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THE CONCEPT OF THE THERAPEUTIC ALLIANCE

by

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A dissertation submitted to the Graduate Faculty in Psychology of the City University of New York in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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Dedicated to my mother and father

PREFACE

I became interested in the concept of the therapeutic alliance through my clinical experiences conducting psychoanalytic psychotherapy at the Psychological Center of City College. I was puzzled to understand why certain patients became more and more engaged in their treatment, while others terminated early. Of those who stayed, I could not fully ascribe their allegiance to transference; and of those who left, I could not truly dismiss their disloyalty as resistance.

The concept of a therapeutic alliance provided for me a rough handle by which to grasp these intriguing clinical experiences. After entrenching myself in the literature on the therapeutic alliance and discussing the subject with supervisors and mentors, I was left with one dominant impression: that this entire concept was highly problematic. It was problematic whether the therapeutic alliance was based on transference or reality; whether it was a peripheral or a central part of treatment; whether the patient or the therapist was responsible for its emergence; and whether there were any special technical measures that facilitated its development.

I began investigating the problems surrounding this concept of a therapeutic alliance in January, 1977. I took as my objective the task of identifying the problems and controversies concerning this idea and to put these issues in an orderly framework. The first fruits of these labors are presented in the pages that follow.

During my work on this project, I had the help and support of many people whom I would like to acknowledge here, though their inclusion by no means implies that they share my responsibility for the final product.

First, I am appreciative of the patients whom I had the privilege of treating at the Psychological Center of City College and at Psychiatric Institute. That note of thanks extends equally to the supervisors and teachers who shared their knowledge of psychotherapy with me, especially Arthur Goldweber and Anni Bergman.

I also wish to thank the librarians and staff at the library of Psychiatric Institute and the Blauvelt Free Library for their unflagging service in providing me with needed bibliographic material.

I want to acknowledge my dissertation committee for the freedom of inquiry granted me in pursuing this topic in my own way. I especially thank my thesis sponsor, Laurence Gould, for his encouragement, assistance, and support during this project as well as throughout my graduate training. I also want to acknowledge the administrative help of Nurith Schwartzbaum at the Psychological Center and Mrs. Daniels at the Graduate Center -- both of whom were always patient, efficient, and reliable.

I am especially appreciative of my fellow graduate students and friends for their help. To Larry Hauser, I am grateful for his tireless assistance in reading and discussing the numerous drafts and revisions of this project. To Susan Taylor, I am grateful for her interest in my project, for her useful editorial suggestions, and for her skillful typing of the final manuscript.

Finally, I want to acknowledge the role my family played throughout this endeavor. I thank my wife Andrea for her unshakeable confidence in me, and I both thank and dedicate this work to my mother and father for all that they have done to make this possible.

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INTRODUCTION

This dissertation attempts to explicate the concept of the therapeutic alliance from historical and theoretical perspectives. Some words of explanation about my method of inquiry are in order.

A conceptual analysis of any major idea in analytic theory rightly begins with a review of its historical development. Usually, such reviews trace the roots of the term under discussion to one of Freud's original papers. This practice is not, I believe, merely a ceremonial obeisance to the founder of the psychoanalytic movement but is, rather, a useful critical method. Since many key analytic notions -- the therapeutic alliance among them -- have been widely accepted into clinical parlance and even everyday language, they have lost their original and quite specific meaning. A study of their historical origins helps restore this lost precision and specificity.

Anyone who has followed a single idea in psychoanalysis from its inception in a paper by Freud to its latest appearance in an analytic journal will be mindful of the dramatic changes that have occurred in analytic theory during this time, and of the corresponding shifts in the significance of the term under investigation. A simple chronology of the relevant papers on a given topic is unlikely, though, to reveal directly these broader shifts in the basic framework of psychoanalytic theory. A more useful historical approach, in my opinion, is one that situates ideas within a basic theoretical framework, or "paradigm" (Kuhn, 1962).

Entailed in this kind of paradigmatic historical investigation is an understanding of the specific theoretical contexts which define particular terms. There are two main advantages to such an approach. First, by recognizing that terms such as "ego" or "transference" are constructs in a particular theory, we avoid the tendency to reify concepts, to use our theoretical language as though it were the thing-language of everyday discourse. Second, by situating terms in their proper theoretical context, we sharpen the focus of our inquiry. The "therapeutic alliance" is a term in psychoanalytic theory, as opposed to learning theory or any other psychological theory. Even more specifically, as I shall later document, the "therapeutic alliance" is a term belonging to psychoanalytic ego psychology.

There are, of course, difficulties in the historical and theoretical approach I have suggested. First of all, it is difficult to assess and evaluate the existence of a paradigm or framework while working within it, and to discern the basic assumptions that limit and shape our own inquiry. Furthermore, psychoanalytic theory is an incompletely formulated system, thereby making it difficult to evaluate on logical grounds alone what terms properly belong to it.

Despite these difficulties in defining historical paradigms and theoretical frameworks in psychoanalytic theory, I believe that such a historical-theoretical method is helpful in explicating the concept of the therapeutic alliance. Accordingly, my investigation of the therapeutic alliance will attempt to understand this concept as it has developed historically within the framework of psychoanalytic ego psychology.

To accomplish this aim, I have organized my material into the

following sequence of chapters:

Chapter One outlines the history of the alliance concept, beginning with Freud's early technical papers and his later clinical writings. The endpoint of my historical review is Zetzel's (1956) paper, a landmark presentation in that it introduced the specific term "therapeutic alliance" into the literature.

Chapter Two begins with a statement of Hartmann's contributions to psychoanalytic theory as a conceptual bridge between Freud's structural theory and modern ego psychology. Within this framework, Greenson's papers on the "working alliance" (Greenson, 1965, 1967) provide a definitive statement of the alliance concept in modern ego psychological terms. In this chapter, I begin my critical examination of the ego psychological approach to the therapeutic alliance, here calling into question the basic dichotomy between the "transference neurosis" and "working alliance."

Chapter Three carries forward this critique, and it specifically addresses the notion that a therapeutic dissociation of the ego into an observing and an experiencing component is the basis of the patient-therapist alliance.

Chapter Four summarizes recent trends in psychoanalysis toward a synthesis of ego psychology and object relations theory. This chapter reviews two major approaches to the alliance concept, building upon this theoretical integration: a developmental approach, stressing the early genetic roots of the alliance; and an interactional approach, highlighting the adaptive significance of the alliance.

Chapter Five presents a synopsis of my own reformulation of the alliance concept as the core of psychoanalytic treatment. This

presentation builds upon earlier arguments against various crucial dichotomies, such as that between the transference neurosis and working alliance, the observing ego and the experiencing ego, and ego psychology and object relations theory. My positive statement considers the therapeutic alliance as the key concept in a theory of the therapeutic process, and it outlines the basic elements in this overall conception.

Chapter Six presents a typology of alliance formation, based on the quality of the patient's object relations. This chapter describes in broad outline three specific types of alliances, referring to them as "symbiotic," "therapeutic," and "working," and linking each with stages in the development of object relatedness.

Chapter Seven considers the practical application of this formulation of the alliance concept to the treatment of patients presenting neurotic, borderline, and psychotic personality organizations. I describe the vicissitudes of alliance formation in these cases and portray the achievement of an alliance as central in the curative process.

Finally, my conclusion addresses some of the larger theoretical and clinical issues concerning the alliance concept and my specific version of it. I consider various possible objections to the wisdom, novelty, emphasis, and sophistication of this idea of an alliance between patient and therapist in psychoanalytic treatment, and I point out how I have attempted to answer these objections. How successfully I have accomplished my aim is, of course, left to the reader's judgment.

