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The Therapeutic Alliance in Brief Psychotherapy: General Principles

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The previous chapters provide a wide array of both common and unique perspectives on the conceptualization and management of the therapeutic alliance in short-term psychotherapy. In this chapter, we summarize some of the major principles emerging from our reading of these chapters. We then adapt a model emerging from our own research on resolving ruptures in the therapeutic alliance, for the purposes of further clarifying some of the principles involved in working through termination issues in short-term psychotherapy.

General Principles

Because of the constraints of short-term therapy, patient selection is particularly important. A number of contributors to this book (e.g., Binder, chapter 3; Newman, chapter 5; Watson & Greenberg, chapter 6) emphasize the importance of selecting patients who are at a relatively high level of interpersonal functioning. When time is limited, it is critical to be able to establish an adequate therapeutic alliance reasonably early. Thus, patients who are seriously impaired in their fundamental capacity to trust other people are more likely to benefit from a longer term treatment, in which the establishment of a therapeutic alliance can become the work of the therapy, rather than a precondition for treatment. MacKenzie (chapter 9) adds another important con-

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sideration from a group perspective in suggesting that patients should be selected in terms of homogeneity with respect to important dimensions (e.g., diagnostic conditions such as depression) in order to maximize group cohesiveness.

Facilitate the development of the bond aspect of the therapeutic alliance by conveying warmth, respect, and genuine interest. Although attention to the bond aspect of the therapeutic alliance is important in all forms of therapy, it is particularly important in brief therapies, which are likely to place strains upon the patient–therapist relationship because of the high level of activity and the relatively short time frame. Binder (chapter 3) emphasizes the importance of conveying respect and warm interest in patients and of treating them as "co-equal collaborators." Newman (chapter 5) suggests that cognitive therapists should strive to be "part Marcus Welby and part Sherlock Holmes" (i.e., combine an attitude of warm benevolence with one of systematic, critical thinking). Watson and Greenberg (chapter 6) emphasize that the establishment of safety and trust is critical in order to allow patients to engage in the task of turning attention inward to symbolize experience in new and safe ways.

Outline the therapeutic rationale (including tasks and goals) at the beginning of treatment. Explicitly educating patients about the therapeutic rationale is conventionally more common in the cognitive behavioral tradition than it is in other approaches. This is consistent with the psychoeducational dimension of this approach (Newman, chapter 5). Because the rapid establishment of a therapeutic alliance is a priority in short-term therapy, however, the explicit discussion of therapeutic tasks and goals at the outset can be particularly important (e.g., Been & Winston, chapter 2; Watson & Greenberg, chapter 6). In longer term therapies, the ongoing negotiation of therapeutic tasks and goals is a central part of the therapeutic process. Although this is true to some extent in short-term therapy, a clear lack of fit at the outset between the therapeutic rationale and the patient's sensibilities may be grounds for trying a different therapeutic modality. In some cases, a patient's skepticism about the therapeutic rationale may reflect a more general and fundamental skepticism that may make it difficult to establish a therapeutic alliance in a short period of time. In such cases, long-term treatment may be indicated.

Establish realistic goals. Whether the therapeutic goals are framed in terms of specific target problems (as is more common in the cognitive–behavioral approach) or in terms of more general capacities (e.g., the ability to self-observe), it is critical to establish limited and realistic goals (e.g., Newman, chapter 5; Watson & Greenberg, chapter 6). Coyne and Pepper (chapter 7) add that from a strategic perspective it can be useful to work toward specific, small changes in behavior in order to ultimately

instigate change of a more general nature. Limiting one's therapeutic ambitions can be as difficult for therapists as it is for patients; the ability to do so can require a fundamental change in attitude for therapists who are more accustomed to practicing long-term therapy. Furthermore, even when limited and realistic goals have been agreed upon, it is highly likely that patients will experience some degree of disappointment and resentment when the reality of this limitation is experienced at termination (e.g., Been & Winston, chapter 2, and MacKenzie, chapter 9). It is thus critical for the therapist to be prepared to process whatever painful and negative feelings that emerge about termination in a nondefensive fashion.

