# Clinicians Reading Research: Is the Alliance Really Therapeutic?

*By Dr. Karl Stukenberg, commenting on:*

> Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist, 72*, (4), 311-325. http://psycnet.apa.org/journals/amp/72/4/311/

Last year I was surprised to read an article in JAPA that was filled with statistics. This week I was equally surprised to receive an email from APA about the current American Psychologist, to click on the link, and to find that the first reference in the article was to Freud. Once upon a time I won a bet with a behaviorist friend that Freud was cited more during a specific time frame than Skinner, but it seemed to me that the time was long past when psychoanalytic or psychodynamic articles would be the lead in the American Psychologist.

The second surprise was the title. It appears from the title that the article is calling into question the primacy of the alliance as a predictor of therapeutic outcome. Both my clinical and my evidence based selves reacted to this.

Haven't we fought long and hard to have Freud's (1937/1964) "unobjectionable" transference (which this article cites in its opening passage and which in itself was wrestled from the "objectionable", meaning pathological, transferences - as if these and other transferences really could be, in the words of one my favorite supervisors, "analyzed away") to become, again following the article's lead, Greenson's (1965) working alliance and the many mutations of that before and since?

On the evidence based side, haven't we learned from the various editions of Bergin and Garfield (Lambert, 2013) that the best two predictors of treatment outcome are: Number one: patient variables and Number two: the quality of the treatment alliance? OK, I decided, for the first time in a long time, that I have to read this American Psychologist article…

The long and short of it is that the author is suggesting that the alliance has been seen in two different ways theoretically – "…as a byproduct of effective treatment or as a common nonspecific factor enabling the truly effective ingredients of treatment to work." (p. 311) The research problem has been that the correlation between the quality of the alliance and the outcome of treatment has been used by both camps to support their positions. The author states that her new empirical approaches have allowed us to begin to question how the alliance works – and she proposes two different ways this can happen.

Her empirical work has been to distinguish between two types of alliance – trait-like alliance and state-like alliance. Trait-like alliance is essentially the capacity of the patient, pre-treatment, to engage in relationships with other people. If the patient forms strong relationships with others before going into treatment, they will likely do this relatively quickly within the context of a treatment relationship. If this is a strength for the patient, Zilcha-Mano posits that they are likely to quickly feel connected with the therapist and be ready to work on issues.

State-like alliance is the development of the alliance across the course of the treatment. It is a measure of the strength of the alliance at this moment with this treater. As the paragraph above suggests, when trait-like alliance is high, we expect state-like alliance to be high from the beginning of treatment. For many of our patients, of course, they do not have high trait-like alliance – and the focus of our work is on developing state-like alliance, with the intention of this generalizing beyond the treatment to trait-like alliance.

The author uses the data not to support one or the other of the existing hypotheses, but, as often turns out to be the case (e.g. the nature vs. nurture debate) to propose that both have some truth and she creates a more complex, dynamic, and, I think, potentially useful way to think about the alliance. She suggests that the trait like alliance enables the active elements of the treatment to work – essentially supporting the nonspecific factor position. The treatment implication of this is that – if the alliance is good at the outset, it makes sense to focus on the "other" active ingredients of the treatment. But she goes on to suggest that, especially for those who do not come to treatment with trait-like alliance, the process of working on the state-like component of the alliance in the current treatment is a potential curative factor in and of itself. She uses, as evidence, that when the alliance is measured across time in treatments with initially low state-like alliance, symptom reduction occurs only *after* state-like alliance has begun to improve. The treatment implication, then, is that attending to the alliance should be a central focus of the early part of the work in patients with impaired trait-alliance – and thus state-alliance.

How do we measure alliance? Most of these studies used the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). I think one way of applying this study would be to administer the WAI at each session and track the changes in it across time. A less intrusive and more clinically reasonable way of applying these results would be to use the initial assessment of the patient as a time, which we usually do, to assess object relations and representations of self and others and then to apply that to predicting the trait-like alliance. At this point decisions could be made about the focus of treatment. When we do this assessment, we should, of course, not be flat-footed about it but think about the quality of the relationships the patient is likely to engage in. As the author points out, highly anxiety driven attachment styles may predict a high trait-like alliance – but this highly defensively tinged alliance, one based primarily on a wish for merger – may interfere with the patient being able to productively engage autonomously – and state-like alliance may be an important focus of treatment in this apparently high-trait alliance patient (for instance noting that the alliance is not as solid as it seems because the patient does not yet authentically believe the therapist will be there for them).

Zilcha-Mano also points out that the results of this work are pan-theoretical. CBT generally assumes a good trait-alliance and therefore state alliance. If that isn't present, the process needs to be altered to include more of what that camp refers to as "listening skills". I think we might want to, in our training clinics, be thinking about which of our trainees have these "listening skills" – which we might characterize as the ability to focus on the process and the here and now transference experience. We might want to both refer appropriate cases to them (low trait-alliance patients), but also use them as exemplars for the other trainees. Our trainees seem to increasingly want to know how to do, on a step by step basis, therapy. Reviewing tapes in group supervision of those who more naturally are able to do this complex but also

intuitive work may help the jittery novice see that they, too, can engage in this kind of conversation.

From my early days of working as a paraprofessional, I have always preferred to work with more challenging cases. I used to take the position that this was because the expectations were lower with more difficult cases and, if they failed, I could blame it on the patient rather than myself. While I think there is some truth to that, I actually think that what this article illustrates is that one of the therapeutic draws for me is to build relationships with people who have difficulty trusting in others. I find that a challenge and an opportunity. And I think the author of this paper believes that this allows the state-like alliance issues to come into play – and affords us (the therapeutic pair) more room to focus on the interaction between us, something that I also find engaging (OK, and gratifying too – apparently that hasn't been "analyzed away"…). Of course, the shifts in state-analysis will, if internalized, lead to shifts in trait-alliance which will prepare the patient to make better use of future relationships.

I have also found, though, that some types of trait-like alliances are better for me to work with than others. I am better able to work with Blatt's (1995) introjective and alliance challenged patients than with his anaclitic and alliance challenged ones. Perhaps as the research expands into looking at the trait-like alliance capacities of therapists, it will also take into account the nuances of those alliance capacities so that we can continue to move towards a goal of finding what treater using what treatment will work best with which patient at what moment in their developmental arc.

By the way, my focus on the type of client with whom I work best is intended to be illustrative. Having a case load full of patients with trait-like alliance difficulties is probably not good for anyone. We also need to be responsive to our patients – and having the ability to distinguish clinically and conceptually between trait-like and state-like alliance should help us better be able to do that.

Blatt, S. J. (1995). The destructiveness of perfectionism: Implications for the treatment of depression. The American Psychologist, 50, 1003-1020. http://psycnet.apa.org/journals/amp/50/12/1003.pdf

Freud, S. (1964). Analysis terminable and interminable. In J. Strachey (Ed.), *The standard edition of the complete psychological work of Sigmund Freud* (pp.209-254). London, United Kingdom: Hogarth Press. (Original work published 1937).

Green R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, *34*, 155-181.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*, 223-233. http://dx.doi.org/10.1037/0022-0167.36.2.223

Lambert, M. J. (2013). Bergin and Garfield's handbook of psychotherapy and behavior change. Hoboken, N.J. : John Wiley & Sons, c2013.

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