CHAPTER ONE

THE ORIGINS OF THE ALLIANCE CONCEPT IN FREUD'S LIBIDO THEORY AND STRUCTURAL MODEL

In an amusing anecdote to the audience of his "Introductory Lectures," Freud (1917) illustrated the vagaries of his success in treating patients with hypnosis:

> On one occasion a severe condition in a woman, which I had entirely got rid of by a short hypnotic treatment, returned unchanged after the patient had, through no action on my part, got annoyed with me; after a reconciliation, I removed the trouble again and far more thoroughly; yet it returned once more after she had fallen foul of me a second time. (pp. 449-50)

Though Freud eventually abandoned the hypnotic method in favor of psychoanalysis, clinical experiences such as this must have impressed upon him the importance of the patient-doctor relationship in determining the outcome of treatment.

Freud found his therapeutic efforts stymied once again by the capriciousness of the patient's attitude toward the physician when he treated a young woman, Dora, psychoanalytically. In this celebrated case (Freud, 1905), Dora abruptly terminated treatment, just at the point where Freud believed he was on the verge of unraveling the true unconscious meaning of his patient's dreams and hysterical symptoms.

In his later reflections on the case, Freud surmised that Dora's termination was a vindictive act on her part, deriving from her hostile

feelings toward her father and his friend, Herr K. Dora had, in short, transferred feelings and attitudes properly belonging to these other figures onto the person of her analyst. Freud had at last come up with the key to the puzzling vicissitudes in the patient-doctor relationship: the phenomenon of transference.

The libido theory of transference

Freud developed his concept of transference in the context of his libido theory of neurosis (Freud, 1915, 1917), which posited an opposition between the self-preservative instincts of the "ego" and the sexual instincts called "libido." According to this theory, neurosis results from the repression of sexual instincts and the partial fulfillment of sexual aims in the form of symptoms.

In psychoanalytic treatment, the original conflicts that had resulted in the formation of symptoms appear anew in relation to the analyst. The analyst attempts to resolve the patient's neurosis in two ways: first, by interpreting the patient's reactions to him as a repetition of the past, he frees the libido bound up in the artificial "transference illness" (Freud, 1917, p. 454); and second, by suggesting to the patient a more enlightened and liberal attitude toward these sexual instincts, he prevents further repression from occurring.

Freud was aware of the paradoxical role that transference played in this model of the therapeutic process.* On the one hand, transference was responsible for the patient's trust, friendliness, and

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*Friedman (1969) has elegantly presented the major arguments which I am here elaborating.

optimism -- in short, his suggestibility. Even more important, transference was the means by which the analyst could gain insight into the nature of the patient's repressed conflicts. On the other hand, as in Dora's case, transference appeared to be a major obstacle to treatment, giving rise to hostile and vindictive motives to defeat the analyst and remain ill. As Freud (1905) noted in his concluding remarks on Dora's case,

> Transference, which seems ordained to be the greatest obstacle to psycho-analysis, becomes <u>its most powerful ally</u>, if its presence can be detected each time and explained to the patient. (p. 117) [emphasis added]

Freud set forth his resolution of this dilemma in "The Dynamics of Transference" (Freud, 1912). In this paper, Freud identified the varieties of transference that serve as an "ally" of the therapeutic process and those which present an obstacle in its path.

The form of transference <u>favorable</u> to the patient-doctor alliance is a "positive transference" that has become "softened" with respect to its sexual aim. This aim-inhibited positive transference appears clinically as the patient's "friendly or affectionate feelings which are admissable to consciousness" (p. 105). The term "positive transference" thus provided a new name for what Freud had described earlier as the patient's suggestibility.

The transference that is <u>unfavorable</u> to analytic work has two forms: the first is the erotic basis of the aim-inhibited positive transference that serves as a therapeutic ally; and the second is a negative transference that appears in the form of hostile feelings and attitudes to the analyst.

The analyst aims to "remove" (via interpretation) only these

latter two kinds of transference, erotic and hostile. The more moderate and unobjectionable "aim-softened" positive transference "persists and is the vehicle of success in psychoanalysis exactly as it is in other methods of treatment" (p. 105).

In basing his alliance with the patient on the appetitive aspects of transference, Freud was admittedly relying upon an inherently unstable factor. By his own theory, even the patient's aim-inhibited transference derives from sexual instincts and instincts must inevitably oppose being revealed as such. Freud's ally is likely, then, to prove traitorous, just when the analyst might most require assistance in uncovering the true nature of the repressed!

The patient-doctor alliance in the structural model

Freud introduced a new psychoanalytic model in his paper "The Ego and the Id" (Freud, 1923). In this seminal work, Freud outlined a structural model of the psychic apparatus and described the nature and functions of the ego and the id. This structural model enabled Freud and other analysts working within its framework to formulate a more precise description of the alliance between patient and analyst.

Freud's alliance with the "normal" ego

Freud used his new structural theory to describe the therapeutic process as follows:

> . . . the analytic situation consists in our allying ourselves with the ego of the person under treatment, in order to subdue portions of his id which are uncontrolled -- that is to say, to include them in the synthesis of his ego. (Freud, 1937, p. 235)

Freud's alliance with the patient's ego suffers from the same inherent problem encountered with his ally of the libido theory, positive

transference. What happens with the ego is that it

> . . . ceases to support our efforts at uncovering the id; it opposes them, disobeys the fundamental rule of analysis, and allows no further derivatives of the repressed to emerge. (Freud, 1937, p. 239)

Freud's "analytic pact" (Freud, 1937, 1940) with the ego dissolves because of the ego's true allegiance to the task of preventing the unconscious instinctual demands of the id from discovery.

Freud stressed two factors that militated against the alliance between patient and doctor: the strength of the id's instinctual drives, a constitutional factor; and the degree to which the ego had been "modified" or "altered" by the long-term activity of its defensive operations, an environmental factor.

Freud posited a hypothetical "normal ego" that was free of such defects in its structure. He claimed that "unswerving loyalty" to the analytic pact could be expected only from such an ideally "normal" ego.

Sterba's alliance with a dissociated ego

Predating Freud's final formulations of the analytic process were two crucially important papers by Richard Sterba (1929, 1934). Also using the structural model, Sterba described -- in perhaps more optimistic terms than Freud believed warranted -- how an alliance might form between the analyst and the more realistic and rational side of the patient's ego. In effect, Sterba's alliance required a fundamental split within the ego, or what he termed a "therapeutic dissociation" of the ego.

The essence of Sterba's theoretical and technical approach to the alliance is to

> . . . separate those parts of the patient's ego that face and assess reality, from another part which functions in carrying out the unconscious instinctual wishes, or works to suppress those wishes which create the anxiety reaction. (Sterba, 1929, p. 371)

The analyst effects this division within the ego through his interpretations of the transference situation, thereby opposing ". . . those elements in the ego which are focussed on reality to those which have a cathexis of instinctual or defensive energy" (Sterba, 1934, p. 119).

In Sterba's influential account of the therapeutic process, dissociation of the ego is the necessary condition for the formation of an alliance with the patient. As Sterba explained in a key passage,

> This capacity of the ego for dissociation gives the analyst a chance . . . to effect an alliance with the ego [emphasis added] against the powerful forces of instinct and repression and, with the help of one part of it, to try to vanquish the opposing forces. (Sterba, 1934, p. 120)

Three factors contribute to this process of ego dissociation and alliance formation. The first is the analyst's interpretations of transference, as described above; the second factor is the patient's identification with the therapist in his analyzing function; and the third factor is the patient's moderate and friendly positive transference, which serves as a spur to the patient's identifying with the analyst.

