Therapist Actions That Address Initially Poor Therapeutic Alliances in Psychotherapy

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The authors studied six patients treated in time-limited dynamic psychotherapy who had initially poor therapeutic alliance scores; three patients went on to have improved alliances and good outcomes, and three had unimproved alliances and poor outcomes. The therapist actions that most strongly differentiated the two groups and occurred more frequently in the cases with improved alliances and good outcomes were 1) addressing the patient's defenses, 2) addressing the patient's guilt and expectation of punishment, 3) addressing the patient's problematic feelings in relation to the therapist, and 4) linking the problematic feelings in relation to the therapist with the patient's defenses.
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It has been reported that ratings of the therapeutic alliance early in therapy are highly correlated with outcome. This suggests that the therapeutic alliance becomes established and fixed early in therapy, sealing the fate for the course and outcome of brief treatment (1–4). However, recent data from the Center for the Study of Neuroses at Langley Porter Institute indicate that, in selected cases, therapeutic alliance scores are not fixed and can change over the course of therapy (5). We wanted to see which therapist actions were differentially present in cases with initial poor alliances that developed into better alliances and ultimately had good outcomes in contrast to those cases in which alliances remained poor and that had unsatisfactory outcomes.

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The term "therapeutic alliance" (6) was defined by Zetzel as "a working relationship between patient and analyst" (7); it is related to similar concepts such as the "working alliance" described by Greenson (8) and the "helping alliance" discussed by Luborsky (3). Opinions differ as to how distinct the therapeutic alliance is from early positive transference feelings the patient has for the therapist (9). We use the term "therapeutic alliance" to refer to 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.

The question of what therapists can do in response to a problematic alliance has been addressed in the theoretical literature. If a misalliance develops, Langs (10) recommended that the therapist must "look first at his or her counter-transference," make appropriate interpretations, and avoid the invitation to cajole, advise, direct, seduce, or attack the patient. Greenson (8) warned that the therapist must recognize that a real working alliance has not developed if the patient becomes submissive and compliant rather than allied and participating, adding that the therapist must then address this problem in the formation of the alliance. Basch (11) noted that the therapist's ability to remain thoughtful and reasonable in the face of the patient's challenges and deprecations allows the patient to feel safe in bringing up whatever is proving to be troublesome.

Some authors (8, 12) have suggested that it would be very difficult or impossible to do therapeutic work with patients having major deficits, such as those with narcissistic or borderline personality disorders. Others (11, 13) have suggested that narcissistic patients can be treated with empathic attention to transference. Masterson (14), noting that the alliance with borderline patients is at first brittle and fragile and requires ongoing strengthening and maintenance, recommended a technique in which the therapist gradually builds up a therapeutic alliance by confronting the aspects of the transference that are destructive to the alliance. For example, the therapist should actively interpret both the patient's expectation that the therapist will hurt or abandon him and the patient's expectation that he will be rewarded for symbiotic clinging to the therapist. Masterson emphasized providing a framework for therapy by establishing ground

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rules and continually reinforcing—tactfully but firmly—the limits of reality.

General psychoanalytic interpretive techniques, which we felt might be relevant to improving a poor alliance, included identifying the patient's defense against anxiety about an underlying hidden feeling or impulse (15–17), as well as interpreting defense before impulse (16, 17). Menninger (18) and others (17) have emphasized that the patient's conflict should be interpreted in relation to others in his everyday life, in relation to the therapist (in the here-and-now transference), and in relation to the parents (usually in the past).

METHOD

The six female subjects of this study were drawn from a cohort of 52 patients treated by faculty therapists in a university clinical research center. The subjects came seeking psychotherapy after the death of either a parent or their husband. The majority of patients met *DSM-III* criteria for either a posttraumatic stress disorder or an adjustment disorder. They presented with symptoms of anxiety; depression; sleep disturbance; numbness; and intrusive thoughts, feelings, and images. This cohort of bereaved patients was found to be comparable (5) in terms of pretreatment levels of anxiety and depression to a cohort of 209 general psychiatric outpatients studied by Derogatis et al. (19). Therapy was conducted by experienced faculty therapists. The therapies were time-limited, dynamic psychotherapies 12 weeks in duration, at a frequency of one session per week. The subjects, process and outcome measures, and treatment guidelines for conducting these therapies have been described in detail elsewhere (5, 20–22).