As therapy proceeds, be prepared to educate or remind patients about the purpose or function of therapeutic tasks that do not make sense to them. Whether the task consists of speaking to an empty chair (as in Gestalt therapy), trying an experiment between sessions, or exploring the therapeutic relationship in the here and now, outlining or reminding the patient of the underlying rationale can play an important role in developing and maintaining a therapeutic alliance (e.g., Watson & Greenberg, chapter, 6; Been & Winston, chapter 2). This is particularly important when the relevance of the task to the patient's problem is not immediately apparent to him or her or when the task is anxiety provoking.

Establish and maintain a therapeutic focus. Different approaches tend to do this in different ways. Short-term dynamic approaches tend to emphasize the importance of case formulation. Binder (chapter 3), for example, emphasizes the importance of making proplan interpretations, that is, interpretations that are likely to disconfirm patients' pathogenic beliefs. Cognitive–behavioral approaches (e.g., Newman, chapter, 5) tend to emphasize the importance of working collaboratively with patients to establish therapeutic agendas. Watson and Greenberg (chapter 6) emphasize the importance of attending to the live, poignant aspects of patients' experience in order to help illuminate their inner tracks. Been and Winston (chapter 2) emphasize that although it is important to establish a focus, it is also important to be attuned to rapid shifts in the dynamic issue that is salient in a given session.

Maintain a balance between activity and receptivity. Because short-term therapies tend to be relatively active, it can be easy to misattune to the patient's fluctuating needs and experience, thereby jeopardizing the therapeutic alliance. On the other hand, failure to be sufficiently active with the patient can lead to a lack of therapeutic focus and a subsequent deterioration in the alliance. Been and Winston (chapter 2) emphasize that the consistent confrontation of defenses must be balanced with the reduction of pressure when the alliance is strained.

Watson and Greenberg (chapter 6) emphasize the importance of balancing the directiveness characteristic of Gestalt therapy and process–experiential work with adequate responsiveness to patients' moment-by-moment experiences.

Where possible, minimize the enactment of vicious cycles. Strategic therapists (e.g., Coyne & Pepper, chapter 7) suggest that therapists can establish an alliance by avoiding others' problem-maintaining solutions. Psychodynamically oriented therapists speak about the importance of minimizing transference and countertransference enactments. As Binder (chapter 3) points out, it is inevitable that therapists will be recruited into the countertransferential roles associated with the patient's salient maladaptive interpersonal patterns. In long-term therapy, therapists have more time within which to disembed themselves from these enactments. Short-term treatment places greater pressure on therapists to be alert to these patterns and to avoid them when possible. It is critical to recognize, however, that such enactments are inevitable, and that in fact, the belief that one can avoid them can make it more difficult to recognize them when they occur.

Alliance ruptures must be detected early on and addressed. Most contributors to this volume emphasize the importance of detecting and addressing problems in the therapeutic alliance. Binder (chapter 3) maintains that it is critical for the therapist to pick up on subtle patient communications about problems in the alliance and also on disguised allusions to the therapeutic relationship. Although he agrees with interpersonal and relational theorists who theorize that transference and countertransference enactments are an inevitable part of therapy, he believes that in short-term therapy, it is crucial for therapists to minimize the amount of time participating in these enactments and to establish the examination of these enactments when they occur as the first priority. Consistent with a relational perspective, he emphasizes the importance of recognizing the therapist's contribution to the rupture and the importance of acknowledging this contribution to the patient when appropriate. Been and Winston (chapter 2) maintain that it is critical for therapists to be sensitive to patients' communications about therapist errors and not to interpret patients' experience in such cases as fantasies about the therapist or as transference. Kohlenberg, Yeater, and Kohlenberg (chapter 4) maintain that problems in the therapeutic relationship may be functionally similar to problematic interpersonal patterns that are characteristic for the patient. Consistent with a central thrust of psychoanalytic thinking, they emphasize the valuable opportunity that alliance ruptures present for providing patients with a corrective interpersonal experience. Watson and Greenberg (chapter 6) suggest that therapists should be particularly alert to difficulties patients may have in engaging in vari-