Fenichel's alliance with the observing ego

Fenichel's model of the alliance between patient and analyst closely followed Sterba's dissociation theory. In one paper Fenichel (1937) described the division of the ego into

> . . . a part which judges reasonably and a part which experiences, the former recognizing that

> the latter is not appropriate to the real situation but is a legacy from the past. (p. 134)

Elaborating on this distinction in his later and classic monograph, Problems of Psychoanalytic Technique, Fenichel (1941) wrote:

> . . . the effective factor in interpretation lies in the division of the ego into an experiencing portion and an observing portion [emphases added] which results from the positive transference and an identification with the analyst. (p. 104)

Fenichel's succinct summary of Sterba's dissociation theory provided labels for the two parts of the ego: an observing ego, which perceives the analyst realistically and makes appropriate judgments about the analytic situation; and an experiencing ego, which acts irrationally and defensively in response to the demands of the id and superego. Because the "observing ego" enables the patient to cooperate rationally with the analyst, Fenichel sometimes referred to this portion of the ego as the "reasonable ego." Likewise, because the "experiencing ego" carries out defensive functions, Fenichel at times referred to it as the "defensive ego."

Also following Sterba, Fenichel stressed the role of interpretation in effecting the necessary dissociation of the ego and the alliance with its reasonable, observing portion. Fenichel reluctantly granted that positive transference provides some support for this formation, and he even proposed the term "rational transference" to describe its favorable influence. Fenichel ultimately regarded such a term to be self-contradictory, because transference alwyas pursues instinctual, hence potentially irrational, aims. For example, a belief that the analyst has magical powers may prompt some initial cooperation, but such alliances can only prove short-lived. As Fenichel put it,

> . . . we always work with the 'normal remainder of the personality.' It must be our ally against resistance and, in spite of our utilization of the transference, without it we shall not succeed. (Fenichel, 1937, p. 138)

Fenichel's summary and integration of the alliance with the ego may be taken as a definitive statement of the alliance concept in this early ego psychological literature.

The alliance as a military metaphor

Freud was particularly fond of likening analytic treatment to the conditions of warfare. In this military metaphor, transference was the "battlefield" (Freud, 1917, p. 454) on which a titanic struggle between opposing forces within the patient took place. On the one side were all the forces that resisted the curative process: the strength of the instincts, the punitive demands of the superego, and the weakness and deformity of the ego. On the other side were all those forces that strove for recovery: intellectual curiosity; the desire for relief from suffering; and the wish to have the analyst's love, admiration, or power. Comparing the relative strength of the forces of resistance and the forces of recovery led Freud (1937) to his pessimistic conclusion that ". . . victory is in fact as a rule on the side of the big battalions [of resistance]" (p. 240). The notion of an "alliance" between patient and doctor is a part of this extended military metaphor of the analytic situation which Freud, Sterba, and Fenichel all used in their technical writings.

In Freud's model, the analyst is the ally who comes to the aid of an embattled ego. Freud described the process thus:

> The ego is weakened by internal conflict and we must go to its help. The position is like that

> in a civil war which has to be decided by the assistance of an ally [emphasis added] from outside. The analytic physician and the patient's weakened ego, basing themselves on the real external world, have to band themselves together into a party against the enemies, the instinctual demands of the id and the conscientious demands of the superego. We form a pact with each other. (Freud, 1940, p. 173)

In this account, the patient's part of the alliance or "pact" is primarily one of providing accurate intelligence reports about the "enemy," the id and the superego. "The sick ego," Freud commented, "promises us the most complete candour -- promises, that is, to put at our disposal all the material which its self-perception yields it. . . ." (Freud, 1940, p. 173) To be consistent with his own metaphorical description of a battle-worn and weakened ego, Freud could hardly expect his flagging ally to spearhead the attack against instinct and repression. Though Freud often spoke of the patient as a "collaborator"* of the analyst's, it is clear from this passage that he did not expect much in the way of help.

Sterba, in contrast, demanded more wholehearted allegiance from his ego-ally, once it had been sequestered from the enemy's camp. Sterba's strategy was clearly one of divide and conquer. By dissociating the ego, the analyst gained a chance of

> . . . winning over part of it to his side, conquering it, strengthening it by means of identification with himself and opposing it in the transference to those parts which have a cathexis of instinctual or defensive energy. (Sterba, 1934, p. 120)

What Sterba has added to Freud's account is the strengthening influence

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*See Freud, 1917, p. 443 and 451.

of identification. A part of the ego joins the analyst's side and actively opposes the forces of resistance.

Fenichel's rendition of the divide-and-conquer strategem added still another element to the patient-doctor alliance:

> The unconscious impulse which pushes toward consciousness and motility is our ally, the defensive ego our enemy. But we are in the situation of a commander whose troops are separated from his allies by the enemy's front. In order to unite our forces with those of our ally, the warded off instinct, we must first break through to him, and for that we need another ally accessible to us, the reasonable ego, which must be detached from the defensive ego. To remain in the metaphor, we must first disintegrate the enemy's ranks with propaganda and win over large portions of his forces. (Fenichel, 1941, p. 37, emphases added)

In Fenichel's metaphor, then, the analyst joins forces with the reasonable ego to rescue instinctual impulses from behind a veritable "iron curtain" of repression. Unlike Freud, Fenichel here does not seem to regard instinct as fundamentally opposed to the goals of analysis. In striving for conscious expression, these unconscious processes share a common purpose with the reasonable ego and the analyst. Fenichel's statement is noteworthy because of his inclusion of unconscious impulses in an otherwise rational alliance with the ego.

The military imagery used by Freud, Sterba, and Fenichel reflects, not only the wider historical events of the period, but also a fundamental way of looking at the patient-doctor relationship. Especially in Freud's writing, the analogy between analysis and warfare implies a basic opposition between patient and analyst. Though the patient's conflicts are really internal, he or she is likely to regard the analyst

as the inimical influence.

It would be misleading to construe Freud's use of the alliance imagery as suggesting a largely harmonious relationship between patient and doctor. Yet, however capricious an ally he regarded positive transference, or however weakened an ally he regarded the ego, Freud continued to hold out some limited hope for a collaboration between patient and analyst in the pursuit of analytic objectives.

Sterba's alliance imagery highlights the patient's rational, intellectual interest in analytic work. Sterba's alliance with a reality-oriented ego makes no compromises to the patient's infantile demands.

Where Freud's alliance relied on positive transference and Sterba's on reason and intellect, Fenichel attempted to build an alliance with both instinct and reason against a common enemy, repression.

The therapeutic alliance and transference neurosis

The basic tenets of the alliance concept appear in these papers by Freud, Sterba, and Fenichel: aim-inhibited positive transference, the root of the patient's friendly rapport with the analyst; identification with the therapist, a process by which the patient adopts a detached objective attitude toward his own behavior; and dissociation of the ego, the means by which the analyst sequesters the healthier portion of the patient's ego. These aspects of the patient-doctor relationship -- positive transference, identification with the therapist, and therapeutic ego dissociation -- form the basis of an alliance or pact to "join forces" in overcoming the patient's own resistance.

In a symposium presentation on transference, Elizabeth Zetzel

(Zetzel, 1956) summarized the theoretical and technical implications of this alliance notion and introduced the specific term "therapeutic alliance" into the psychoanalytic literature. Zetzel further maintained that the emphasis on the therapeutic alliance was the principle factor differentiating two major orientations within the classical tradition: the ego psychology developing from Freud's structural model, and the object relations theory arising from Melanie Klein's work.

From an ego psychological viewpoint, Zetzel (1956) claimed,

> A differentiation is made between transference as therapeutic alliance and the transference neurosis, which, on the whole, is a manifestation of resistance. (p. 170)

Kleinian analysts, stressing the role of early object relations as the basis of transference, make

> [l]ittle if any differentiation . . . between transference as therapeutic alliance and the transference neurosis as a manifestation of resistance. (p. 171)

In this landmark paper, Zetzel used the therapeutic alliance to etch a sharp contrast between Freudian and Kleinian conceptions of treatment.