Outcomes in the areas of symptoms and social functioning were rated by patient and therapist, as well as by an independent evaluator who did pre- and posttherapy ratings. Process measures included the California Therapeutic Alliance Scale (23), which was completed by independent judges who reviewed videotape recordings of the second, fifth, eighth, and eleventh hours of therapy. The Therapeutic Alliance Scale has 41 items that measure the following four dimensions: the therapist's positive contribution to the alliance, the therapist's negative contribution to the alliance, the patient's positive contribution to the alliance, and the patient's negative contribution to the alliance.

We wished to study therapist actions that might differentiate patients with improved alliances from those with sustained problematic alliances. We therefore chose six patients, all of whom were rated as having high initial negative contributions to the alliance, as determined by the independent judges' review of videotapes of the second hour of treatment. Three of the patients went on to have improved, that is, lower, negative alliance scores and had good or excellent

TABLE 1. Negative Contribution Scores on the Therapeutic Alliance Scale for Three Patients Who Subsequently Improved and for Three Who Did Not

| Patient Group | Score[a] | | | | | |
| | Treatment Hour | | | | | |
	2	5	8	11	Mean	Outcome
Improved						
1	8.5	6.5	2.5	1.0	4.6	Excellent
2	6.5	4.0	2.5	2.5	3.9	Good
3	5.0	8.5	3.0	0.5	4.3	Excellent
Unimproved						
4	7.0	15.5	11.0	6.5	10.0	Poor
5	8.5	7.0	18.0	16.5	12.5	Poor
6	10.0	7.5	7.5	12.5	9.4	Poor

[a]Mean rating of two judges on five negative contribution items; each item was scored from 0 (not present) to 5 (intensely present).

outcomes. The other three patients had sustained poor negative alliance ratings and had poor outcomes (see table 1). The six patients had comparable scores of initial symptomatic distress (see table 2). They also had comparable scores on a measure of the quality of the therapist's collaboration and the therapist's contribution to the alliance, as rated by independent judges' blind review of videotaped sessions.

An intensive clinical review of the six cases was performed using several sources of data. Summaries of pre- and posttherapy evaluations and process notes from each hour were carefully studied. Videotape segments of 3–6 hours of therapy in each case were reviewed. The review focused on videotapes of the initial therapy hours in an effort to understand the nature and determinants of the poor alliance. The reviewer also carefully examined videotapes of the therapy hours that preceded hours marked by a decline in the patient's negative alliance scores in an attempt to discern which therapist actions were differentially present and which ones seemed clinically relevant to the improvement in the alliance. Because this was an exploratory study, the review was performed by one person (S.A.F.), who was not blind to process or outcome ratings.

Prior to the review of these six cases, a preliminary list of therapist actions was developed on the basis of the theoretical and empirical literature reviewed earlier, as well as intensive studies of other patients with initial poor alliances treated in our university psychotherapy research center. The list of actions was refined as the intensive clinical review of these six cases proceeded. On the basis of the review of clinical data, each therapy was rated on the revised action checklist for the relative presence or absence of each therapist action, from 0 (did not occur) to 3 (major emphasis) (see table 3).

The therapist actions were studied with the intention of refining, objectifying, and testing in a preliminary way the clinical hypotheses reviewed earlier regarding techniques pertinent to the establishment of the alliance. We paid particular attention to interventions that addressed the patient-therapist relationship, as

TABLE 2. Characteristics of Six Women Who Sought Psychotherapy After the Death of a Relative

Patient	Age (years)	Deceased Relative	Marital Status	Occupation	GAS	Pretherapy Scores[a]		
						SCL-90		IES
						Depression	Anxiety	Intrusion
1	33	Mother	Single	Research technician	68	0.77	0.40	12
2	53	Mother	Married	Part-time salesperson	62	1.00	0.30	21
3	21	Father	Single	Student	52	3.38	2.70	26
4	51	Mother	Single	Teacher	55	2.46	1.10	20
5	42	Husband	Widowed	Bank accountant	52	0.67	2.00	27
6	65	Husband	Widowed	Housewife	54	1.19	2.00	15

[a]GAS=Global Adjustment Scale, SCL-90=Hopkins Symptom Checklist-90, and IES=Impact of Event Scale.

