memories of birth experiences can be etched in a woman's mind for the rest of her life. Current research stresses the importance of the emotional aspects of birth, such as women feeling respected, listened to, supported, and having a sense of control during the birth process (Hodnett, 2002). Self-esteem and mothering abilities are enhanced when women experience a sense of pride, accomplishment, and satisfaction after childbirth. Thus, a positive birth experience facilitates confidence, responsiveness to babies, less postpartum depression, and promotion of breastfeeding (Hodnett, Gates, Hofmeyr, & Sakala, 2003).

Goldberg (2003) explored the notion of autonomy situated within the context of birth stories. In this way, autonomy is conceptualized as contextual and concrete, providing an embodied view of the woman as she experiences labor and birth. Simmonds (2008) employed a feminist ethics perspective to examine how moral responsibilities are enacted in the perinatal nurse-patient relationship and to explore the interaction between various threads that influence, and are in turn affected

by, this relationship. This perspective allows for consideration of the contextual and relational factors that impact the way nursing care is given and received. It also provides a framework for exploring ways in which patient autonomy, advocacy, and choice are experienced by childbearing women and their nurses during the birth process.

FIELDWORK PHASE

Seven women who had received midwifery care in three private midwifery practices were recruited for participation in the present study. The unit of analysis was at the individual level. Indicators of therapeutic alliance from the literature included collaboration, a working relationship, and shared responsibility.

The study proposal was approved by the institutional review board at the educational facility where I was employed. Prior to being interviewed, participants were given written and verbal explanations regarding the purpose and nature of the study. Participation was voluntary, and women could withdraw at any time. Procedures concerning data collection, analysis, use, and storage were explained.

Participants were asked to describe their experiences with midwives for antepartal, intrapartal, and postpartal care. In addition, they were asked to comment on their childbirth preparation classes taught by midwives. Each client was interviewed in her home, and the interviews lasted between 45 and 90 minutes. Data collection included the audio recording of the interviews, which were later transcribed verbatim. Observations during interviews were recorded in field notes, using the notation system of Schatzman and Strauss (1973).

The trustworthiness of the study was ensured by establishing credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Member checking was completed with the seven participants. Each participant reviewed a summary of the data analysis procedures and the study's findings. All of the participants commented that the findings of the data analysis were strongly credible and that the findings were interpreted in a manner congruent with the women's experiences. Transferability was addressed by the study's paper trail of documents used to examine the phenomenon of interest. Access to these documents gives others the chance to transfer the conclusions of the present study to other cases. The issues of dependability and confirmability were addressed by having an independent audit of my research methods by a seasoned qualitative researcher who was familiar with the hybrid model of concept development. The auditor examined my original transcripts, data analysis documents, field journal, and comments from member checking and found the materials to be complete.

Sample

The seven women gave birth at three community hospitals. All births were normal, spontaneous, vaginal births. Of the participants, three women had three children, and four women had two children. The seven participants sought midwifery care for all of their birth experiences. Participant ages at the time of giving birth ranged from 26–36 years old. Participant ages at the time of the interview were 36–46 years old. Two women had associate's degrees, two women had bachelor's degrees, two women had master's degrees, and one woman had a doctorate. All women were middle class. All reported being married to the father of their children at the time of each birth. However, two women stated that they were currently divorced from the father of their children. Each woman had been married only once.

Presentation of Cases

Model cases reflecting therapeutic alliance are illustrated in the following excerpts from the interviews:

> *Case A: I was 3 centimeters dilated and 90% effaced. . .and then hours later I was only 4 centimeters. I felt really discouraged. I remember my midwife saying to me that I was making progress. She really tuned in to how I was feeling. She was encouraging and reminded me that the labor process was not for nothing. She made helpful suggestions like, "Why don't you try this or try that?" She recommended a relaxing shower, using the birthing ball, changing positions, and varying my activities. You have to understand that walking in labor did not work well for me, so I did a lot of rocking and sitting on the toilet. My midwife was so good at picking up on my cues.*

> *Case B: I had been laboring for many hours when I asked my midwife if she could do anything to speed things up because I was so tired. She said that she could break my water to try to move things along. I agreed, and she broke my water. But you know what was so good about it. . .? She didn't make the decision on her own, she consulted me. We*

discussed the situation, and everything she said was with such sensitivity. She was so positive and encouraging. I felt empowered, involved, and capable.