Zetzel made only scattered references to the "therapeutic alliance" in this paper. She pointed out that, as ego psychologists use the idea, the alliance concept refers to the ". . . integration, before analysis, of certain mature ego functions" (Zetzel, 1956, p. 170). Even when the patient acts regressively, as in the transference neurosis, the continued functioning of the ego at an "adult level" is necessary for successful analysis. Zetzel did not specify the mature ego functions that maintain the therapeutic alliance, but presumably she meant the kind of abilities Fenichel attributed to the observing or reasonable ego: the ability to test reality and exercise appropriate judgments

about the analytic situation, even when experiencing irrational, infantile, and regressive thoughts, feelings, fantasies, and action-tendencies.

One obvious practical implication of this ego psychological model is that "very young" and "severely distrubed" patients, who lack the necessary mature ego functions, will be unable to form a therapeutic alliance and hence cannot be treated by psychoanalysis. Freud had intimated this same conclusion when he described the relationship between the "normality" of the ego and its ability to adhere to the analytic pact. These early formulations of the alliance concept thereby restrict analytic treatment to reasonably well-integrated adult neurotic patients.

Another practical implication of the alliance concept at this time is that it provides a governing set of tactical and strategic objectives. Especially at the outset of treatment, the analyst endeavors to form an alliance with the relatively healthy, mature, rational aspects of the patient's personality. Zetzel deduced a specific technical implication of this approach, which further distinguished Freudians and Kleinians: Freudians avoid early interpretations of the transference material lest the alliance with the rational ego be undermined, while Kleinians stress such interpretations to alleviate unconscious sources of anxiety.

In this early psychoanalytic literature, the concept of the therapeutic alliance demarcates several important distinctions: (i) between the positive transference facilitating treatment and the erotic or hostile transference hindering it; (ii) between the reasonable or observing ego that cooperates with the analytic task and the

unreasonable, defensive experiencing ego that opposes it; (iii) between a Freudian approach to treatment that relies on an alliance with the observing ego and a Kleinian approach that does not; and (iv) between adult neurotic patients who can form a therapeutic alliance and younger, more disturbed patients who cannot.

CHAPTER TWO

MODERN EGO PSYCHOLOGY AND THE ALLIANCE CONCEPT

Heinz Hartmann's contributions to psychoanalysis (Hartmann, 1939, 1964) herald what I shall refer to as the "modern" era of psychoanalytic ego psychology.* Elaborating on Freud's structural model, Hartmann introduced a new terminology that allowed for a more precise articulation of the ego's structure and functioning in and out of conflict situations with the id, superego, and environment.

Hartmann's ideas provided the conceptual tools necessary for a more sophisticated ego psychological formulation of the patient-doctor alliance. While the entire body of Hartmann's work influenced modern conceptions of this alliance, the following four notions were especially significant:

(i) The notion of a conflict free sphere of the ego, a sector functioning outside of conflict situations with the id and superego, helped explain the basis of the patient's participation in a non-neurotic relationship with the analyst;

(ii) The notion of an autonomous ego apparatus that exists at birth (primary autonomy) or develops later (secondary autonomy) helped explain the patient's capacity for forming an alliance;

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*Hartmann's monograph, Ego psychology and the problem of adaptation, did not become available in English until 1958.

(iii) The notion of neutralized psychic energy, a de-instinctualized form of psychic energy available to the conflict free sphere of the ego, helped explain the energic resources available for an alliance; and

(iv) The notion of intrasystemic processes within the ego itself helped explain the basis of the therapeutic dissociation of the ego into observing and experiencing components.

Hartmann himself forecasted the potential contribution of his ego psychology to clinical psychoanalysis. Explicitly endorsing the directions taken by Freud and Sterba, Hartmann (1951) wrote:

> No doubt what Freud (1937) says about resistances in a certain sense being segregated within the ego, or about splitting of the ego in the process of defense (1940), or what Richard Sterba (1934) says about splitting of the ego in analysis, are examples of intrasystemic thinking, . . . A differential consideration of the ego is indicated. (pp. 145-46)

Hartmann's description of the nature and origins of the conflict-free sphere of the ego provided a conceptual bridge between the early descriptions of the alliance found in Freud, Sterba, and Fenichel, and modern renditions of the alliance concept found most notably in the work of Ralph Greenson (Greenson, 1965, 1967).

Greenson's writings have had a seminal influence on the conception of the therapeutic or working alliance in the ego psychological literature. I consider Greenson's work to be representative of a larger "alliance" literature including papers by DeWald (1964, 1976), Dickes (1967, 1975), Evans (1976), Fleming (1972), Frankl and Hellman (1962), Hani (1973), Keith (1968), Hamm (1967), Kanzer (1975), Langs (1973, 1974), Meeks (1971), Sandler et al. (1973), Schowatter (1976), Shapiro et al.

(1977), and Stone (1961, 1967).

If, in the critical examination that follows, I appear to be taking Greenson's delineation of the working alliance too literally, my reply is that I am doing so in an effort to introduce greater clarity to the discussion of a difficult and muddled area.

Greenson's basic conception of the working alliance

When Elizabeth Zetzel first differentiated between the therapeutic alliance and transference neurosis (Zetzel, 1956), she implicitly stated that the therapeutic alliance was a form of transference. In his own original statement of the alliance concept, Greenson (1965) accepted this premise. He referred to the working alliance and transference neurosis as ". . . two essentially different transference reactions" (p. 156), and he defined the working alliance as the ". . . relatively non-neurotic, rational rapport [emphasis added] which the patient has with his analyst" (p. 157). This "rapport" is simply the friendly, moderate, trusting, cooperative attitude Freud had previously described as "positive transference" (Freud, 1917). In his later textbook, Greenson (1967) stated even more explicitly that the working alliance was a form of transference, describing it as a ". . . relatively rational, desexualized and de-aggressified transference phenomenon" (p. 207).

Greenson's description of the working alliance as a form of transference yet a relatively non-neurotic phenomenon is problematic. According to his own definition of transference (Greenson, 1967), transference reactions are essentially inappropriate, repetitive, ambivalent, and exaggerated phenomena -- in a word, neurotic. By qualifying

his definition of the working alliance as relatively non-neurotic, Greenson avoided an outright logical contradiction (an alliance that is both neurotic and non-neurotic), but he did not satisfactorily resolve this terminological confusion.

Greenson was grappling with the same dilemma Freud had faced fifty years before him. Freud's resolution, we will recall, was to differentiate between aim-inhibited positive transference and erotic or hostile transference. The problem with this solution, as I mentioned in Chapter One, is that the patient's moderate friendly feeling derives from repressed sexual instincts, so that any alliance resting solely on positive transference is inherently unstable. Greenson, then, is still caught on the horns of this dilemma.

Greenson's eventual attempt to resolve this problem was to posit a "transference-free" relationship with the analyst, or what he called a "real relationship" (Greenson, 1967; Greenson and Wexler, 1969, 1970; Greenson, 1971, 1972, 1974). In his later publications, Greenson affirmed the importance of the real relationship as a third distinguishable feature of the patient-analyst relationship. What is crucial for the present discussion is that Greenson shifted the basis of the working alliance from positive transference to this transference-free "real relationship." As Greenson (1969) explicitly stated:

> The positive transference, the over-estimation and over-valuation of the psychoanalyst may . . . be a powerful ally, but it is treacherous. Above all, the working alliance is to be found in the 'real' or non-transference relationship between patient and analyst. (p. 29)

While Greenson's description of a "real" relationship rests on the important observation that patients do form accurate views of their

analysts, his threefold division of the total therapeutic relationship is another matter. Has Greenson settled the problems of his earlier working alliance/transference neurosis dichotomy, or has he merely shifted its ground to include a "real relationship" too? How, we must ask, does Greenson explain the patient's ability and motivation to form a transference free relationship? Does the real relationship, once formed, then exert any motivating influence on the patient to continue treatment despite his resistance? If so, where does this influence derive from? Do we once again have to rely upon the patient's sublimated love to explain his loyalty to the analytic task? If that is the case, should we then not simply consider the real relationship, as Friedman (1969) has suggested, to be the outcome of treatment, a banner to hoist after the analytic work of resolving transference and resistance has been accomplished?

