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Relational complexity and conflict in psychotherapy

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Abstract
Psychotherapy tends to be more effective when therapist and patient form a strong working alliance. However, existing accounts of the therapeutic relationship underplay its complexity and ambiguity. I offer a new account grounded in the theory of relational models, arguing that the therapeutic relationship is an unusually tangled combination of communal, egalitarian, authority, and market elements. Coordinating an effective healing relationship requires therapist and patient to align their modes of relating in the face of this complexity. That task is made more challenging by the relationship's uniqueness, by the intrinsic ambiguity of psychotherapy itself, and by the tacit relational assumptions and idiosyncrasies of the two parties. I argue that misalignments based on the use of discrepant relational models by therapist and patient are likely to be common and should take predictable forms. Implications for the theoretical and empirical study of psychotherapy are discussed.

Keywords Psychotherapy · Relational models · Transference · Working alliance

Introduction

Psychotherapy is a broad church with hundreds of denominations. Whether it follows Freud or Pavlov, Buddhism or feminism, randomized controlled trials or sacred texts, each school of therapy has its own preferred way of administering the talking cure. In classical psychoanalysis, the encouched patient free associates while the analyst, unseen and mostly unheard, offers the occasional interpretation. In the cognitive-behavioral tradition the therapist is usually more active and didactic: a treatment plan is laid out, directives are given, homework is prescribed, and the patient's irra-

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tionalities are exposed and corrected. In the humanistic, narrative, or client-centered traditions, therapists engage in more open-ended exploration and reflection. Some psychotherapies rely on talk alone, whereas others supplement it with breathing exercises, meditation, exposure to feared objects, or physical bodywork.

Like Wittgenstein's "game", psychotherapy might seem to have no defining element. However, all forms of therapy involve a relationship of some kind. That relationship may be understood and enacted in different ways in different traditions, but invariably a therapist and a patient interact in the hope of enhancing the patient's welfare. Therapists may prefer to view themselves as health professionals, spiritual guides, problem solvers, or emotional supports. Patients may be comfortable with that designation or prefer to be called clients or consumers. But whatever labels are applied to each party, they form a dyad.

Most clinicians consider the therapeutic relationship to be of paramount importance to their work. Although stringent evidence that the relationship is causally potent is only beginning to emerge (Zilcha-Mano, 2017; Zilcha-Mano & Fisher, 2022), studies find that the "working alliance" between therapist and patient (Bordin, 1979) is strongly associated with treatment outcome (Horvath et al., 2011). The quality of the relationship is generally more predictive of therapeutic outcome than the therapist's orientation or use of specific techniques (Wampold et al., 1997). A range of relationship elements feature among the "common factors" that underpin effective therapy regardless of its brand (Wampold, 2015). Quantitative reviews commissioned by a recent taskforce (Norcross & Lambert, 2018) found that the alliance, collaboration, goal consensus, empathy, and positive regard and affirmation are "demonstrably effective," and that genuineness, emotional expression, cultivation of positive expectations, and repair of alliance ruptures are "probably effective". It is now common sense in the psychotherapy field that forging a relationship in which therapist and patient work together with trust, openness, honesty, and shared goals is an essential foundation of effective treatment.

Developing such a relationship can be challenging, however. Patients in distress may be fragile and often come to therapy to address enduring interpersonal difficulties. Therapists also vary in their capacity to form positive alliances. The challenges of forging an effective therapeutic relationship extend beyond the vulnerabilities and limitations of the individual participants because that relationship is intrinsically complex. As Orlinsky and Howard (1995) observe, the "combination of professional service with personal attachment. . is a defining and distinctive feature of modern psychotherapy" (p. 9). It is simultaneously intimate and transactional, combining levels of closeness and emotional disclosure typically reserved for intimate partners with the commercial arrangements of a paid service. Patients expect a compassionate connection but also a good and affordable outcome. Similarly, some aspects of the relationship resemble a collaborative alliance of the sort one might have with friends or workplace colleagues, but others involve a clear imbalance of authority, power, and expertise. Therapist and patient are united in working towards a shared goal, but only one of them has been sought out because they are believed to have expertise and authority in the arts of healing. There is no other relationship quite like it, so familiar in some respects – like lovers, friends, teacher and student, parent and child, seller and buyer – but so unfamiliar in its hybridity. It is hardly surprising that therapist and

patient may not always find it easy to align their expectations and coordinate their interactions.

In this article I explore the complexity of the therapeutic relationship through the lens of Alan Fiske's Relational Models Theory. Most of the voluminous literature on the psychotherapeutic relationship (e.g., Norcross & Lambert, 2019; Norcross & Wampold, 2019) uses concepts and theories drawn from clinical psychology and psychiatry rather than social theory. Relational Models Theory offers a broader perspective by enabling us to consider the therapeutic alliance as one social relationship among many: unique in some respects but cut from the same cloth as other forms of human sociality. In theory, the therapeutic relationship can be understood using the same concepts that capture the relational structure not only of all interpersonal relationships but also of organizations, institutions, and cultures. I will argue that a Fiskean approach provides insight into the conflicts and difficulties that beset the therapeutic relationship by allowing us to see them as frictions between distinct models for constructing relationships.

I begin the paper with an overview of mainstream views on the nature and importance of the therapeutic relationship, followed by a brief review of Relational Models Theory. I then explore how the theory clarifies the complexities of the therapeutic relationship, and how mismatches between the models that therapist and patient employ in their relationship might underlie frictions within it. I move on to examine how this analysis of conflicting models sheds new light on some of the relational challenges of psychotherapy. I then speculate on how the general patterns of conflict that I identify may also be qualified by attributes of patients and therapies. Particular kinds of conflicts may be more likely for patients with particular forms of mental ill health, in particular forms of therapy, and as a function of the genders, ages, or cultural backgrounds of the therapist and patient. In sum, I propose that a rich and versatile form of social theory offers new insights into the therapeutic relationship.

To preempt misunderstanding, I am not claiming that theorists and researchers have failed to recognize the complexity or potential conflictedness of the therapeutic relationship. Rather, I argue that it is complex and conflictual in ways that are not adequately captured by existing approaches. In particular, I propose a specific account of the nature of that relational complexity and a specific account of the forms that conflict is therefore likely to take. I also claim that existing expositions of the therapeutic relationship typically underplay the truly relational – as distinct from interpersonal – nature of its complexity and the extent to which it involves a process of relational alignment and coordination. A beneficial therapeutic relationship requires that therapist and patient agree not only on their goals and the means of achieving them, but also on what kind of relationship they are in.