Case C: At 35 weeks, I remember thinking that this baby felt different in my body than my first. I had been wondering if the baby was breech. I shared my concerns with the midwife at my prenatal visit and, after she did Leopold maneuvers, she said, "I'm not sure—let's get an ultrasound." Well, it turned out that the baby was breech. My midwife really listened to me and trusted my assessment based on the fact that this was my second pregnancy. My midwife and I were on the same wavelength—working together. This was so important to me.

Case D: I remember my first childbirth class. I confessed to everyone that I was more afraid of caring for a newborn than dealing with labor and birth. I had never even held a baby in my arms. My husband and I stayed after class to talk to the midwife about our concerns and fears. Besides suggesting books to read and videos to watch, she had me do something that literally allayed my anxiety about handling babies. She placed her 3-month-old daughter in my arms while she guided, supported, and encouraged me. We must have stayed 30 minutes after class, and I must say this made all the difference in the world for me. I left class feeling, "I can do this, knowing that my midwife would be there for me."

A contrary case is illustrated in the following excerpt from an interview with a client recounting the precipitous birth of her second child in the emergency room.

Case E: Everything happened so fast—as soon as I walked through the emergency room doors. I gave birth on a stretcher and, later, I realized that I still had my coat on. They paged the midwife-on-call, and she got there just in time to catch the baby. Afterwards, I asked the midwife to inject more local anesthetic as she put in a few stitches because I could still feel it. But instead of complying with my wishes, she said, "I've already numbed you." I have to say that this was a bit of a negative experience for me. I wasn't being listened to. My request was ignored.

Another contrary case is depicted in the following excerpt:

Case F: I developed superficial thrombophlebitis in my left leg after giving birth to my third child. My midwife explained the importance of warm compresses and aspirin therapy, which was prescribed for me. However, the nurses were not good at microwaving the warm packs and bringing them to me with any regularity. I kept having to ask them, and I felt like I was being a "pain." It was a very frustrating 5 days in the hospital for me.

A related case is illustrated by the following excerpt from an interview describing an encounter with a nurse in the immediate postpartum period:

Case G: The nurse came in to clean up the baby, to get me up to the bathroom, and do all that kind of stuff. She was such a doll! She was so nice and made me feel special. She paid so much attention to me and stayed with us for a long time. She was so warm and accommodating—I felt like she was doing the kind of things a friend would do for you to make you feel better.

Another related case is depicted in the following excerpt:

Case H: I was going home from the hospital, and I had extremely sore nipples. They were cracked and bleeding. When the nurse brought the wheelchair for me, I started to cry. She talked to me about breastfeeding, gave me pamphlets to read, brought me some topical cream, and made a referral to the lactation consultant. She helped me.

FINAL ANALYTICAL PHASE

The final analytical phase asked the following questions: To what extent is therapeutic alliance important to maternal-newborn nursing, midwifery, and childbirth education? Was the selection of therapeutic alliance for a concept analysis justified? To what extent does the theoretical phase and data from the fieldwork phase support the presence of therapeutic alliance in the childbearing season?

DISCUSSION

The theoretical phase introduced the concept of therapeutic alliance and provided a thorough literature review that served as a foundation for the current study. Madden's (1990) definition of therapeutic alliance was useful in the beginning of the present study, even though Madden focused her research on a different client population and a

different area of nursing. However, Madden's definition did not fit the childbearing population and their developmental stage within the life span. A simple and concise, as well as refined and robust, definition of therapeutic alliance was needed. This definition should be not only applicable to the selected population but also general enough to be used across the entire spectrum of health care.