Metapsychological analysis of the working alliance

The difficulties with Greenson's basic dichotomy between the working alliance and transference neurosis appear in sharper relief when we consider the problem from the metapsychological viewpoints of modern ego psychology. We are aided in this endeavor by Hartmann's conceptual framework, which Greenson implicitly relied upon throughout his writings. Some of the difficulties we shall consider presently are attributable to problems in this ego psychological framework; others are attributable to Greenson's particular use of that framework; and still others are attributable to logical and linguistic difficulties in clinical psychoanalytic terminology.

Metapsychologically, what is the nature of the distinction

between the working alliance and transference neurosis? There are two basic alternative approaches to the question. The first alternative is to preserve a sharp dichotomy between the working alliance and transference neurosis. In this case, the working alliance depends upon the conscious, rational, autonomous, self-observing functions of the ego, fueled with neutralized psychic energy. In contrast, the transference neurosis involves unconscious, irrational, defensive experiencing functions of the ego, along with punitive demands from the superego and instinctual demands from the id. These neurotic transference manifestations exhibit instinctualized libidinal and aggressive properties.

A neat dichotomy such as this is metapsychologically elegant but clinically rather limited. To emphasize the importance of the patient's rational and consious desire to be rid of neurotic suffering as the basis of the working alliance underplays the significance of resistance.

A second alternative is to grant that there may be unconscious as well as conscious, transference as well as nontransference, irrational as well as rational components to the working alliance. By this approach, instinctualized sources of energy would also come into play in the working alliance, along with the more completely aim-inhibited transference phenomena. Not only would the interests of the ego be satisfied by the working alliance, but so too would demands stemming from the id and superego.

This second alternative is clinically richer than the first, but it obscures the distinctness of the working alliance and the transference neurosis. Given this latter formulation, it is in fact difficult to

describe much difference at all between the two concepts.

The first alternative is metapsychologically pure but clinically naive; the second alternative, clinically rich but theoretically imprecise. In the first case we have a clearly delimited but superficial alliance concept; and, in the second case, we have a broader but theoretically redundant formulation, suggesting that one of our basic terms -- working alliance or transference neurosis -- is eliminable from our theroy.

I shall now show how Greenson straddled these clear-cut alternatives. At first, Greenson emphasized the conscious, rational, conflict-free ego sphere in his description of the working alliance. Later, he included more and more unconscious, transferential, and irrational elements in the alliance. Ultimately, he enshrined the drive-free basis of the working alliance as the real relationship and allowed the sharp distinction between transference neurosis and working alliance to blur. These developments merit closer inspection.

Topographic and structural analysis

Greenson relied on Sterba's model of ego dissociation to formulate the structural underpinnings of the working alliance/transference neurosis dichotomy. Greenson stated that

> [t]he patient's ability to oscillate between the working alliance and the neurotic transference reactions . . . is parallel to the split in the patient's ego between a reasonable, observing, analyzing ego, and an experiencing, subjective, irrational ego. (p. 47)

Elsewhere, Greenson (1967) also commented that the ". . . capacity to split off ego functions . . . makes it possible to separate the working alliance from the neurotic transference" (p. 48).

In Chapter Three, I will examine this notion of a therapeutic split in the ego in greater detail. What I wish to emphasize here is Greenson's linkage of the observing ego and the working alliance, on the one hand, and the experiencing ego and transference neurosis, on the other. My later discussion will argue that this idea of a "therapeutic dissociation" in untenable.

Greenson also adopted Sterba's idea that identification with the therapist enhances the patient's ability and willingness ". . . to give up his experiencing, free-associating ego and to observe along with his therapist what he has just been experiencing" (Greenson, 1967, p. 245). Such an identification reinforces the therapeutic split in the ego, according to Greenson.

We may wonder, though, what sort of identification process can remain consistently conscious, rational, nontransferential, and drive-free. Or, does the identification with the therapist also involve unconscious homosexual, narcissistic, rivalrous, and defensive aspects too? If so, then the identification with the therapist that subserves the working alliance must also involve areas of conflict, precisely those which make up the transference neurosis. In that case, it is difficult to see how the working alliance/transference neurosis dichotomy can be sustained, theoretically, logically, or clinically.

The role of identification in the working alliance points up important questions about Greenson's topographic and structural assumptions. Though it would have been neater to restrict the alliance to the conscious ego, Greenson eventually added contributions from the unconscious and from the id and the superego. In one place,

Greenson (1967) included as part of the working alliance "[t]he id, the repressed, and their derivatives [and] all those forces within the patient seeking discharge . . ." (p. 99). Similarly, Greenson (1967) coined the term "rational superego" to describe the patient's motivation to fulfill his "duties and obligations" (p. 99) to the analyst. Finally, in a clear statement of the involvement of unconscious transferential processes, Greenson (1967) noted that ". . . the working alliance is composed of an admixture of unconscious [emphasis added] motherly and fatherly components" (p. 240).

As Greenson extended his analysis of the working alliance to include the entire psychic apparatus, we are forced to ask how he could maintain a distinction between the working alliance and the transference neurosis. While enriching his conception of the working alliance, Greenson's addition of unconscious, drive-related, id and superego processes now renders the term redundant with the term "transference neurosis."

Dynamic and economic analysis

Similar problems arise with regard to the patient's motivation to form a working alliance with the analyst against countervailing pressures from the id and superego.

Greenson's motivational analysis of the working alliance at first stressed the patient's rational desire to cooperate with the analyst to obtain relief from suffering. This "rational wish for cure" prompts the patient to continue with the analytic work, despite the opposing forces within the patient to resist that work. Like all rational behavior, it draws upon the ego's reservoir of neutralized

psychic energy.

Greenson's account of the patient's motivation for allying with the analyst is thus far strongly reminiscent of Sterba's drive-free alliance. Unlike Sterba, Greenson also acknowledged that magical fantasies also motivate the patient to cooperate with the therapist. For example, idealizing the analyst's competence or believing in his omnipotence may prompt the patient to cooperate initially, but the inevitable disappointment of this "magical" fantasy will sooner or later disrupt the alliance.

Once again, it appears difficult to hold on to the idea of a de-instinctualized rational alliance. As irrational and instinctualized processes enter into the alliance, it also appears difficult to maintain the distinctness conceptually between the working alliance and the transference neurosis.

Genetic analysis

Greenson has not provided a detailed analysis of the genetic roots of the working alliance. He did indicate in one place that the working alliance stems from previous "neutralized relationships" (Greenson, 1967, p. 46), and, in another place, he cited its "unconscious motherly and fatherly components" (p. 240), suggesting both pre-oedipal and oedipal roots. The question we must once again raise is the following: If the working alliance includes unconscious processes and identifications with parental objects dating back to pre-oedipal or oedipal stages of development, how separate or distinct are these origins from those of the transference neurosis? We might pose this question in terms of the underlying metapsychological problem: How

conflict-free is the conflict-free sphere of the ego, considering that it too has been shaped by the same set of influences and experiences that molded the rest of the personality? Once we begin acknowledging the interpenetration of influences in the development of the working alliance and the transference neurosis, is it still parsimonious to retain two separate terms?

Adaptational analysis

Greenson included the analyst and the analytic situation in his overall conception of the working alliance. He pointed out that certain aspects of the situation encourage the formation of the working alliance, while very disparate aspects lead to the formation of the transference neurosis. Accordingly, the analyst's attitudes of caring, warmth, acceptance, understanding, genuineness, trustworthiness, and respect along with the consistency and predictability of sessions, all contribute to the working alliance. In contrast, the analyst's frustrating, depriving, anonymous, neutral, and abstinent conduct, along with the regressive influence of the recumbent position, limited visual contact, and lengthy duration of treatment, all foster the development of the transference neurosis.