TABLE 3. Ratings of Therapist Actions in Three Cases With Improved and Three Cases With Unimproved Therapeutic Alliances

Factor Addressed by the Therapist	Rating of Therapist Actions[a]					
	Improved Cases			Unimproved Cases		
	1	2	3	4	5	6
Patient-therapist relationship						
Defenses	3	3	3	1	1	0
Problematic feelings	3	3	3	1	3	0
Problematic relationship patterns	3	2	2	1	3	0
Problematic powerful images	3	2	1	0	3	0
Problematic vulnerable images	2	3	2	1	2	1
Triangle of punishment	3	0	1	0	0	0
Patient-other relationships						
Defenses	3	2	2	0	0	1
Problematic feelings	3	3	3	3	1	3
Problematic relationship patterns	3	3	3	3	3	3
Problematic powerful images	3	3	2	0	3	3
Problematic vulnerable images	2	3	3	3	1	2
Triangle of punishment	3	2	2	0	0	0

[a]0=did not occur, 1=minor emphasis, 2=moderate emphasis, and 3=major emphasis.

well as the patient's past or current relationship with anyone other than the therapist (the latter was designated as the patient-other relationship). We looked at therapist actions in terms of the standard analytic technique of interpreting 1) defense, 2) anxiety, and 3) the underlying feeling or impulse (15–18, 24, 25). We noted whether the therapist addressed the defense the patient used to ward off problematic feelings and whether the problematic feelings themselves were addressed. Our observations focused on the patient's interpersonal behavior patterns, not just his or her intrapsychic representations. The problematic feelings and defenses were noted to occur in relation to the therapist or in relation to others in the patient's life.

As an example of addressing a problematic feeling in relation to the therapist, the therapist might say, "You seem uncomfortable with me today," or "You are feeling angry toward me." As an example of addressing defenses in relation to the therapist, the therapist might say, "You change topics just when you begin to express feelings about me," or "When you begin to feel angry with me, you withdraw and fall silent."

We looked at whether the therapist addressed prob-

lematic relationship patterns that the patient repeated in important interpersonal experiences. We conceptualized problematic relationship patterns in the following two ways: 1) that the patient had a problematic powerful self-image as a strong and hurtful person in relation to a weak and vulnerable other, and 2) that the patient had a problematic vulnerable self-image as a weak and injured person in relation to a powerful and hurtful other.

As an example of addressing a problematic vulnerable image in the patient-therapist relationship, the therapist might say, "When I made that comment, you felt I was being critical of you," or "You felt I abandoned you when I was away on vacation." As an example of addressing a problematic powerful image in the patient-therapist relationship, the therapist might say, "You are very afraid you're going to hurt me if you tell me what you think of me," or "You feel you have to take care of me the same way you felt protective toward your father."

We conceptualized a dynamic constellation related to the problematic powerful image as the "triangle of punishment." It involves three interrelated elements: a problematic powerful image, the associated guilt, and the expectation or need for punishment. In this dynamic the patient feels guilty about his underlying sense of powerfulness, destructiveness, or omnipotence and expects punishment or punishes himself. Self-punishment may take the form of gross self-destructive acts such as suicide or drug abuse or more subtle forms such as the compulsive need to recreate or remain in unsatisfying relationships, retain symptoms, or avoid valuable opportunities for change.

RESULTS

The ratings of therapist actions in cases 1–6 are presented in table 3. The therapist actions that were differentially present in the two groups with improved alliances and unimproved alliances are the following.

1. The therapist addressed defenses the patient used to deal with feelings in relation to the therapist and to others in the improved alliance cases but not in the unimproved alliance group. This was the most salient and consistent finding that differentiated the groups.

2. The therapist addressed the triangle of punishment, that is, the patient's need for self-punishment to assuage the guilt over feelings of anger or responsibility for another person's suffering. The therapist did not address the triangle of punishment in the cases with unimproved negative alliances but did so in the improved alliance cases in both the patient-therapist relationship and the patient-other relationship.