ous tasks and should be careful not to coerce them. They emphasize the value of therapeutic metacommunication, both for purposes of negotiating agreement about tasks and goals and for illuminating characteristic patient patterns that may be contributing to misunderstandings. Finally, MacKenzie (chapter 9) highlights the complexity of the group setting by pointing out the importance of exploring and negotiating conflict between group members, as well as between group members and the therapist. From his perspective, the emergence of conflict between group members is a characteristic of the differentiation stage of group development, and the management of group conflict is an important change process.

Be aware of the types of alliance ruptures characteristic of particular approaches. Different therapeutic approaches emphasize different therapeutic tasks and goals, which are likely to be associated with different characteristic strains upon the alliance. Newman (chapter 5) points out that patients in cognitive therapy may perceive the therapist as "Pollyannaish" or patronizing, rather than optimistic or energizing, and he emphasizes the importance of being sensitive to this possibility. He also suggests the importance of being alert to struggles over control that may be emerging in response to the active and prescriptive nature of the approach. Watson and Greenberg (chapter 6) maintain that patients in person-centered therapy may feel particularly frustrated at the nondirective aspect of the approach, especially in the context of time-limited therapy. Been and Winston (chapter 2) note that brief psychodynamic approaches that emphasize the repeated confrontation of defenses and consistent pressure to experience underlying affect put particular strains on the alliance. High levels of therapist activity, they note, are by their very nature intrusive. They emphasize the importance of repeatedly reminding patients about goals that have been agreed upon and of processing alliance ruptures when they emerge. In general, it seems important to be aware of and prepared to acknowledge patients' realistic perceptions of problematic features of the approach, while at the same time, being prepared to explore the idiosyncratic meaning of these features for patients (e.g., Binder, chapter 3; Kohlenberg, Yeater, & Kohlenberg, chapter 4).

Be aware of the multiple alliances within a system. From different perspectives, both MacKenzie (chapter 9) and Rait (chapter 8) emphasize the importance of recognizing the multiple alliances within systems. In groups, therapists need to be concerned both with their alliance to the group and the alliances among members of the group (group cohesion). MacKenzie gives priority to the promotion of group cohesiveness, through the use of interventions such as promoting dialogue between members of the group rather than with the therapist. Rait discusses different perspectives on the establishment of the alliance

with couples and families. Some systemic therapists emphasize the importance of maintaining an equidistant position from members of the system and a stance of neutrality. Others emphasize the importance of joining with different parts of the system at different times in order to shift the functioning of the system. The second perspective views the alliance as dynamic and shifting in nature and as a potent mechanism of change in and of itself.

Prepare patients for termination and explore its meaning for them. Preparing for and dealing with the meaning of the time limit is a central feature of all short-term therapy approaches. Been and Winston (chapter 2) follow Mann in suggesting that the constraints of brief therapy heighten the universal conflicts surrounding the repetitive separation crises experienced throughout life. MacKenzie (chapter 9) devotes the last few sessions of time-limited group therapy to processing predictable themes emerging around termination, such as feelings of not getting enough from therapy, facing loss, assuming responsibility for the self, and attendant feelings of anger and resentment. Newman (chapter 5) describes two extreme patient styles of dealing with the time limit. One extreme involves failing to invest in the therapy and to form a solid alliance because of the fear of loss and abandonment. The other involves throwing oneself into the treatment and the therapeutic relationship and then responding with intense grief or resentment, which if not dealt with adequately can jeopardize the alliance and the treatment. Kohlenberg, Yeater, and Kohlenberg (chapter 4) emphasize the importance of exploring the idiosyncratic meaning of termination for patients and responding accordingly. They suggest, for example, that for one patient, processing the meaning of an unchangeable time limit may be therapeutic, whereas for another, extending the termination date in response to his or her request may be therapeutic.