Theorizing the therapeutic relationship

The psychotherapy literature has apprehended the therapeutic relationship through a wide range of concepts. Followers of Carl Rogers (1957) identify empathy, unconditional positive regard and congruence (honesty and genuineness) as necessary and sufficient conditions for therapeutic change. Others invoke the authentically

personal "real relationship" (Gelso, 2009), the profound engagement of "relational depth" (Wiggins et al., 2012) or, on the negative side, experiences of "rupture" when emotional connection or trust are disturbed (Safran et al., 2011). Two concepts that emerged from the psychoanalytic tradition have been particularly central to research and theorizing. In that tradition the relationship is understood to be distorted by a process of "transference" in which the patient unconsciously imposes relational patterns from childhood onto their relationship with the analyst, but also includes a collaborative "therapeutic alliance" or "working alliance" between therapist and patient. A large body of empirical work on the determinants and implications of this alliance has accumulated, in addition to a smaller volume of research on transference processes.

Transference

As the original form of "talking cure", psychoanalysis developed the first theoretical understanding of the therapeutic relationship. According to Freud, patients come to treatment with deep-seated emotional conflicts that are rooted in childhood relationships with their parents.

> The patient is not satisfied with regarding the analyst in the light of reality as a helper and adviser who, moreover, is remunerated for the trouble he takes and who would himself be content with some such role as that of a guide on a difficult mountain climb. On the contrary, the patient sees in him the return, the reincarnation, of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions which undoubtedly applied to this prototype. (Freud, 1938, p.173).

As these feelings and reactions inevitably permeate the psychoanalytic relationship, the analyst must be alert to them and interpret them back to the patient. All relationships are colored by this kind of repetition, analysts argue, but psychoanalytic treatment brings it into high relief because the analyst's principled neutrality or "abstinence" serves as a blank screen onto which the "transference neurosis" is projected.

Transference has been a central concept in psychoanalytic thinking about the therapeutic relationship, but it has some significant limitations. First, its overwhelming emphasis falls on one side of the dyad, attributing distortions in the relationship to the patient's unconscious dynamics. The analyst's counter-transference is sometimes mentioned, but without real symmetry. Second, transference is usually characterized on the purely evaluative dimension of positive or negative – idealizing or erotic on the one side, hostile on the other – rather than capturing the qualitative complexity of the therapeutic relationship. Third, the idea of transference says little about how the relationship is configured in the here and now, such as its rules, expectations, and positioning of therapist and patient, focusing instead on how previous adult-child relationships are repeated. Finally, the concept is endemic to the clinical world. Even if, as Freud (1925, p.42) wrote, transference "is a universal phenomenon of the human mind", the concept was developed to make sense of interpersonal dramas occurring in the emotional hothouse of the psychoanalytic session.

Some researchers have attempted to extend the psychoanalytic understanding of transference. Clinical psychologists Lester Luborsky and Paul Crits-Cristoph (1998) developed a method for assessing it in terms of specific conflictual themes, viewed as the patient's basic wish, how others respond to the wish, and how the patient responds to these responses. Clinical psychologist Jerome Singer (1985) translated the concept of transference into the social-cognitive language of schemas and prototypes. Social psychologist Susan Andersen broadened it to include any way in which perceptions of unfamiliar people are shaped by mental representations of significant others (Andersen et al., 1995). In all of these research programs, the concept departs from its psychoanalytic origins, jettisoning the claims that transference must involve the recapitulation of early familial relationships and that it is in any sense neurotic. Nevertheless, transference remains poorly specified in terms of characteristic relationship patterns and focused asymmetrically on one half of the relationship. Transference is understood chiefly as the patient's idiosyncratic interpersonal stance rather than as a feature of the therapeutic relationship itself: it is a feature of individuals rather than dyads.

The working alliance

The concept of transference was developed to account for distortions in the therapeutic relationship. The concept of working alliance was instead coined to capture the undistorted aspects of the relationship that enable productive collaboration. In the work of Bordin (1979) this concept became applicable to all schools of psychotherapy rather than being exclusive to the psychoanalytic tradition. Rising interest in the alliance was driven in part by the growing recognition of the importance of "common factors" in psychotherapy that underpin therapeutic outcomes, independent of theoretical orientation or technique (Frank, 1961).

Definitions of the working alliance vary, but it is generally accepted that a high-quality alliance is one in which patient and therapist have a positive bond of mutual trust and acceptance and agree on the goals of therapy and on the therapeutic tasks used to achieve them. For example, a popular psychometric scale used to quantify the alliance (Horvath & Greenberg, 1989) includes items such as "My therapist understands what I hope to get out of therapy" (goal agreement), "What I do in treatment gives me new ways of understanding my problems" (task agreement), and "My therapist and I trust one another" (bond). These elements largely boil down to confidence in the therapist and confidence in the treatment itself (Finsrud et al., 2022). Researchers have devoted considerable effort to exploring the determinants of a positive working alliance, showing that it is moderately related to treatment outcomes (Flückiger et al., 2018). They have also examined how transient ruptures of the alliance within therapy sessions can be identified and repaired (Safran et al., 2011).

The concept of working alliance is a useful distillation of the therapeutic relationship's desirable features, but like the idea of transference it is theoretically limited. For a start, it does not specify the processes or mechanisms that generate it. Agreeing with questionnaire items such as "I am clear on what my responsibilities are in therapy" implies that the patient believes they are on the same wavelength as the therapist but does not capture whether the belief is accurate or identify the wavelength. To

label an alliance as “positive” is to posit that the client and the therapist are aligned, but it does not specify what alignment consists of or what exactly is being aligned. The working alliance concept also says nothing about the forms that suboptimal alliances take or what undermines them, so the concept reduces the complexity of the therapeutic relationship to a single evaluative dimension. Finally, like transference, the concept of alliance is tailored to the specific context of psychotherapy. Rather than applying a general framework for making sense of relationships to the context of therapy, it was developed for clinical applications.

