Therapist Actions That Address Initially Poor Therapeutic Alliances in Psychotherapy

Steven A. Foreman, M.D., and Charles R. Marmar, M.D.
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. (Am J Psychiatry 142:922-926, 1985)

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.

Presented at the 15th annual meeting of the Society for Psychotherapy Research, Lake Louise, Alta., Canada, June 19-23, 1984. Received Oct. 4, 1984; revised Feb. 19, 1985; accepted March 19, 1985. From the Center for the Study of Neuroses, Department of Psychiatry, Langley Porter Psychiatric Institute, University of California, San Francisco. Address reprint requests to Dr. Marmor, Langley Porter Psychiatric Institute, Box 17A, 401 Parnassus Ave., San Francisco, CA 94143.

Supported in part by Clinical Research Center grant 5M01-30889 and grant MH-34337 from NIMH.

The authors thank Merril J. Fischwitz, M.D., and Daniel S. Weisz, Ph.D., who provided consultation in this study; Michael Windholz, Ph.D., and William Dickman, M.D., who served as clinical editors; Nancy Wilcox for editorial assistance; and Susan Remmer for help with manuscript preparation.

Copyright © 1985 American Psychiatric Association.

The term "therapeutic alliance" (6) was defined by Zeidler 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 castrate, 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 to the face of the patient's challenges and deprivations 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 border-line patients is at first fragile 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 acutely 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
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 post-traumatic 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 patient's positive contribution to the alliance, the patient's negative 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 outcomes 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 and determined by 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 outcomes. The other three patients had sustained poor alliance 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' blinded 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 reviewer was preformed by one person (S.A.E.), 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 action 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 manner the clinical phenomena 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

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (years)</th>
<th>Marital Status</th>
<th>Occupation</th>
<th>SCL-90 T Score</th>
<th>ISQ T Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33</td>
<td>Mother, Single</td>
<td>Research technician</td>
<td>68</td>
<td>0.77</td>
</tr>
<tr>
<td>2</td>
<td>53</td>
<td>Father, Married</td>
<td>PTTT salesperson</td>
<td>62</td>
<td>1.00</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>Mother, Single</td>
<td>Student</td>
<td>52</td>
<td>3.38</td>
</tr>
<tr>
<td>4</td>
<td>51</td>
<td>Mother, Single</td>
<td>Teacher</td>
<td>55</td>
<td>2.46</td>
</tr>
<tr>
<td>5</td>
<td>42</td>
<td>Husband, Widowed</td>
<td>Bilk accountant</td>
<td>52</td>
<td>0.67</td>
</tr>
<tr>
<td>6</td>
<td>65</td>
<td>Husband, Widowed</td>
<td>Housewife</td>
<td>54</td>
<td>1.19</td>
</tr>
</tbody>
</table>

*ISQ=Impact Scale.

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

<table>
<thead>
<tr>
<th>Rating of Therapist Actions</th>
<th>Improved Cases</th>
<th>Unimproved Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-therapist relationship</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>Defenses</td>
<td>3 3 3 1 1 0</td>
<td></td>
</tr>
<tr>
<td>Problematic feelings</td>
<td>3 3 3 1 1 0</td>
<td></td>
</tr>
<tr>
<td>Problematic relationship patterns</td>
<td>3 2 3 2 1 0</td>
<td></td>
</tr>
<tr>
<td>Problematic powerful images</td>
<td>3 2 1 0 3 0</td>
<td></td>
</tr>
<tr>
<td>Problematic vulnerable images</td>
<td>3 2 1 0 3 0</td>
<td></td>
</tr>
<tr>
<td>Triangle of punishment</td>
<td>3 0 1 0 0 0</td>
<td></td>
</tr>
</tbody>
</table>

*ISQ=Impact Scale.

As an example of addressing a problematic vulnerable image in the patient-therapist relationship, the therapist might say, "You feel 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." As an example of addressing a problematic vulnerable image, the therapist might say, "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 underestimation of the therapist's power, destructiveness, or omnipotence and expects punishment or punishes himself. Self-punishment may take the form of more 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 therapist 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 alliance 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 important therapist actions.

The following brief transcript from hour 6 in a case with improved alliance and good outcome illustrates how the therapist addressed be 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 because 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 defenses 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 took place in an apparently supportive, caring, and empathic therapeutic milieu, as indicated by comparatively 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 repudied 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 probably generated for better or worse by the patient 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 pragmatic 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
12. Lang B: Psychotherapy, a Basic Text. New York, Jason Aronson, 1982