Termination in short-term therapy can be thought of as the ultimate rupture of the therapeutic alliance. It is inevitable that patients will have intense, conflicting feelings around termination: feelings of gratitude mixed with feelings of loss, disappointment, and resentment. If the therapeutic alliance is solid enough, these feelings can be tolerated and accepted by the therapist and processed in a fashion that allows the patient to come to terms with the meaning of termination. This process can help patients come to accept both the validity of their needs for help and support and the reality of the limitations of the therapeutic frame, without invalidating their own needs or devaluing what the therapist can offer. If, however, therapists become threatened by patients' needs and intense feelings around termination, they are likely to respond defensively by attempting to reassure them about the value of therapy or by blaming them for not benefiting. This can

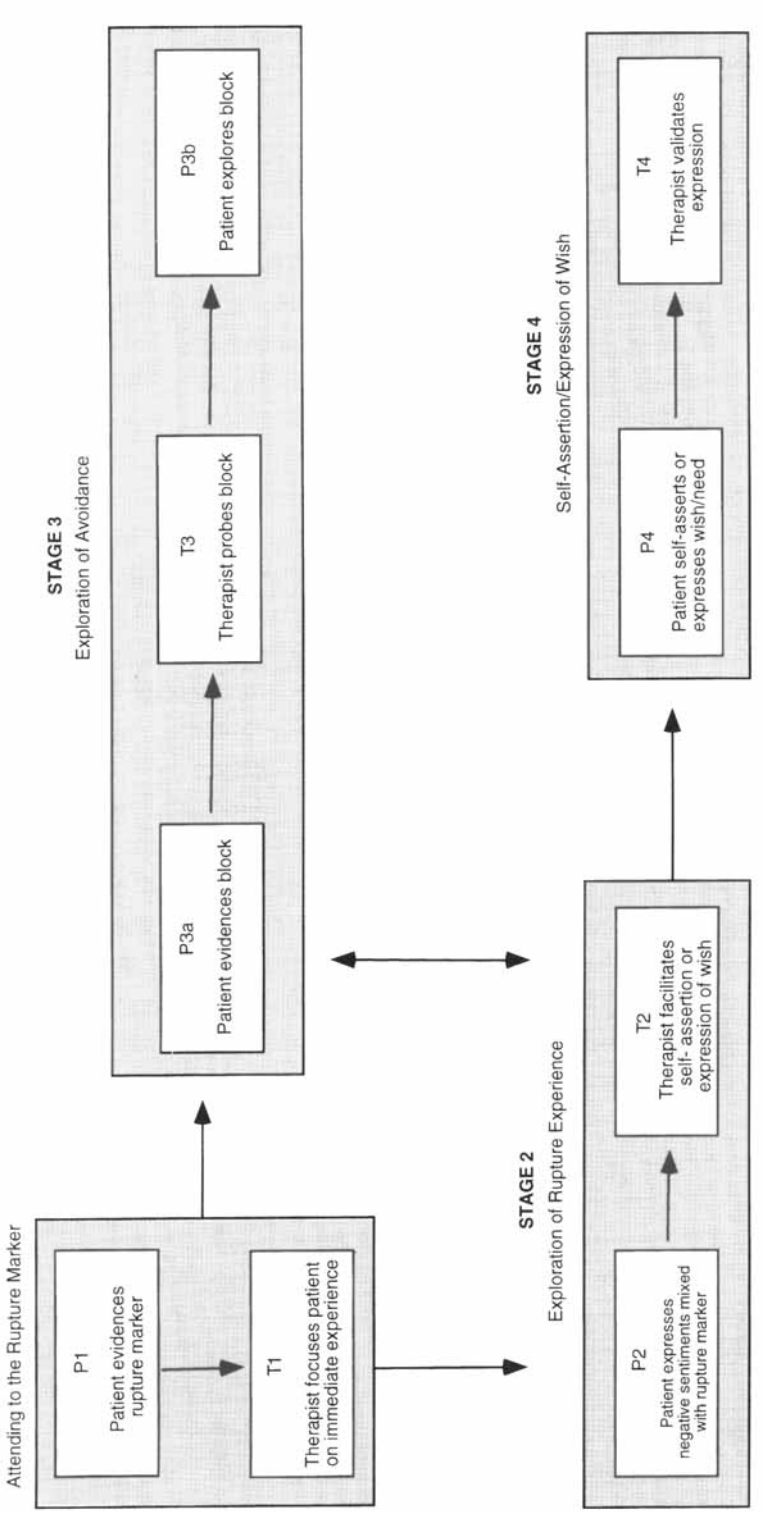
take a severe toll upon the therapeutic relationship and interfere with the opportunity to make constructive use of the termination.