The therapeutic relationship may be complex but there is no reason to believe that what we know about social relationships in the world at large does not apply inside the consulting room. Existing accounts of the relationship have made only limited use of social psychological models of interpersonal processes. For example, research on transference has organized the patient’s transferential wishes into the interpersonal circle, a model that characterizes social behavior along axes of dominance and affiliation (Crits-Cristoph et al., 1994). Studies of alliance ruptures have distinguished rupture types using the closely related distinction between agency and communion (Muran & Eubanks, 2020). Although they have merit in making sense of therapeutic phenomena, these borrowings from social psychology are limited in two primary ways. First, they are reductive in resting on simple binary distinctions. Second, they operate at an interpersonal rather than relational level of analysis because they describe the patient’s or therapist’s individual behavior towards the other rather than the dyadic relationship itself. Addressing the interpersonal behavior of individuals cannot fully capture the processes that coordinate that relationship. Ideally, then, an account of the therapeutic relationship would apply a general framework that does not reduce the relationship to a simple evaluative dimension like the working alliance or to the interpersonal behavior of individuals.

Relational models theory

A promising foundation for such an account can be found in Alan Fiske’s Relational Models Theory (Fiske, 1991, 2025), an influential synthesis of classical social theory, the ethnographic record, and contemporary research across the human sciences. In the context of this symposium Relational Models Theory needs little introduction, but it proposes that relationships are constructed from four fundamental models: Communal Sharing, Authority Ranking, Equality Matching, and Market Pricing. These models are understood as universal features of human nature that organize all aspects of social cognition, motivation, and interaction, and represent a crucial underpinning of culture. They operate at multiple levels of analysis, from individual psychological processes to interpersonal dynamics, up to social institutions and political systems. Aligning these models of relationships and how they are to be implemented is crucial for the coordination of social action and interaction.

If our goal is to understand relational complexity and conflict, three elements of Relational Models Theory have special importance. First, by proposing four relational models the theory explicitly recognizes that relationships have complex underpinnings. Its account of relationships is more differentiated than some alternatives,

such as the binary distinction between communal and exchange relationships (Clark & Mills, 1979). Fiske argues that relationships may combine elements of multiple models, and the implementation of each model is typically subject to specific practices or parameters. Social competence in a particular cultural setting requires learning which relational models govern which relationships, and the specific precedents and precepts for how that is to be done in each concrete situation. Learning these complexities is the key task of the child during socialization, and of the ethnographer trying to learn a culture.

A second element that makes Relational Models Theory a promising account of relational conflict and complexity involves how the relational models are conceptualized. The models are theorized as incommensurable frames: they can be combined as discrete elements, but they cannot simply be blended. Any particular relationship or activity either is or is not governed by a particular model. This categorical conjecture has received empirical support from analyses that directly compare dimensional and categorical representations of the relational models (Haslam, 1994). If the relational models are discrete, incommensurable categories, people who bring discrepant relational models to bear in a relationship cannot resolve their disagreement by simply splitting the difference. If relationships varied along a continuum of closeness, for example, individuals who differed in their desired level of closeness could compromise on an intermediate level. However, if relationships are constructed from incommensurable models, discrepancies can only be rectified if the two parties settle on one model, agree to use their respective models in different domains of the relationship, or remain in conflict. Relational conflict of this kind is more radical than in the dimensional case, and the process of conflict resolution is more fraught. According to Relational Models Theory, social coordination requires the categorical alignment of people's models of relating, and the process of alignment may not be straightforward.

Third, because different relational models dictate fundamentally different ways of relating, conflict between people approaching a relationship with discrepant models will often be sharp and moralized. As Rai and Fiske (2011, p.65) argue, "conflicting moral judgments and behaviors may be due in part to individuals and groups constituting different social-relational models and corresponding moral motives for otherwise identical situations". Fiske and Tetlock (1994, pp. 256-7) remark that "people view trade-offs as impermissible and respond with varying degrees of indignation whenever the trade-offs require assessing the value of something governed by the socially meaningful relations and operations of one relational model in the terms of a disparate relational model." Empirical studies (Fiske & Tetlock, 1997; McGraw & Tetlock, 2005) bear out this claim, showing that people respond with indignation when asked to make trade-offs that imply a conflict between different relational models, such as assigning a monetary value (Market Pricing) to their children (Communal Sharing relationships). These taboo trade-offs illustrate the emotional friction that results when relational frames conflict and imply that some forms of relational conflict in psychotherapy may be vexed.

Conflict in the therapeutic relationship

If the relational models are discrete frames and discrepancies between frames are a source of emotionally fraught confusion and conflict, then the potential for relational conflict in psychotherapy, and the coordination effort required to avoid or address it, should be significant. Three factors reinforce this possibility. First, the therapeutic relationship is unusually complex (in ways that Relational Models Theory illuminates), making discrepant relational framings more likely. Second, the nature of the relationship is often ambiguous and sometimes misrepresented or mystified. Patients receive little advance guidance on how the relationship will be configured, different therapists and schools of therapy take different default approaches to it, and some therapists fail to acknowledge some of its dimensions. Third, patients often come to therapy with problems that are interpersonal in nature, and patients may have a high propensity for relationship disturbance. In this context, it is hardly surprising that conflicts arise frequently in psychotherapy.

Relational complexity

Writers on psychotherapy rarely acknowledge the extent to which the therapeutic relationship is both complex and unique. Taking a Relational Models Theory approach clarifies that complexity and reinforces why reducing the relationship to a one-dimensional working alliance is inadequate. From the Relational Models Theory perspective, therapy can and usually does contain elements of all four relational models.

Communal Sharing

The Communal element may not be equally salient in all schools of psychotherapy, but it is generally understood that the therapeutic relationship should be characterized by emotional closeness, compassion, and self-disclosure. Patients reveal intimate details that they might not ordinarily divulge to their closest confidants. The therapeutic dyad exists in a private bubble, creating a clear boundary between inside and out. The therapist is guided by an ethic of care and responds to the patient's need without expecting reciprocation. A large majority of therapists report having cried in sessions (Blume-Marcovici et al., 2013). All of these features are typical of the relationships with lovers, family members, or close friends that are usually governed by Communal Sharing. Therapists are warned of the professional boundary breaches that can occur if the relationship becomes overly fused, but this admonition merely reinforces how a Communal element is always implicit in it.