3. The therapist addressed the patient's problematic feelings in relation to the therapist in the improved alliance cases. In two of the three unimproved alliance cases, the therapist tended to ignore or avoid addressing the patient's problematic feelings in relation to the therapist. Even when the therapist was cognizant of problematic feelings the patient had about him (as noted in the process notes) and even when the patient was fairly explicit in expressing negative reactions to the therapist, the therapists in the unimproved alliance cases tended to focus the discussion on problematic feelings and conflicts in the patient's current or past interpersonal relationships rather than directly on the patient-therapist relationship. In all of the improved alliance cases, both the problematic feelings and defenses were addressed and appropriately linked by the therapist. In the unimproved alliance cases, either the defense or the problematic feeling was addressed, or neither was addressed.

The therapist actions that did *not* differentiate the two groups with improved and unimproved therapeutic alliances included the following: 1) vigorously addressing the problematic feelings and the problematic role relationships in the patient-other relationships, and 2) addressing problematic powerful images or problematic vulnerable images; interpretations linking the patient's reactions to parents in the past to the patient's similar reactions to the therapist in the present were infrequent therapist actions.

The following brief transcript from hour 6 in a case with improved alliance and good outcome illustrates how the therapist addressed the problematic feelings and the defenses used to ward them off.

Therapist: I wonder if you're not angry with me.
Patient: I don't think so. . . .
Therapist: Silence is an effective way of expressing anger. With me, if hostility comes up you have to bite your tongue because you can't say anything bad. . . . Instead of having angry or disappointed feelings [toward your boyfriend] it is safer to have no feelings. . . . It's hard for you to see feelings in yourself you see as hurtful. . . . You lock feelings away— you think they're destructive. . . . You talk about anger, but you smile. How do you put that together?
The patient later said, "I don't tell him—it goes along with what you said—I give him the silent treatment. I must be angry."

DISCUSSION

Earlier studies of the therapeutic alliance reported fairly stable alliance scores over the course of brief therapy (1–4). We have found that while this may be generally true, there are at least some instances in which the alliance scores reflect an increased willingness and capacity of the patient and therapist to work together. There seem to be therapeutic approaches that can improve an initially poor therapeutic alliance and ultimately contribute to a better therapeutic outcome.

The findings of this study are quite consistent with current standard psychoanalytic theory and technique. Brenner (24) emphasized interpreting defense and underlying feelings together. Gill (25) placed a high value on interpreting the patient's feelings about the therapist in the here-and-now. It seems that in the cases of unimproved alliance and poor outcome reviewed in this study, the therapists deviated from standard technique. These cases seemed to illustrate what Langs called "misalliances" (10), in which the therapists overemphasized reality problems at the expense of exploring feelings about the treatment situation. This all took place in an apparently supportive, caring, and empathic therapeutic milieu, as indicated by comparably positive ratings for both groups on the therapist contribution to the alliance.

Our results may help explain the negative findings of certain earlier psychotherapy research studies (1, 26, 27), which reported that interpretive work did not correlate with outcome. In all six cases in this study, there was substantial interpretive work done. We found that a highly specific set of interpretations which were relevant to the alliance made the difference. Interpretive work that avoided rather than addressed a poor alliance was not ultimately successful in attaining an improved alliance or good outcome.

LIMITATIONS OF THE STUDY

This was an exploratory study and not a carefully controlled correlational study. While alliance ratings were reliably generated by raters blind to process and outcome, the clinical review of therapist actions was done by one person and therefore was subject to bias. The six cases studied were not balanced for several possible confounding variables including age, type of stress event, quality of social support, or other patient factors that might play a prognostic role. Future studies will address these issues as well as systematically examine the role of countertransference in cases of problematic alliances.

Even though these subjects were selected from a larger cohort of patients found to be comparable to general psychiatric outpatients in terms of presenting symptoms, the generalizability of these findings for nonbereaved samples requires further investigation.