The model cases in the present study provided a picture of therapeutic alliance from the vantage point of the clients. Their recollection of specific events from health-care experiences, coupled with their acute awareness of thoughts and feelings, document the significance that the entire childbearing season had for these women. Both positive and negative memories are etched in their minds, illustrating the historical and psychological importance of this vulnerable time in their lives.

The contrary cases clearly indicated what therapeutic alliance is not. These negative representations presented a picture of unmet needs and neglected voices.

The related cases depicted the concept of caring. Interactions were unidirectional and did not involve the client and health-care provider "working together." However, caring is a corollary concept and, in both cases, postpartum nurses exhibited sensitivity and nurturance. In the second related case, the nurse also engaged in teaching, counseling, and referral.

The notion of client and provider "working together" conveys a particular form of collaboration and suggests a possible emotional bond because of the different ways people work together. For example, there may be at least three ways of working together, such as the following: a merging of efforts or meeting of minds; the offering of alternatives or options by a provider, with a client selecting one of them; or a provider suggesting a healthful action, with a client either accepting or rejecting the suggestion.

This concept analysis leads to the following proposed definition of therapeutic alliance, which can be applied to the childbearing season as well as to a plethora of other health-care situations: Therapeutic alliance is a process within a health-care provider-client interaction that is initiated by an identified need for positive client health-care behaviors, whereby both parties work together toward this goal with consideration of the client's current health status and developmental stage within the life span. The definition specifies that therapeutic alliance is a process that begins with the identification of a need for positive client behaviors. The process continues as the client and health-care provider work together toward the goal of positive client health-care behaviors, with consideration of the client's current health status and developmental stage within the life span.

This proposed definition of therapeutic alliance lends itself to myriad health-care scenarios without limitations of time, setting, and individuals. Indicators undergirding the definition include collaboration, a working relationship, shared responsibility, joint decision making, purposeful communication, mutual respect, trust, and support. These indicators were present in the current study's model cases.

A wide array of sources from the psychotherapy and nursing literature suggest that the personalities of the parties involved in a therapeutic alliance may also influence its development. For example, many of the women interviewed in the current study described their health-care providers as warm, caring, helpful, and sensitive. Yet, the contrary cases presented an opposing picture. This poses the following questions: Are there personality characteristics that foster or hinder the development of a therapeutic alliance? If so, what are they?

CONCLUSION

Therapeutic alliance is a concept that reflects the character of an interaction and is present in many health-care provider-client encounters. The cases generated in the present study suggest that therapeutic alliance can be differentiated from related concepts such as caring, bonding, and attachment. Therapeutic alliance involves a working partnership toward health goals.

The hybrid model of concept development (Schwartz-Barcott & Kim, 1986, 1993) proved to be an effective and worthwhile tool for analyzing and clarifying therapeutic alliance. As an inductive process, it facilitated the use of empirical data from client interviews to refine the concept and also aided in the identification of indicators. The adaptability of the model allowed flexibility in moving back and forth between the theoretical and fieldwork phases, which generated additional knowledge.

A limitation of this concept analysis may have been the fact that data were collected through interviews rather than direct observation during prenatal visits, childbirth classes, labor and birth, and in the

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postpartum period. Yet, the seven women who participated in the study were articulate and detailed in their narrative accounts of experiences during the childbearing season. Some indicated that they found the recall process to be cathartic. Others related that the sharing of their birth stories proved to be a meaningful endeavor.

Another possible limitation of the study may have been the fact that all of the participants were educated at least at the junior college level and were in the middle class. Similarly, the facts that all of the women were married at the time of giving birth and that all of them were healthy, low-risk clients may have been additional limitations.