Equality Matching

Psychotherapy is not strictly egalitarian in most respects. Therapist and patient do not take turns helping one another or track favors and obligations in an effort to maintain relational balance. Nevertheless, the ethos of the therapeutic relationship – manifest in concepts like the "working alliance" – is often framed as two people laboring together towards shared goals like co-workers or workmates, relationships that are typically construed as egalitarian in Western settings.

Authority Ranking

Therapists hold and wield several forms of authority: behavioral, epistemic, and status-related. They are authorized to give directions, to guide the course of treatment, and often to define the nature of the presenting problem, sometimes via the act of diagnosis. They hold authority as experts in mental health and its treatment, often backed by titles and framed diplomas. They dictate rules regarding attendance, payment and vacations and – tele-therapy excepted – the patient always comes to their place of work. These differentials may be correlated with power relations but Fiske argues they are not reducible to power.

Market Pricing

The therapeutic relationship generally has a Market Pricing component in at least two respects. It is transactional, in the sense that money is exchanged for a professional service, and both participants are likely to be concerned about efficiency: whether the benefit received by the patient is proportional to the effort, time, and money expended. As an extended rather than one-shot activity, the quantity of therapy is salient: patients (and therapists) are likely to judge whether it is paying off sufficiently in proportion to their investment. Dropout often results from the patient's assessment that they are not receiving the benefit they expected from the sessions they have attended, an evaluation necessarily based on considering proportions. Although many therapists will prefer to continue treatment as long as there is a perceived need for it (a Communal Sharing framing), they are also subject to expectations about the optimal "dose" of treatment for effective treatment, sometimes enforced by the actuarial and commercial calculations of insurance companies.

Relational ambiguity

The therapeutic relationship is evidently a unique conglomerate of the four relational models. It is difficult to imagine another common relationship that combines so many elements. The uniqueness and complexity of the psychotherapeutic relationship create ambiguity about how it should be understood, an ambiguity that arises even in the terms used to describe the person who seeks treatment. "Patient" is sometimes avoided for having a hierarchical connotation, implying an Authority Ranking model in which one person administers a treatment to a passive recipient (although the term derives from the Latin for suffering rather than passivity). "Client" implies a more egalitarian or transactional framing of the relationship, whereas "consumer" unambiguously invokes a Market Pricing frame.

The extent to which the therapeutic relationship has multiple components is often opaque to the patient, in part because there are few precedents for it outside the psychotherapeutic setting. Relationally speaking, psychotherapy is not identical to more familiar encounters such as undergoing a medical procedure, being taught in a classroom, exchanging secrets with a best friend, or purchasing a consumer good from a store, although it can resemble each of these prototypes to some degree. In addition, the nature of the therapeutic relationship that a new patient enters will depends on

the theoretical orientation or school of therapy and the personality, ideology or relational style of their therapist. Even therapists of ostensibly the same orientation can approach the therapeutic relationship in radically different ways. Writing of the differences between early psychoanalysts Sigmund Freud and Sandor Ferenczi, for example, Berman (1997, p.188) writes:

> From their first letters one notices the contrast between Freud's belief in the benefits of a firm hierarchical structure regulating the interaction … between patients and therapists (a structure in which boundaries are firm, and knowledge is passed on or withheld wisely and cautiously), and Ferenczi's opposing enthusiasm about equality, openness, and mutuality, about blurring boundaries, transcending hierarchies, and sharing knowledge freely.

In Fiskean terms, this stylistic difference is readily translated into preferences for more Authority Ranking- and Communal Sharing- or Equality Matching-based therapeutic relationships, respectively, arguably a more accurate characterization than the gendered paternal versus maternal framing that is sometimes proposed.

Differences in primary relational emphasis between theoretical schools are widespread. Client-centered therapists, for example, tend to adopt a more communal style, in which empathy and provision of emotional support are central, whereas therapists with a more didactic approach, or whose approach more closely resembles a traditional medical consultation, are likely to embody a more authoritative expert stance. Differences in clinical settings may also influence default approaches to the relationship, with fee-for-service private practices and care-rationing managed care arrangements likely to raise the salience of Market Pricing considerations and national health services likely to reduce it.

Moreover, given widespread ideological ambivalence about authority relations, therapists may often under-recognize the extent to which the therapeutic relationship has an Authority Ranking element, a selective denial demonstrated in people's failure to identify their personal relationships as having these elements when they demonstrably did (Haslam, 1994). Similarly, the uneasy conjunction of Communal Sharing and Market Pricing relations, observed in studies of taboo trade-offs and expressed in frequently drawn parallels between therapy and prostitution, may lead some therapists to underplay the Market Pricing element.

Faced with this ambiguity, prospective patients can only bring to therapy their best guesses about how the relationship will be configured, using established precedents from other contexts, and their repertoire of relational models. Fiske and Tetlock (1994, p.263) make this point in their discussion of taboo trade-offs:

> When people face novel situations that raise the possibility of alternative implementation rules, debate will revolve around analogies to more familiar situations that people use as prototype implementations of the competing relational models.

If obvious, uncomplicated and reliable relational prototypes existed this search for analogies might be easy, but as we have seen, it is not. Consequently, patients enter-

ing psychotherapy must learn and co-construct how the therapeutic relationship operates, and it is highly likely that some discrepancies with their therapist will arise along the way.

Relational disturbance

Mental health problems are ascribed to individuals and typically attributed to intrapersonal causes, such as the person's neurobiology, personality, or cognitive biases, but they are often profoundly relational. This is true whether we consider their manifestations, effects, causes, or mechanisms. Many features or symptoms of mental illness involve problems of social inhibition, insensitivity, incompetence, conflict, or exclusion. Many of its primary impacts fall on partners, parents, children, and colleagues rather than a solitary identified patient. Interpersonal experiences such as relationship conflict, loss, isolation, and maltreatment are all potent sources of psychological distress. The cognitive and emotional processes and structures that psychologists invoke causes of mental ill health – biases in social perception, deficiencies in mind-reading, distortions of attachment – are often directly linked to social interaction and relationships.