Here, too, we may question the value of this polarization of the therapeutic situation. In pursuit of their collaborative work, the analyst must necessarily make demands of the patient and frustrate him in certain ways. Similarly, to foster the patient's regression, the analyst must also show his caring, concern, and trustworthiness. If indeed the patient is adapting to an environment created at least in part by the analyst, is there any useful purpose served in describing

two separate adaptations to that environment, calling one the working alliance and the other the transference neurosis? If aspects of the analytic situation conducive to the transference neurosis are also necessary for building a working alliance, and if aspects of the analytic situation conducive to the working alliance are also necessary for facilitating the patient's regression, then these two terms once again are coextensive or redundant.

In summary, I have attempted to show in this metapsychological analysis of the working alliance/transference neurosis distinction that preserving a neat dichotomy renders the alliance concept superfluous, while expanding the scope of the working alliance renders it redundant with the transference neurosis. I have also argued that the addition of the "real relationship" merely begs the questions raised by this dichotomy.

In the next chapter, I shall extend the lines of this critique to consider the idea of the therapeutic dissociation of the ego. My own eventual effort at resolving these dilemmas appears in Chapters Five, Six, and Seven, where I propose that the therapeutic alliance be regarded as the central construct in a theory of the therapeutic process, eliminating the working alliance/transference neurosis dichotomy.

CHAPTER THREE

A RE-EXAMINATION OF THE CONCEPT OF THERAPEUTIC EGO DISSOCIATION

The cornerstone of the ego psychological model of the therapeutic alliance is the notion of a therapeutic split or dissociation of the patient's ego into an observing and experiencing component. According to this view, the patient's observing ego splits off from the experiencing ego to enter into an alliance with the analyst or, in certain accounts (Greenson, 1967), the analyst's "analyzing ego."

As originally formulated by Sterba (1929, 1934) and elaborated by Fenichel (1937, 1941) and Greenson (1965, 1967), therapeutic dissociation has occupied a central place in most ego psychological formulations of the therapeutic alliance. Hartmann (1954) praised the idea as the kind of "differential consideration" of the ego needed to advance psychoanalytic understanding of the treatment process.

The therapeutic dissociation of the ego has not always enjoyed such widespread acceptance. In a recent review of his own work, Sterba (1975) described the consternation with which members of the Vienna Psycho-Analytic Society greeted his presentation of the idea. One member, Paul Federn, considered splitting to be pathognomonic of schizophrenia and hence an inapt description of a neurotic patient's functioning in psychoanalysis.

Even Fenichel, who promulgated the idea, evidently had doubts

about it too. Echoing a question he had raised in an earlier presentation (Fenichel, 1937), Fenichel (1941) again noted in his monograph:

> It remains to be investigated how this desirable 'splitting of the ego' and 'self-observation' are to be differentiated from the pathological cleavage and self-observation which . . . prevent the production of derivatives. (p. 19)

This chapter addresses Fenichel's long-standing query about the therapeutic dissociation of the ego. A re-examination of this old issue is not an antiquarian pursuit, for recent critics of psychoanalytic theory (Thalberg, 1974; Pruyser, 1975; Schafer, 1976) have also raised objections of a more general kind to this split-off model of the mind.

My argument here is more focused and restricted that these general critiques of "splitting" in psychoanalytic theory. I argue only that the notion of <u>therapeutic</u> splitting is untenable. In support of this conclusion, I will attempt to show that the observing ego and the experiencing ego operate <u>integratively</u> under favored circumstances.

This critique of the dissociation theory has, I believe, important implications for the conception of the therapeutic alliance. In the traditional ego psychological account (see Greenson, 1967), an alliance takes place between the patient's split-off observing ego and analogous ego functions in the analyst. I shall argue that such a formulation of the therapeutic alliance has serious shortcomings, both theoretically and clinically.

<u>Clinical observations</u>

What clinical observations support the idea of a dissociation of the ego as a regular and desirable occurrence in psychoanalytic treatment?

"Psychic distance"

The first kind of clinical phenomenon explicitly described as a "therapeutic dissociation" appeared in Sterba's (1934) paper. Sterba regarded the patient's attitude of "intellectual contemplation" as a sign of a dissociation of the ego. He used the spatial metaphor of "psychic distance" to convey the patient's "detached" or "objective" appraisal of his or her own actions, and he claimed that the patient modelled this attitude after the analyst's nonjudgmental or "neutral" stance.

Sterba illustrated this process of ego dissociation with a vignette from the analysis of a hysterical patient. At the outset of treatment, this patient's demeanor was one of "obstinate silence" and "obvious ill humour." Sterba discovered that these attitudes masked erotic, hostile, and guilty feelings. His clue to the sexual basis of the patient's resistive behavior came when she asked one day if there was a room where she might change her clothing after the session. Her fear was that a woman whom she was to meet after the hour would form the impression, from her rumpled clothing, that she had been engaging in sexual intercourse with her analyst!

When Sterba commented on the defensive quality of the patient's silence and moodiness and linked these attitudes with her fear of embarrassment her attitude and behavior changed. She recalled past situations associated with the present one (e.g., her mother's punitive reaction to her love for her father in childhood), and she pursued these reminiscences in a spirit of curious exploration. Sterba remarked that his interpretations ". . . had begun the process which I have called therapeutic ego dissociation" (p. 124).

This case report is illustrative of the kind of data often described as a dissociation of the ego. A patient's ability to look at his or her own emotional behavior analytically reflects, according to this usage, a dissociation of the observing ego from the experiencing ego. "Gaining distance" or "taking a step back" are common spatial metaphors used to describe this dissociative process.

Regression in the service of the ego

A second kind of clinical phenomenon often cited as evidence of therapeutic ego dissociation is the patient's ability to associate freely. Effective free association requires that the patient oscillate between "regressive" and "progressive" mental processes. Greenson (1967) has offered a description of this process of therapeutic splitting:

> This split can be seen in free association. When the patient permits himself [emphasis added] to be carried away by a painful memory or fantasy, the experiencing ego is in the foreground, and there is no awareness of the meaning or appropriateness of the emotions at the time. If the analyst were to intervene at this point, the patient's reasonable ego would come back into the fore and the patient would now be able to recognize that the affects in question came from the past. . . . (p. 47)

In this passage, it is not entirely clear what splits off from what. Is it the "experiencing ego" that splits off from the mental agency that "permits" regressive fantasies? Or is it the "reasonable ego" that splits off from the experiencing ego to resume ordinary contact with reality and with the analyst?

These ambiguities aside, Greenson's account typifies another kind of clinical phenomenon usually labelled "therapeutic splitting." In this usage, therapeutic splitting is an instance of the more general

phenomenon of "adaptive regression in the service of the ego," in which the ego partially and temporarily relaxes certain of its functions.

"Psychic distance" and "adaptive regression" are both construed in psychoanalytic ego psychology as evidence of splitting of the ego. The patient's ability at times to oscillate between fantasy and reality are thus the clinical data upon which the notion of therapeutic ego dissociation is based.

The observing ego and the experiencing ego

The implausibility of the dissociation thesis becomes evident upon close examination of the nature of the observing and experiencing functions of the ego. In the following sections, I shall attempt to show that there is no "dissociation" or "split" between these two egos. Rather, under optimal conditions, they function together in an integrative manner.

Basic terminology

Ego psychologists have used "observing ego" and "experiencing ego" interchangeably with other closely related terms, thereby combining a variety of different psychological processes under these two conceptual headings. This fact alone suggests that the dichotomy between observing ego and experiencing ego is an oversimplification.