In previous articles, we have explicated a model, emerging from our ongoing research program, that captures the stages that are typically involved in resolving ruptures in the therapeutic alliance (Safran & Muran, 1995, 1996, in press; Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Samstag, 1994). This model can easily be adapted to clarify some of the processes involved in resolving tensions in the therapeutic relationship that emerge around termination in short-term therapy as well. The model consists of four stages: attending to the rupture, exploration of the rupture experience, exploration of the avoidance, and self-assertion or expression of the underlying wish. Each of these stages consists of a combination of patient states and therapist interventions that facilitate the transition between states (see Figure 10.1).

Stage 1 begins with the patient state (P1) involving a verbalization or action that indicates the presence of a rupture in the alliance. There are two major subtypes of ruptures: confrontation and withdrawal. In confrontation ruptures, the patient directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy. For example, the patient says, "We only have four sessions left, and we're not getting anywhere" or " I need more direction from you." In withdrawal markers, the patient withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process. For example, a patient may give up as therapy approaches termination, and she feels that she has gotten what she hoped for. She may not say anything directly, but the therapist may have an intuitive sense that she has withdrawn her investment in the treatment.

Confrontation and withdrawal ruptures reflect different ways of coping with the dialectical tension between the needs for agency and relatedness. In confrontation ruptures, the patient negotiates the conflict by favoring the need for agency or self-definition over the need for relatedness. In withdrawal ruptures, he or she strives for relatedness at the cost of the need for agency or self-definition. Different patients are likely to experience or exhibit a predominance of one type of rupture marker over another, and this reflects different characteristic styles of coping or adaptation. Nevertheless, over the course of treatment, both types of markers may emerge with a specific patient, or a specific impasse may involve both confrontation and withdrawal features. Thus it is critical for therapists to be sensitive to the specific qualities of the rupture that are emerging in the moment, rather than to become locked into viewing patients as exclusively confrontation types or exclusively withdrawal types. It is also important to recognize that these ruptures mark that both patient and therapist are embed-

FIGURE 10.1



Therapeutic alliance rupture resolution model.

ded or hooked in an enactment of a vicious cycle. Thus, it is critical for therapists to become mindful of their contributions to the cycle that is being enacted and to be open to exploring them at any point along the way.

Completing Stage 1, the first therapist intervention (T1) facilitates the exploration of the rupture by directing the patient's attention to the here and now of the therapeutic relationship or to his or her experience. Such a facilitative intervention reflects the therapist's openness and ability to unhook from a vicious cycle. Common examples are statements such as, "What are you experiencing?" or "I have a sense of you withdrawing from me" or "How are you feeling about what's going on between us right now?" Alternatively, the therapist may directly inquire how the patient is feeling about termination. This intervention leads to two parallel pathways of exploration. The first involves the exploration of thoughts and feelings around termination. For example, a desire to extend the treatment beyond the termination date or resentment and disappointment that more changes have not taken place. The second pathway involves the internal processes that block the exploration of feelings and thoughts about termination.