The relationality of mental ill health is especially evident in the personality disorders, a group of conditions characterized by enduring patterns of inflexible self-defeating behavior. Most of these patterns are primarily interpersonal in their manifestations, patients typically bringing a long history of troubled relationships and interpersonal upheavals in life, love, and work. Dependent personalities, for example, are excessively reliant on others, taking a passive and submissive stance towards others that often leads to their abuse and exploitation. Narcissistic personalities believe they are entitled to special treatment and demand admiration, erupting when it is not forthcoming, and are hypersensitive to criticism. Antisocial personalities lack empathy and concern for others and lack the usual moral emotions and convictions that restrain cruelty in most of us.

It is increasingly acknowledged that disorders such as these are intrinsically rather than merely incidentally relational. Lilienfeld and colleagues (2019), for example, argue that many personality disorders are "emergent interpersonal syndromes", defined as "distinctive patterns—specific constellations—of signs and symptoms that generate characteristic adverse reactions in others" (p. 582). There is also evidence that these patterns are generally well captured by existing models of the structure of interpersonal behavior such as the interpersonal circle. Most personality disorders are characterized by distinctive profiles on the circle's dimensions of warmth *versus* coldness and dominance *versus* submission: the problems dependent personalities experience fall in the warm submissiveness quadrant, whereas those of narcissists and antisocial personalities in the cold dominance quadrant (Widiger & Hagemoser, 1997).

There is some evidence that tendencies to employ relational models in distinctive ways underpin some of these profiles. Haslam, Reichert and Fiske (2002) found that people who reported difficulties in communal, egalitarian, and authority relationships had high levels of personality disorder features, as did people with unusually strong motivation to engage in Authority Ranking and Market Pricing relationships and

those who tended to construe everyday relationships in authority-related terms. Specific personality disorders also had unique relational signatures: narcissistic, dependent, and paranoid personalities were particularly high in authority, communal, and market motivations, respectively, for example. These findings accord with evidence that the major dimensions of personality are also associated with idiosyncratic ways of seeking and implementing relationships (Caralis & Haslam, 2004), and that such patterns also underlie vulnerability to conditions such as depression, bipolar disorder, and psychosis (Allen et al., 2005).

Findings such as these point to a further reason why the therapeutic relationship might be fraught with conflict. If patients commonly bring atypical ways of understanding and constructing relationships to therapy – dispositions implicated in their presenting problems – we would expect relational discrepancies to be more likely than in other interpersonal contexts. This expectation accords with the finding that patients with personality disorders drop out of therapy at high rates (Cooper & Conklin, 2015).

Manifestations of relational discrepancy in psychotherapy

I have argued that the psychotherapy can be a relational minefield and that its complexity goes beyond anything that can be captured by the simple dual dimensions of interpersonal behavior employed in some analyses of psychotherapy (e.g., Crits-Cristoph et al., 1994). Coordinating any relationship requires that the participants' relational models be aligned, but the alignment of therapist and patient faces numerous obstacles. It involves an unusually complex and unfamiliar combination of models, that combination differs depending on the therapist and their school of thought, and at least one of the participants is likely to be experiencing distress and unusually vulnerable to relational difficulties. This judgment may make it seem remarkable that effective working alliances are sustained or that psychotherapy ever succeeds, but these outcomes undoubtedly eventuate. A relational models analysis should at least clarify its fault-lines: the difficulties that arise when the relational models of patient and therapist misalign.

In this section I speculate on the implications of therapist and patient holding discrepant understandings of their relationship. What is likely to transpire, that is, if one person employs a particular relational model when the other does not, or if they fail to employ it when the other does. If such discrepancies undermine the agreement of therapist and patient on the goals or tasks of therapy, or their trust and confidence in one another, they will interfere with the working alliance and thereby undermine therapeutic success. The feeling of uncertainty about what sort of relationship this is, or the perception of differing expectations, is likely to derail the working alliance.

Communal sharing

Psychotherapy is an intimate relationship in which normally private thoughts and emotions are shared. Popular representations of it often emphasize how its interpersonal hallmarks are openness, empathy, and trust. The Communal Sharing model is always likely to be implicated in psychotherapy, but it will be more salient in some forms and

for some patients. Patients who fail to employ the model are likely to find emotional disclosure difficult. Forging a relationship of intimate openness will be more difficult when patients are reluctant to reveal themselves and prefer to maintain distance from the therapist. This reluctance would be less problematic in relatively brief, didactic, and task-focused forms of therapy, but it would be a serious impediment to developing a strong therapeutic alliance in longer-term exploratory or supportive forms.

A tendency to employ Communal Sharing more than the therapist expects would have quite different implications. Patients expecting a thoroughly Communal Sharing relationship may be confused or feel rejected if the therapist is more reserved. This relational model implements a sense of fused identity and intimacy motivation, and these can also endanger the maintenance of professional boundaries. Patients who view the relationship with their therapist as fundamentally communal in nature – involving a sense of unity, "what's mine is yours", and an enactive or kinesthetic way of marking the relationship (Fiske, 1991) – may be more liable to overstep these boundaries and less cognizant that the relationship differs from the relationships they have had with a parent, lover, or best friend. In a Communal Sharing relationship there is no boundary between self and other, only one around them. Such communal tendencies may underpin what psychoanalysts theorized as a positive or erotic transference and might also manifest as excessive dependency on the therapist. Patients who view the relationship in primarily communal terms may wish for more than a professional relationship with the therapist, view therapy as need-satisfying nurture rather than treatment, and be hurt by the relationship's lack of mutuality and the therapist's unwillingness to offer unconditional love.

Equality matching

The therapeutic relationship may not usually be an egalitarian one, but patients who fail to recognize its Equality Matching elements may experience predictable difficulties. Strict turn-taking may not be expected, but a working alliance requires that both parties contribute as part of a team. Any tendency not to appreciate this requirement might lead the patient to expect that they are simply a recipient of treatment rather than an indispensable and active part of it (as the old joke goes, it only takes one therapist to change a light bulb, but the light bulb has to want to change). Passivity of this sort, based on a discrepant understanding of the nature of the therapeutic relationship, would hinder progress, and generate dissatisfaction in both parties. The therapist might view the patient as lacking motivation to change or view them as disengaged when the patient is simply misconstruing the nature of the relationship desired by the therapist. In turn, the patient is likely to be frustrated that the therapist is failing to deliver an effective treatment.