1. "Observing ego" and cognate terms

Greenson (1967), for example, used "reasonable ego" as a synonym of "observing ego." What is reasonable about this part of the ego is that it favors cooperation with the analyst. While it is not surprising

that the analyst would find the patient's compliance "reasonable," the term "reasonable ego" introduces a value-laden bias into the theoretical language.

Similarly, "rational ego" as a synonym of "observing ego" implies that the patient's alliance with the analyst derives from purely "rational" or drive-free motives. Such a term thereby carries forward a questionable assumption about the patient's motivation for allying with the analyst.

Originally, as Freud used the term, the "observing ego" referred to a part of the ego that separates from the remainder of the psyche to observe, judge, and ultimately punish the ego. In other words, Freud's "observing ego" is synonymous with the "superego."* (Later in this section, I will explore further whether observing is an ego or a superego function.)

2. "Experiencing ego" and cognate terms

The experiencing ego also has several cognate terms with which it is used interchangeably, such as the "defensive ego," "irrational ego," and "acting ego." Here again several different kinds of psychological activity -- affect, defense, action -- are combined as though they were all of a piece.

The "defensive ego" presumably refers to the ego as the "compromiser" of the demands of the id, superego, and environment. "Acting ego" refers to the ego that "acts out" conflicts rather than

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*Freud (1933) wrote: "I formed the idea that the separation of the observing agency from the rest of the ego might be a regular feature of the ego's structure, . . . I will describe this agency in the ego [emphasis added] as the 'super-ego'". (p. 524)

analyzing them. Used in opposition to the observing ego, this term implies that action is inimical to therapeutic process. Finally, the "experiencing ego" refers to the ego as the "seat" of affective experience, such as anxiety, guilt, depression, shame, and other modds and feelings.

Of this array of terms, the "observing ego" and "experiencing ego" are, I believe, the most commonplace and also the richest in meaning. I shall therefore concentrate on these two notions, with the proviso that they are not strictly equivalent to the other terms I have mentioned.

The mutual influence of observing and experiencing ego functions

1. The observing ego as observer

What is it that the observing ego observes?

Sterba (1929) emphasized the ". . . parts of the ego that face and assess reality" (p. 37) in his conception of the alliance, distinguishing these reality-oriented functions from defensive processes.

Freud, on the other hand, stressed the role of the ego as an observer of "internal" reality, that is, the "inner world" of fantasies, unconscious ideas, and affects. Anna Freud (1936 [1966]) referred to a similar kind of observation when she described the "endopsychic perceptions" which the ego as a "seat of observation" carries out, thus enabling the analyst to gain access to the patient's unconscious life.

Complicating matters still further, Freud ascribed a special observing function to the superego, an agency that literally "rises above" the ego to observe and punish its transgressions. He distinguished

this observing function from the ego's conscious perceptions of external reality.

What emerges from these accounts is an image of a Janus-headed observing ego, one aspect facing the inner world of private thoughts, feelings, and fantasies; the other aspect facing the external world of ordinary social reality, including the analyst as he "actually" is.

Presumably, both kinds of observing are necessary for therapeutic work: internal perceptions enable the patient to report "derivatives" of unconscious processes, in the form of dreams, fantasies, and associations; external perceptions secure the analysand's grasp of the reality of the analytic situation, preventing untoward or psychotic regression.

Given this dual aspect model of the observing ego, we may ask where the "split" with the experiencing ego could possibly take place. How does the observing ego come to know anything about the inner world if it does not experience it in some way? And, if its knowledge of the inner world is necessarily experiential, how could a dissociation between observing and experiencing occur under optimal citcumstances? The observing ego must, it seems, include subjective experience.

The dilemma facing the dissociation model of the therapeutic alliance is this: If the observing ego refers only to the perception of external reality, then the alliance with the observing ego omits subjective experience. On the other hand, if the observing ego refers to unconscious perceptions, too, then it includes subjective experience, hence eliding the dichotomy between observing ego and experiencing ego.

Such paradoxes are inescapable when we talk about observing ego and experiencing ego as "partitions" of the total ego. If we think of

the ego, along the lines Schafer (1968) has suggested, as an organized and organizing system of aims or motives, subserved by various mental processes, we may be able to avoid some of the logical entanglements of this partitioning approach.

Should we eliminate the term "observing ego" altogether? I think no. In a later chapter (Chapter Five), I will present a framework in which the "observing ego" is used essentially as Freud originally intended it -- as a synonym for the superego. The "observing ego," then, is another way of describing the influence of the "observing parent" who watches the child punitively. But this observing ego (= superego) is not the therapeutic ally of Sterba's model. That kind of observing function is a part of the ego, hence serves not as a prelude to punishment but as a means to achieving ego-syntonic aims, such as insight and understanding.

I shall turn now to a more detailed examination of this kind of non-punitively observing and subjectively experiencing ego.

2. Observing ego functions: cognitive and affective processes

In the sections that follow, I shall examine the cognitive and effective processes that constitute the observing functions of the ego, and I shall try to show why we cannot simply sequester the patient's cognitive processes from his subjective experience.

(i) Attending: the perceptual function

Attentional processes are of prime importance in observing and experiencing in analytic therapy. The patient's instruction is to attend to stimuli that he would ordinarily ignore or censor. For his part, the analyst endeavors to maintain an "even-hovering" attention

that will facilitate his understanding the full implications of the patient's communications.

Acts of self-observation refer to certain kinds of attentional processes with two characteristic features: (a) a characteristic mode of attending, namely, "attentively" (Schafer, 1976); and (b) a characteristic focus of attention, namely, one's own actions. From this standpoint, the "observing ego" refers to actions where a person observes his own behavior attentively, or "analytically."

There are frequent shifts in the mode and focus of attention during the analytic process. In the traditional view, the analyst's interpretations effect a dissociation in the ego, thereby arousing the patient's dormant "observing ego." Another way of describing the effect of the analyst's interventions is in terms of attentional processes. Whenever an analyst intervenes in the patient's stream of associations, he is perforce issuing the directive, "Now hear this! Pay attention to this!" In response, the patient may shift the focus of his attention from, say, an event in the past to the present situation; he may use the content of the analyst's intervention as a guide to examining some aspect of his own actions attentively. Once he understands this way of working analytically, he might institute these shifts in mode and focus of attention on his own. He might himself pause a moment and say aloud, "Now why have I been so critical of my wife lately?" He may then pay close attention to the circumstances around his critical remarks, his own feelings at the time, and so forth.

These shifts in attention give rise, I believe, to the impression that a "split" has occurred in the patient's ego between observing and experiencing. All that has happened, though, is that the patient has

shifted the focus of his attention to his own actions, which he then examines in an attentive or careful mode. That these shifts occur when the analyst intervenes with an interpretation creates the further impression that interpretations "dissociate" the ego. I suggest that, among other effects, they command a shift in the focus of attention and serve as a guide for careful scrutinizing. Similarly, that the patient sometimes shifts the mode and focus of attention without prompting leads the analyst to believe he has "identified" with him. While this may be the case, an attentional shift in itself is inconclusive data upon which to base an inference of identification.

(ii) Remembering: the memory function

Psychoanalysis also requires a certain kind of remembering. In contrast to remembering isolated events, analytic remembering evokes the feeling associated with the event. In this sense, remembering in psychoanalysis is hardly a dissociative process. The analysand remembers vivaciously through an integration of cognitive and emotive processes.

Analytic remembering also differs from the kind of remembering observed in hypnosis. In a trance state (a hypnotic dissociation), a patient may vividly remember a past event, but when out of the trance state, he will remember nothing. What the analysand remembers in psychoanalysis, though, is part of conscious awareness. Considering that Freud abandoned the hypnotic method for this very reason, it is surprising that a dissociative model developed to explain the analytic process. Once again, dissociation of observing and experiencing is a misleading way of describing the analytic process.