CONCLUSIONS

One of the conclusions drawn in both the clinical (8, 12) and empirical (1, 4, 26) literatures is that patients

who are not readily able to form an initial working alliance with the therapist should be excluded from brief dynamic psychotherapy. In our study some patients with initially poor therapeutic alliances did develop improved alliances during the course of brief therapy and did have successful outcomes. We suggest that there were some therapist actions which were present in the improved alliance cases, as contrasted with the unimproved alliance cases.

REFERENCES

1. Gomes-Schwartz B: Effective ingredients in psychotherapy: prediction of outcome from process variables. J Consult Clin Psychol 46:1023–1035, 1978
2. Hartley D, Strupp H: The therapeutic alliance: its relationship to outcome in brief psychotherapy, in Empirical Studies of Psychoanalytic Theories, vol 1. Edited by Masling J. Hillsdale, NJ, Erlbaum, 1983
3. Luborsky L: Helping alliances in psychotherapy, in Successful Psychotherapy. Edited by Cleghorn JL. New York, Brunner/Mazel, 1976
4. Strupp HH: Success and failure in time-limited psychotherapy, a systematic comparison of two cases: comparison 2. Arch Gen Psychiatry 37:708–716, 1980
5. Horowitz M, Marmar C, Weiss D, et al: Brief psychotherapy of bereavement reactions: the relationship of process to oucome. Arch Gen Psychiatry 41:438–448, 1984
6. Zetzel E: Current concepts of transference. Int J Psychoanal 37:369–376, 1956
7. Zetzel E: The Capacity for Emotional Growth. New York, International Universities Press, 1970, pp 182–196
8. Greenson R: The Technique and Practice of Psychoanalysis. New York, International Universities Press, 1968, pp 190–224
9. Gutheil TG, Havens LL: The therapeutic alliance: contemporary meanings and confusions. Int Rev Psychoanal 6:467–481, 1979
10. Langs R: Therapeutic misalliances. Int J Psychoanal Psychother 4:77–105, 1975
11. Basch MF: Doing Psychotherapy. New York, Basic Books, 1980
12. Langs R: Psychotherapy, a Basic Text. New York, Jason Aronson, 1982
13. Kohut H, Wolf ES: The disorders of the self and their treatment: an outline. Int J Psychoanal 59:413–425, 1978
14. Masterson JF: The borderline adult: therapeutic alliance and transference. Am J Psychiatry 135:437–441, 1978
15. Arlow JA: Conflict, regression, and symptom formation. Int J Psychoanal 44:12–22, 1963
16. Fenichel O: Problems of Psychoanalytic Technique. Albany, Psychoanalytic Quarterly, 1941, pp 38–64
17. Malan D: Individual Psychotherapy and the Science of Psychodynamics. London, Butterworths, 1981
18. Menninger K: The Theory of Psychoanalytic Technique. New York, Basic Books, 1958
19. Derogatis LR, Rickels K, Rock AF: The SCL-90 and the MMPI: a step in the validation of a new self report scale. Br J Psychiatry 128:280–289, 1976
20. Horowitz MJ: Phase oriented treatment of stress response syndromes. Am J Psychother 27:506–515, 1973
21. Horowitz MJ: Stress Response Syndromes. New York, Jason Aronson, 1976
22. Horowitz MJ, Kaltreider N: Brief psychotherapy of stress response syndromes, in Specialized Techniques in Individual Psychotherapy. Edited by Karasu TB, Bellak L. New York, Brunner/Mazel, 1980
23. Marmar C, Marziali E, Horowitz et al: The development of the therapeutic alliance rating system, in The Psychotherapeutic Process: A Research Handbook. Edited by Greenberg L, Pinsot W. New York, Guilford Press (in press)
24. Brenner C: Psychoanalytic Technique and Psychic Conflict. New York, International Universities Press, 1976
25. Gill MM: Analysis of Transference, vol 1: Theory and Technique. New York, International Universities Press, 1982
26. Luborsky LR, Mintz J, Auerbach A, et al: Predicting the outcome of psychotherapy: findings of the Penn Psychotherapy Project. Arch Gen Psychiatry 37:471–481, 1980
27. Sloane RB, Staples FR, Cristol AH, et al: Psychotherapy Versus Behavior Therapy. Cambridge, Harvard University Press, 1975