People with narcissistic traits, who feel superior and entitled to special treatment, have a focal difficulty with egalitarian relationships. They would be expected to have trouble forging a working alliance due to a failure to grasp the Equality Matching component of the relationship. That difficulty might be less acute in forms of therapy in which emotional support and exploration are prioritized, than in forms with a more task-oriented focus. Patients who do not employ an Equality Matching frame in therapy should be less likely to engage and benefit when it is configured as a form of collaborative partnership, rather than as an emotional safe space or a professional intervention.

It is also possible that some patients might employ Equality Matching more than their therapists expect. That discrepancy might become manifest in their frustration at the lack of reciprocity of self-disclosure in therapy – the calibration of which is an issue of major concern among therapists (Henretty & Levitt, 2010) – or in actions that therapists might take as a challenge to their authority or disrespect of their expertise. If therapists see themselves as professionals directing the treatment, they may view patients who act as if they are equal partners, as an egalitarian team-mate or friend would and as some descriptions of therapy suggest, as disrespectful and presumptuous. Regardless of whether the discrepancy is ascribed to one party employing Equality Matching excessively or to the other employing it insufficiently, poorly coordinated interactions of this kind are likely to result in a relationship where the enactment of equality is equivocal.

Authority ranking

Elements of authority and differences of status, expertise, and responsibility are inevitable aspects of psychotherapy. Therapists have professional standing as experts on the treatment of mental illness and are expected if not to direct every aspect of treatment, at least to set its course. The Authority Ranking element may be more salient in some schools of psychotherapy, such as traditional psychoanalysis and the relatively didactic forms of cognitive-behavior therapy, but it is absent from none, even if it is disavowed in more client-centered and humanistic traditions.

A patient who failed to recognize this element would be less likely than others to attribute expertise and efficacy to the therapist. Liberman (1962) argues that the perceived authority of the healers plays a role in the placebo effect, quoting King Charles II's physician, who opined that his majesty's laying on of hands "cureth more in any one year than all our surgeons of London have done in an age". The placebo effect accounts for a substantial component of psychotherapy's efficacy (Wampold et al., 2005), so patients who do not ascribe authority to their therapists would be expected to derive less benefit from them. Therapists are likely to see such patients as resistant, stubborn, or unresponsive.

In view of evidence that distressed and emotionally vulnerable people are especially apt to perceive relationships in Authority Ranking terms (Haslam et al., 2002), a more likely eventuality is that patients will employ this model to excess in the therapeutic relationship. That bias is most likely to take the form of positioning the self as subordinate to the therapist. That stance would be expected to undermine the patient's agency and to conceptualize therapy as an operation performed on them. Patients who are overly inclined to defer and subordinate themselves should be reluctant to take initiatives, and although they might be compliant with the therapist's directives they risk becoming dependent and unable to take shared ownership of their treatment. Contrarily, patients who apply Authority Ranking to excess and position themselves as higher ranking than the therapist – by virtue of cultural background, education, gender, class, age, or other status markers – may also fail to engage productively in the treatment or form an effective working alliance.

Market pricing

The financial aspect of psychotherapy is a common source of discomfort and friction for patients and therapists alike. One study (Andrews et al., 2003) found that most therapists perceive a tension between providing care and receiving compensation. One therapist interviewed by the researchers remarked that "Charging is a necessity, but part of my job that I don't really enjoy. Charging and caring don't always go well together, and it can feel a little awkward." They went on to note that they would "prefer to be paid by the Government instead of by the clients", indicating that their discomfort is with the transactional nature of the exchange in the relationship rather than with charging itself. Patients also commonly express dissatisfaction with fees, which can be an ongoing source of friction with private practitioners.

A patient who approached therapy primarily as a Market Pricing relationship would be expected to be highly concerned about receiving value for money, unusually focused on issues surrounding payment, and likely to leave treatment early if they perceived a lack of benefit proportional to the number and quality of sessions they have paid for. They might also be expected to de-emphasize the therapeutic relationship as a close and confiding alliance and assimilate it instead to more typical commercial arrangements. Consistent with these speculations, people with antisocial personalities are disposed to understand relationships in Market Pricing terms, and this personality dimension has been shown to predict premature dropout from therapy (Bennemann et al., 2022). In contrast, patients who fail to recognize the Market Pricing element in psychotherapy are likely to feel aggrieved about the transactional element in therapy and see it as demonstrating a lack of genuine care and concern on the part of the therapist.

Implications and future directions

The analysis presented here proposes that the therapeutic relationship can be compromised when patient and therapist bring discrepant relational models to it. A well-coordinated therapeutic relationship requires alignment of these models, and specific kinds of misalignment should produce distinct forms of poor coordination. These discordances would be expected to manifest as chronic tensions in the therapeutic relationship or acute ruptures of it. If it is true that these varied forms of discord produce a diverse array of relational challenges, then the concept of "working alliance" becomes a one-dimensional simplification of a complex reality. A positive working alliance may be a pragmatically useful way of evaluating what a productive therapeutic relationship should look like, but it imperfectly summarizes the results of a more intricate set of coordination processes. Stated more positively, the working alliance should be conceptualized as an outcome of relational processes, an outcome that depends in large part on whether patient and therapist agree on the nature of the relationship they embody.

Despite the widely accepted importance of the therapeutic relationship, psychotherapy researchers have yet to develop a systematic, consensus account of the underlying processes that give rise to more or less positive relationships, or a systematic

taxonomy of the forms that less positive relationships take. There is no lack of recognition that the relationship has consequential ups and downs, and no shortage of concepts for capturing them. Leading psychotherapy researcher Christopher Muran (2019) observes that in addition to his preferred concept of "alliance rupture", other theorists have referred to interpersonal difficulties in therapy as breaches, challenges, derailments, disagreements, disruptions, impasses, misattunements, misunderstandings, and strains, among others. How best to characterize and explain these phenomena has been elusive, and psychotherapy writers typically account for it in terms of the personalities of patient and therapist. Elkind (1992) observes that "mismatches occur when the vulnerabilities and defensive modes of patient and therapist intersect in problematic ways" (p. 7).