The first pathway can be subdivided into two successive stages (Stages 2 and 4). In the first of these (Stage 2), the patient begins to express thoughts and feelings about termination, but these are mixed with features of the initial rupture marker (either withdrawal or confrontation). In the case of withdrawal features, the patient begins to express negative sentiments or an underlying wish, and then qualifies the statement or takes it back. For example, "Sometimes I begin to feel a little upset with you because I haven't changed more, but I know you've done the best you can." Or "The thought occurred to me to ask for more sessions, but I think that would just be dependency." In the case of confrontation features, the patient expresses his or her feelings in a blaming and belittling way, rather than taking responsibility for them. This patient state should be followed by a therapist intervention (T2) that facilitates self-assertion or the expression of the underlying wish, through acknowledging his or her own contributions to the interaction, refocusing on the here and now of the therapeutic relationship, or the use of an awareness experiment. Examples of acknowledging one's own contribution are as follows: A patient accurately points out that the therapist had been trying to point out therapeutic gains to him rather than hearing about his disappointment, and the therapist acknowledges this. In another example, the therapist says, "You deserve to have somebody be there for you in a consistent fashion over time, and a right to be angry at me for abandoning you." In refocusing on the here and now of the therapeutic relationship, the therapist points out a tendency on the patient's part to diffuse the tension by speaking in general terms. In an awareness experiment, the

therapist suggests that the patient should experiment with directly expressing the feelings that are being avoided and attend to whatever feelings are evoked. If the experiment is successful, the patient's evoked feelings will deepen his or her awareness and acknowledgement of the avoided experience. For example, the patient says, "Sometimes I feel a little upset when I stop to think that you won't be here for me, . . . but it's not a big deal." The therapist responds by saying, "Are you willing to experiment with saying 'I'm pissed off at you for abandoning me' just to see how it feels?" The patient tries the experiment, and subsequently begins to contact some of the anger and sadness he was having difficulty acknowledging.

The second pathway or Stage 3 involves the exploration of beliefs, expectations, and other internal processes that inhibit the acknowledgement and expression of feelings and needs associated with the rupture experience. There are two major subtypes of blocks (P3). The first subtype consists of thoughts, beliefs, and expectations about the other (the therapist) that block the exploration of the rupture experience pathway. For example, the patient who expects expressions of anger to evoke retaliation will have difficulty acknowledging and expressing angry feelings. The patient who believes that expressions of vulnerability and need will result in abandonment will have difficulty expressing such feelings. The second subtype consists of self-critical or self-doubting processes that function to block the acknowledgment or the exploration of the rupture experience pathway. For example, a patient who believes she is childish for feeling sad about the termination of therapy will not be able to explore her feelings of sadness. The patient who believes that she is immature for being angry about termination will have difficulty expressing those angry feelings to the therapist.

In a typical resolution process, the exploration of the rupture experience pathway proceeds to a certain point and then becomes blocked. This is indicated by the patient engaging in coping strategies, defensive verbalizations, and actions that function to avoid or manage the emotions associated with the rupture experience. Examples are changing the topic, speaking in a deadened voice tone, and speaking in general terms, rather than the here-and-now specifics of the therapeutic relationship. The most common facilitative response in such cases is to draw the patient's attention to the defensive or security operations and to probe for inner experience. For example, the therapist might metacommunicate by saying, "It feels to me like you attack and then soften the blow. Do you have any awareness of doing this?" This leads the patient to become aware of his attempts to soften the blow, and then the therapist can ask him to explore the reasons for

doing so. Or the therapist might say, "I'm aware of you looking away when you say that. Are you aware of this?" The patient acknowledges that he is, and the therapist then asks him to explore what is going on.