The findings of the study generate new knowledge about therapeutic alliance in health-care provider-client and health-care educator-client relationships with clients during the childbearing season. Applicability of this concept appears to span across the entire spectrum of health care. This study poses important clinical implications for all types of provider-client and educator-client encounters. Research of this nature benefits everyone—consumers, providers, and educators.

Further research using a variety of health-care settings and diverse client populations may facilitate further analysis and clarification of therapeutic alliance. Nurses, midwives, and childbirth educators need to be interviewed, as well as clients, in order to gain knowledge through a different lens. Participant-observation may be helpful in providing direct observational data from provider-client encounters.

There are still many unanswered questions concerning therapeutic alliance that may be addressed by further research. For example, to what extent does the clinical practice philosophy of the health-care providers or the philosophy of care or mission statement of the clinical institution influence the development of a therapeutic alliance? Is the childbearing season more conducive to the formation of a therapeutic alliance than other periods in the life span?

Therapeutic alliance presents a fruitful topic for additional research. Future investigations are needed to expand the breadth and depth of health-care providers' knowledge about therapeutic alliance. Knowledge development focusing on this interactional phenomenon will help formulate strategies and techniques that may assist the formation of therapeutic alliances. Health-care providers will be able to incorporate new knowledge into their clinical practice.

REFERENCES

Berg, M., & Dahlberg, K. (1998). A phenomenological study of women's experiences of complicated childbirth. *Midwifery*, *14*(1), 23–29.

Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women's experience of the encounter with the midwife during childbirth. *Midwifery*, *12*(1), 11–15.

Bluff, R., & Holloway, I. (1994). 'They know best': Women's perceptions of midwifery care during labour and childbirth. *Midwifery*, *10*(3), 157–164.

Bowlby, J. (1969). *Attachment and loss.: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Bylund, C. L. (2005). Mothers' involvement in decision making during the birthing process: A quantitative analysis of women's online birth stories. *Health Communication*, *18*(1), 23–39.

Callister, L. C. (2006). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *33*(4), 508–518.

Daniel, S. I. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review*, *26*(8), 968–984.

Deering, C. (1987). Developing a therapeutic alliance with the anorexia nervosa client. *Journal of Psychosocial Nursing and Mental Health Services*, *25*(3), 11–17.

Dickes, R. (1975). Technical consideration of the therapeutic and working alliances. *International Journal of Psychoanalytic Psychotherapy*, *4*, 1–24.

Edel, M. (1985). Noncompliance: An appropriate nursing diagnosis? *Nursing Outlook*, *33*(4), 183–185.

Foreman, S., & Marmar, C. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *The American Journal of Psychiatry*, *142*, 922–926.

Frank, J. (1971). Therapeutic factors in psychotherapy. *The American Journal of Psychiatry*, *25*, 350–361.

Freud, S. (1912). The dynamics of transference. In J. Strachey (Ed.), *Complete psychosocial works* (Vol. 12). London: Hogarth Press.

Freud, S. (1913). On beginning the treatment. In J. Strachey (Ed.), *Complete psychological works* (Vol. 12). London: Hogarth Press.

Frieswyk, S., Allen, J., Colson, D., Coyne, L., Gabbard, G., Horwitz, L., et al. (1986). Therapeutic alliance: Its place as a process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology*, *54*(1), 32–38.

Gibbins, J., & Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery*, *17*(4), 302–313.

Goldberg, L. (2003). In the company of women: Enacting autonomy within the perinatal nursing relationship. *Nursing Ethics*, *10*(6), 580–587.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology*, *46*, 1023–1035.

Green, J. M., & Baston, H. A. (2003). Feeling in control during labour: Concepts, correlates, and consequences. *Birth (Berkeley, Calif.)*, *30*(4), 235–247.

Greenson, R. (1968). *The technique and practice of psychoanalysis*. New York. International Universities Press.

Hallgren, A., Kihlgren, M., & Olsson, P. (2005). Ways of relating during childbirth: An ethical responsibility and challenge for midwives. *Nursing Ethics*, *12*(6), 606–621.