Although this work appropriately recognizes that therapy involves an "intersubjective negotiation" between therapist and patient, it lacks an account of the relational structures that set the terms for that negotiation. A social relationship is not simply the juxtaposition or statistical interaction of the personalities of the individuals engaged in it. We might hope that theorists will begin to develop a finer-grained understanding of common difficulties in the therapeutic relationship, explore how much these difficulties can be modelled as discrepant relational expectations of patients and therapists, and determine whether Relational Models Theory offers a useful account of these discrepancies.

Such an understanding could yield valuable insights for individual psychotherapists and patients alike. It might also clarify societal and cultural factors that bear on the efficacy and uptake of therapy. It is well established that some groups – for example, men, older adults, less educated people, some ethnic minorities – are more likely to drop out of therapy prematurely (e.g., Zimmermann et al., 2017) and less likely to seek it in the first place. These effects may reflect assumptions about therapy or other relational tendencies that misalign with psychotherapy as it is practiced. For instance, someone who comes into therapy with an expectation that their problems can be fixed by an authoritative intervention, or who have a default deference to professionals, may find it difficult to engage with the more communal and egalitarian aspects of the therapeutic relationship. Viewing these disparities through a relational lens might help us understand and address inequities in the delivery of mental health care.

There is also important theoretical and empirical work to be done on how the therapeutic relationship that psychotherapists offer to patients differs implicitly or explicitly across schools of psychotherapy. Comparative studies of approaches to psychotherapy typically foreground their theoretical and technical differences, but they may also differ in how the therapeutic relationship itself is configured. They may differ in their potential for different kinds of misunderstandings, confusion, disappointment, blame and anger. Systematically studying these differences may shed a revealing light on why some approaches are more effective for some conditions and some patients than for others. Therapeutic outcomes might be improved by matching patients with approaches that are relationally well-aligned or by ensuring that relational expectations are clarified early in treatment. At present, research on the process of psychotherapy lacks an integrated general framework that reckons with the complexity of the relationship. Relational Models Theory is a natural and proven place to start.

Conclusion

Psychotherapy is an integral component of the booming mental health industry. The talking cure has been with us for well over a century, but the idea that human interaction can heal human suffering remains a powerful one. Although much ink has been spilled developing new theories and techniques of therapy, it has become clear that much of the benefit it brings is due to the therapeutic relationship itself. Understanding the therapeutic relationship is therefore crucial for efforts to comprehend the active ingredients of psychological treatment.

As psychotherapy theorists and researchers have proposed, a strong working alliance is surely one such key ingredient. However, this condition of coordinated relating must be achieved. The relational complexity and ambiguity of the therapeutic relationship make that achievement more demanding than theorists of psychotherapy have appreciated. By recognizing that social coordination is cobbled together from several distinct building blocks, Relational Models Theory clarifies the complexities involved in building an alliance and the forms that misalignments may take. Applying the theory also brings an established account of social relationships to bear in a new domain, where existing clinical-domain approaches typically view the psychotherapeutic relationship as *sui generis*.

The account of relational conflict developed here understands it as the outcome of misalignment between qualitatively different ways of structuring interaction. This theoretical approach to understanding relationship conflict might be extended beyond psychotherapy to other forms of interpersonal relationship, and beyond. As an expansive theory of social life, Relational Models Theory argues that the same models that govern micro-level dyadic relationships also govern groups, ideologies, institutions, and social systems. Might conflict within meso- and macro-level social entities also be comprehensible in terms of discrepant or misaligned relational models?

There is some scattered evidence that it might. At the micro-level Goodnow (2004) reported how mothers can experience family conflict when a relationship they take to be communal appears to be framed as an Authority Ranking relationship by children or spouses, with the mother as the subordinate maid service. Similar discrepancies are likely to underpin conflict in romantic relationships. If one partner adopts an egalitarian model based on a strict accounting of turns, distributions, and contributions, while the other takes a communal, shared-pool model, predictable frustrations, resentments, and feelings of betrayal are likely to follow. At the organizational level, Connelly and Folger (2004) examined how retention of female staff was adversely affected by a discrepancy between their egalitarian view of workplace relationships and the (exclusionary) communal "boys' club" model employed by many male staff. In economic decision-making, Fiske and Tetlock's (1997) work on taboo trade-offs shows how relational model discrepancies can provoke moralistic anger and economically irrational behavior. Cultures and political systems can be understood as embodying different models or model combinations, and some political and intercultural conflicts might profitably be analyzed as products of relational discrepancies. Much theoretical and empirical work remains to be done.

Aside from broad critiques of therapy culture (Furedi, 2004), social theorists have neglected psychotherapy as a focus of inquiry, one recent review characterizing sociological work on the topic as “dismal at best” (Huft, 2022). The analysis developed here demonstrates how theoretical ideas originating in the social sciences can enrich the perspectives afforded by clinical disciplines. Relational models theory has the capacity to shed light on the intimate process and practice of psychotherapy, and also to place it in its wider social and cultural context.

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Declarations

Conflict of interest Dr. Nick Haslam declares that he has no conflict of interest.

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References

Allen, N. B., Haslam, N., & Semedar, A. (2005). Relationship patterns associated with dimensions of vulnerability to psychopathology. *Cognitive Therapy and Research*, *29*, 733–746.

Andersen, S. M., Glassman, N. S., Chen, S., & Cole, S. W. (1995). Transference in social perception: The role of chronic accessibility in significant-other representations. *Journal of Personality and Social Psychology*, *69*(1), 41–57.

Andrews, G. J., Peter, E., & Hammond, R. (2003). Receiving money for medicine: Some tensions and resolutions for community-based private complementary therapists. *Health & Social Care in the Community*, *11*(2), 155–167.

Bennemann, B., Schwartz, B., Giesemann, J., & Lutz, W. (2022). Predicting patients who will drop out of out-patient psychotherapy using machine learning algorithms. *The British Journal of Psychiatry*, *220*(4), 192–201.

Berman, E. (1997). Relational psychoanalysis: A historical background. *American Journal of Psychotherapy*, *51*, 185–203.

Blume-Marcovici, A. C., Stolberg, R. A., & Khademi, M. (2013). Do therapists cry in therapy? The role of experience and other factors in therapists’ tears. *Psychotherapy*, *50*(2), 224–234.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory Research & Practice*, *16*(3), 252–260.