As patients explore their avoidance and gain greater awareness of the processes interfering with their experience and more of a sense of agency or ownership of these processes, feelings associated with the rupture experience naturally begin to emerge more fully. Patients may move back to the rupture experience pathway spontaneously, or therapists may redirect attention to it once again. Typically, a resolution process involves an ongoing alternation between experiencing and avoidance pathways with the exploration of each pathway functioning to facilitate a deepening of the exploration of the other. It is critical during the exploration of both pathways that the therapist respond to whatever the patient expresses in a validating and accepting fashion. Accepting the patient's response during the exploration of the rupture pathway is critical because this challenges the patient's core organizing principles and provides a new, constructive interpersonal experience.

Expressions of patient hostility or anger are often responded to defensively by therapists or with counterhostility. The likelihood of this type of defensive response increases as termination approaches and therapists feel more vulnerable to the possibility of failing. At such time it can be difficult not to feel that one's treatment has been ungrateful, especially if one has invested oneself in the patient and there have been periods when it looked like progress was taking place. Compliant or avoidant responses to the rupture are often responded to with overbearing or domineering behavior. For example, the patient who responds to an interpretation in a compliant fashion may elicit further attempts on the therapist's part to control, dominate, or tell the patient what to do.

In such situations, it is critical for therapists to become aware of their countertransference feelings and to begin metacommunicating with the patient about the interaction rather than continuing to participate in a vicious cycle. For example, a patient nearing termination might question whether treatment has really been beneficial. The therapist responds by trying to demonstrate the ways in which change has occurred. In turn, the patient becomes more negative and pessimistic. In this situation, it is critical for therapists to begin realizing that they are embedded in a vicious cycle and to begin metacommunicating about what is taking place. For example, a therapist might say "We seem to be caught in a struggle in which you try to express your concerns and I try to talk you out of them." She can then go on to

explore the patient's experience of the interaction. Or alternatively, she might say something like, "I have a sense that I am responding to your concerns by trying to reassure you, rather than allowing you to really explore and express your concerns more fully."

The final stage (Stage 4) of the resolution process entails the patient accessing primary feelings and asserting underlying wishes or needs directly to the therapist (P4). These may be feelings of anger or sadness. Feelings of sadness and disappointment are often mixed with feelings of gratitude. In some cases the patient may ask if it is possible to extend the treatment. If the therapist, in keeping with the time-limited frame, decides not to extend the treatment, it is still important to recognize the legitimacy of the patient's request.

Conclusion

The growing popularity of short-term psychotherapy has been one of the most prominent developments in the mental health field in recent years. Although there is considerable evidence for the effectiveness of different forms of short-term psychotherapy (Messer & Warren, 1995), it is important not to oversell their benefits. The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, for example, showed that at the 18-month follow-up period, only 30% of patients in short-term cognitive therapy and 26% of patients in short-term interpersonal therapy met stringent criteria for recovery (Elkin, 1994). The *Consumer Report* survey on consumer satisfaction with psychotherapy found a substantial advantage to long-term psychotherapy over short-term psychotherapy ("Mental health," 1995).

It is thus important not to regard short-term therapy with a type of simple-minded optimism, in which it appears to be the treatment of choice for all problems, or in which the complexity of human experience and the deep and intractable nature of many types of human suffering are denied. In fact, from our perspective, one of the most important factors in developing and maintaining a therapeutic alliance in short-term psychotherapy is recognizing the difficulty of the human change process and the impossibility of finding simple and definitive solutions to people's problems, while at the same time maintaining a realistically hopeful attitude about the possibility of meaningful change taking place within a short-term framework. In this light, one of the more intriguing findings emerging from research investigating factors associated with the effectiveness of individual therapists in the NIMH collaborative study on the treatment of depression is that ther-

apists (all of whom were conducting short-term treatment) who believed that people take a long time to change were more helpful than those who believed that people could change more quickly (Blatt, Sanislow, Zuroff, & Pilkonis, 1996). Although this finding may appear counterintuitive, it is consistent with an important paradox of psychotherapy: that change is most likely to take place in the context of acceptance. This is particularly important to remember when working within a short-term framework, where the intensified pressure to achieve therapeutic objectives quickly can make it difficult for therapists to accept limitations—both their patients' and their own.

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