Hodnett, E. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology*, *186*(Suppl. 5), S160–S172.

Hodnett, E., Gates, S., Hofmeyr, G., & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews,* Issue 3, Art. No.: CD 003766.

Howard, I., Turner, R., Olkin, R., & Mohr, D. C. (2006). Therapeutic alliance mediates the relationship between interpersonal problems and depression outcome in a cohort of multiple sclerosis patients. *Journal of Clinical Psychology*, *62*, 1197–1204.

Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery*, *22*(4), 308–322.

Kennedy, H. P., Shannon, M. T., Chuahorm, U., & Kravatz, M. K. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery & Women's Health*, *49*(1), 14–23.

Langs, R. (1975). Therapeutic misalliances. *International Journal of Psychoanalytic Psychotherapy*, *4*, 77–105.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA. Sage Publications.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92–116). New York: Bruner/Mazel.

Luborsky, L., Mintz, J., Auerbach, A., Christoph, P., Bachrach, H., Todd, T., et al. (1980). Predicting the outcome of psychotherapy: Findings of the Penn Psychotherapy Project. *Archives of General Psychiatry*, *37*, 471–481.

Maccoby, E., & Masters, J. (1970). Attachment and dependency. In P. H. Mussen (Ed.), *Carmichael's manual of child psychology* (Vol. 2, 4th ed., pp. 73–158). New York: Wiley.

Madden, B. (1990). The hybrid model for concept development: Its value for the study of therapeutic alliance. *ANS. Advances in Nursing Science*, *12*(3), 75–87.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. *The Journal of Nervous and Mental Disease*, *172*(7), 417–423.

Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: Development and relationship to psychotherapy outcome. *The American Journal of Psychiatry*, *138*, 361–364.

Matthews, R., & Callister, L. C. (2006). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *33*(4), 498–507.

McCrea, H., & Crute, V. (1991). Midwife-client relationship: Midwives' perspectives. *Midwifery*, *7*(4), 183–192.

McGrath, K. (2007). Guest editorial – Finding the path. *The Journal of Perinatal Education*, *16*(2), 7–15.

Moras, K., & Strupp, H. (1982). Pretherapy interpersonal relations, patients' alliance, and outcome in brief therapy. *Archives of General Psychiatry*, *39*(4), 405–409.

Morgan, R., Luborsky, L., Crits-Christoph, M., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry*, *39*(4), 392–402.

Moughton, M. (1982). The patient: A partner in the health care process. *The Nursing Clinics of North America*, *17*(3), 467–479.

Roberts, C. (1982). Identifying the real patient problems. *The Nursing Clinics of North America*, *17*(3), 481–489.

Schatzman, L., & Strauss, A. (1973). *Field research: Strategies for a natural sociology*. Englewood Cliffs, NJ. Prentice-Hall.

Schwartz-Barcott, D., & Kim, H. S. (1986). A hybrid model for concept development. In P. Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 91–101). Rockville, MD: Aspen.

Schwartz-Barcott, D., & Kim, H. S. (1993). An expansion and elaboration of the hybrid model for concept development. In B. Rodgers & K. Knafl (Eds.), *Concept development in nursing: Foundations, techniques and applications* (pp. 107–133). Philadelphia: W. B. Saunders.

Simmonds, A. H. (2008). Autonomy and advocacy in perinatal nursing practice. *Nursing Ethics*, *15*(3), 360–370.

Sokolowski, P. A. (Ed.). (2001). *Merriam-Webster dictionary* (10th ed.). Springfield, MA: Merriam-Webster, Inc.

Strupp, H., & Binder, J. (1984). *Psychotherapy in a new key*. New York: Basic Books.

Zetzel, E. (1956). Current concepts of transference. *The International Journal of Psycho-Analysis*, *37*, 369–376.

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