Caralis, D., & Haslam, N. (2004). Relational tendencies associated with broad personality dimensions. *Psychology and Psychotherapy: Theory Research and Practice*, *77*(3), 397–402.

Clark, M. S., & Mills, J. (1979). Interpersonal attraction in exchange and communal relationships. *Journal of Personality and Social Psychology*, *37*(1), 12–24.

Connelley, D. L., & Folger, R. (2004). Hidden bias: The impact of relational models on perceptions of fairness in human resource systems. In N. Haslam (Ed.), *Relational models theory: A contemporary overview* (pp. 197–220). Lawrence Erlbaum.

Cooper, A. A., & Conklin, L. R. (2015). Dropout from individual psychotherapy for major depression: A meta-analysis of randomized clinical trials. *Clinical Psychology Review*, *40*, 57–65.

Crits-Christoph, P., Demorest, A., Muenz, L. R., & Baranackie, K. (1994). Consistency of interpersonal themes for patients in psychotherapy. *Journal of Personality*, *62*, 499–526.

Elkind, S. N. (1992). *Resolving impasses in therapeutic relationships*. Guilford Press.

Finsrud, I., Nissen-Lie, H. A., Vrabel, K., Høstmælingen, A., Wampold, B. E., & Ulvenes, P. G. (2022). It's the therapist and the treatment: The structure of common therapeutic relationship factors. *Psychotherapy Research*, *32*(2), 139–150.

Fiske, A. P. (1991). *Structures of social life: The four elementary forms of human relations: Communal Sharing, authority ranking, equality Matching, market Pricing*. Free.

Fiske, A. P. (2025). *Representing relationships: Modes of cognition and connection*. Cambridge University Press.

Fiske, A. P., & Tetlock, P. E. (1997). Taboo trade-offs: Reactions to transactions that transgress the spheres of justice. *Political Psychology*, *18*(2), 255–297.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340.

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. John Hopkins.

Freud, S. (1925). An autobiographical study. *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20, pp. 3–74). Hogarth.

Freud, S. (1938). An outline of psycho-analysis. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol. 23 (pp. 139–208). Hogarth.

Furedi, F. (2004). *Therapy culture: Cultivating vulnerability in an uncertain age*. Routledge.

Gelso, C. J. (2009). The real relationship in a postmodern world: Theoretical and empirical explorations. *Psychotherapy Research*, *19*(3), 253–264.

Goodnow, J. J. (2004). The domain of work in households: A relational models approach. In N. Haslam (Ed.), *Relational models theory: A contemporary overview* (pp. 167–196). Lawrence Erlbaum.

Haslam, N. (1994). Categories of social relationship. *Cognition*, *53*(1), 59–90.

Haslam, N., Reichert, T., & Fiske, A. P. (2002). Aberrant social relations in the personality disorders. *Psychology and Psychotherapy: Theory Research and Practice*, *75*(1), 19–31.

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, *30*(1), 63–77.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223–233.

Horvath, A. O., Re, D., Flückiger, A. C., C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9–16.

Huft, J. (2022). The history and future of the sociology of therapy: A review and a research agenda. *The American Sociologist*, *53*(3), 437–464.

Liberman, R. (1962). An analysis of the placebo phenomenon. *Journal of Chronic Diseases*, *15*(8), 761–783.

Lilienfeld, S. O., Watts, A. L., Murphy, B., Costello, T. H., Bowes, S. M., Smith, S. F., & Tabb, K. (2019). Personality disorders as emergent interpersonal syndromes: Psychopathic personality as a case example. *Journal of Personality Disorders*, *33*(5), 577–622.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme method* (2nd ed.). American Psychological Association.

McGraw, A. P., & Tetlock, P. E. (2005). Taboo trade-offs, relational framing, and the acceptability of exchanges. *Journal of Consumer Psychology*, *15*(1), 2–15.

Muran, J. C. (2019). Confessions of a New York rupture researcher: An insider's guide and critique. *Psychotherapy Research*, *29*(1), 1–14.

Muran, J. C., & Eubanks, C. F. (2020). *Therapist performance under pressure: Negotiating emotion, difference, and rupture*. American Psychological Association.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, *55*(4), 303–315.

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work (3rd ed. Vol. 1: Evidence-based therapist contributions)*. Oxford University.

Norcross, J. C., & Wampold, B. E. (Eds.). (2019). *Psychotherapy relationships that work: Evidence-based responsiveness* (3rd ed. Vol., Vol. 2). Oxford University.

Orlinsky, D. E., & Howard, K. I. (1995). Unity and diversity among psychotherapies: A comparative perspective. In B. M. Bongar, & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 3–23). Oxford University Press.

Rai, T. S., & Fiske, A. P. (2011). Moral psychology is relationship regulation: Moral motives for unity, hierarchy, equality, and proportionality. *Psychological Review*, *118*(1), 57–75.

Rogers, C. R. (1957). The necessary and sufficient conditions for therapeutic personality change. *Journal of Counseling Psychology*, *21*, 95–103.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy*, *48*(1), 80–87.

Singer, J. L. (1985). Transference and the human condition: A cognitive-affective perspective. *Psychoanalytic Psychology*, *2*(3), 189–219.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277.

Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from randomized clinical trials. *Journal of Clinical Psychology*, *61*(7), 835–854.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. N. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, all must have prizes. *Psychological Bulletin*, *122*(3), 203–215.

Widiger, T. A., & Hagemoser, S. (1997). Personality disorders and the interpersonal circumplex. In R. Plutchik, & H. R. Conte (Eds.), *Circumplex models of personality and emotions* (pp. 299–325). American Psychological Association.

Wiggins, S., Elliott, R., & Cooper, M. (2012). The prevalence and characteristics of relational depth events in psychotherapy. *Psychotherapy Research*, *22*(2), 139–158.

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist*, *72*(4), 311–325.

Zilcha-Mano, S., & Fisher, H. (2022). Distinct roles of state-like and trait-like patient–therapist alliance in psychotherapy. *Nature Reviews Psychology*, *1*(4), 194–210.

Zimmermann, D., Rubel, J., Page, A. C., & Lutz, W. (2017). Therapist effects on and predictors of non-consensual dropout in psychotherapy. *Clinical Psychology & Psychotherapy*, *24*(2), 312–321.

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