(iii) Monitoring: the control function

Related to my discussion of attending, I might also mention the process of monitoring in psychoanalysis. Monitoring is an activity in which an operator checks either continuously or periodically to compare some output against a standard (Miller and Rice, 1967). A carpenter checks to see whether he is sawing in a straight line. A novice tennis player checks that he is gripping the racquet correctly and following through.

An analyst continually monitors the process of his patient's free associations and intervenes to regulate that process. The patient may carry out some of this monitoring activity himself, noting some characteristic of his own behavior. For example, he might say, "I notice that I've spent this entire session complaining to you." Such an observation might equally have been made by the analyst but it is especially noteworthy when the patient does this himself. Such a statement is evidence of the observing function of the patient's ego. But does this indicate a dissociation of the observing ego from the complaining experiencing ego? Or can we simply say that, for the moment, the patient has stopped complaining and started doing something else (observing his past behavior)? And is he not then also experiencing something different, too (concern for the time wasted, rather than frustrated annoyance at others)?

Now, the carpenter, tennis novice, and analysand may also make comments like, "Who drew this line crooked?" or "Why can't I serve right? What's the matter with me?" That is, each of these operators may monitor his own actions harshly, critically, condemningly, impatiently, or negligently. The difference between monitoring as an

ego rather than superego function concerns, then, the manner (or mode) in which this activity is carried out.

(iv) Talking, reporting, and associating: the language function

Another important characteristic of the analytic situation is that the patient communicates in large part through the medium of language.

Language has both cognitive and emotive purpose (Beardsley, 1958) in the analytic situation, conveying information about the analysand's beliefs and ideas and his feelings. While language may have defensive uses, too, it is in its integrative capacity that language has such a valued place in analytic treatment.

Consider, for example, a patient who is "angry" at his therapist. He might act angrily in a variety of ways, from physically assaulting the therapist to avoiding sessions. He could shout accusingly at the therapist. Or he could articulate verbally his hostile ideas and destructive fantasies concerning the therapist. He could cogently, argumentatively, sarcastically, or fairmindedly discuss the therapist's actions (coming late, going on vacation, making a tactless remark) that evoked an angry response. My point is that in rendering action-tendencies and affect-dispositions into words the patient is acting angrily but also differently from the way the physically assaultive or passively aggressive patient acts. Saying "I'd like to punch you in the nose!" is significantly different from delivering the punch -- and it is the moderating effect of language that spells the difference.

The dissociation theory ignores this integrative function of

language. Even when "carried away" by an affect or fantasy, the free associating patient is still, by definition, talking. To report excitedly or passionately a fantasy about the analyst is both an emotive and a cognitive action. The patient both experiences and observes the fantasy at the same time when he reports in words what he is vividly imagining. Affectless reporting would, of course, be defensive; and purely nonverbal emotive behavior would have at best limited value in terms of the analytic task. Verbal communication that effectively integrates cognitive and emotive actions -- that is, observing and experiencing -- is the effective means to achieve analytic aims.

In short, it is misleading to claim that splitting of the observing ego and experiencing ego is necessary to create a therapeutic alliance. Effective verbal communication in therapy -- talking, reporting, associating freely -- requires an integration of cognitive and emotive processes. And this integration helps foster the therapeutic alliance.

3. Experiencing ego functions: cognitive, affective, and physiological processes

The "experiencing ego" generally refers to emotional behavior and here I may point out the difficulty of segregating physiological, social, and cognitive determinants of the subjective experience of affect. Though a detailed discussion of these factors would take me far afield, I want to stress here the mutually influential and interdependent relationship between the various processes constituting observing and experiencing egos.

A patient's mood, for example, may determine how able or willing he is to observe his own behavior and the quality that observing will have. A depressed patient may observe his own behavior, but he will do so harshly and condemningly. "Sadness," "nostalgia," "joy" and other emotion words poorly describe the cognitive-affective-physiological matrix of the experiencing ego. It would be more descriptive to say that a patient reminisced nostalgically in session, or joyfully reported a promotion, or sadly described his father's funeral, than to say he was "carried away with an emotion" and then observed it too.

4. Observing ego and experiencing ego: a summary statement

I have raised several objections to the dissociation thesis and, in so doing, I have suggested other ways of construing the allegedly split-off observing ego and experiencing ego. Herewith is a summary and elaboration of my provisional conclusions:

(i) I maintain that the observing ego does not dissociate or split off from the experiencing ego (or vice versa) except as a defensive operation.

(ii) I maintain that, under optimal conditions (i.e., when a therapeutic alliance is in effect), the patient's free associations reveal an integration of experiencing and observing. Likewise, the analyst's interpretations aim at facilitating this integration of observing and experiencing, rather than producing a dissociation between them.

(iii) I reject the dialectic opposition of reason and emotion and its metapsychological counterpart, the dichotomy between observing

ego and experiencing ego, as an oversimplification of complex psychological processes.

(iv) I maintain that the terms "observing ego" and "experiencing ego" refer to a variety of cognitive, emotive and physiological processes which mutually influence each other. Among these cognitive and emotive activities are attending, monitoring, remembering, reporting, and associating, and the modes in which these actions are carried out (e.g., vivaciously, deliberately, attentively, carefully, freely). Necessarily included in these processes are emotion-actions, such as "painfully remembering" or "passionately fantasying." In these terms, a precise delineation of observing ego and experiencing ego is impossible, indeed undesirable.

(v) I maintain that shifts in attentional processes during free association give rise to the observer's impression of "splits" in the patient's ego.

(vi) I claim that the clinical phenomena construed as evidence of ego dissociation can be described more aptly in terms of cognitive and emotive actions and modes, following Schafer's (1976) recommendations for an "action language." In this schema, "psychic distance" refers to a certain way of observing one's own actions, namely, dispassionately or carefully or attentively. "Adaptive regression" refers to another kind of action, where the patient verbally reports what he is privately fantasizing.

(vii) I suggest that observing and experiencing be regarded as complex processes that are part of the overall personality; that they comprise various cognitive and emotive activities; and that they define, not "partitions" of the ego, but rather complex sets of motives and

corresponding behavior patterns. Along these same lines, "collaborating," "allying," "resisting," or "cooperating" refer to even more global ego aims. What emerges from this analysis is a view of the personality as a complex system of organized and organizing motives (e.g., cooperating, resisting) and the complex behaviors (observing, experiencing, regressing, etc.) that subserve these motives. (Schafer [1968, 1976] sets forth this view of the ego as an organized system in greater detail.)

Ego dissociation and the therapeutic alliance

Ego psychologists use the dissociation thesis to describe two steps in the process of alliance formation: (i) the dissociation of the ego into observing and experiencing components; and (ii) the formation of an alliance per se between the patient's observing ego and the analyst (or the analyst's "analyzing ego").

In the last section, I raised objections to the formulation of the first step in this process. Here, I shall focus on certain difficulties in the formulation of the second step.

What I believe to be fundamentally wrong with this formulation of the therapeutic alliance is that it conceives of the alliance in terms of split-off ego fragments in the patient and analyst.

Early views of the patient-doctor alliance (Freud, Fenichel, Sterba) claimed that the alliance occurs between the patient's ego and the analyst-as-such, a whole person. It is a mixed metaphor at the least to describe a military pact between ego fragments and persons, for how do egos and persons interact to form pacts or to break them?

It is not much of an improvement to posit, as Greenson (1967)

did, an alliance between two ego fragments, the observing ego and analyzing ego. In the traditional "one-mind" metapsychology, what accommodation has been made to include the analyst's ego along with the patient's ego? Greenson must be talking about something more than the "intrapsychic" representation of the analyst, but his theoretical framework simply is not equipped to described inter-personal processes in any systematic way. In describing an alliance between two egos, Greenson may be making metaphorical sense, but he is talking meta-psychological nonsense.

In referring to the analyst's "analyzing ego" as part of the therapeutic alliance, Greenson does add an important element to the concept. Are we, though, to assume that the analyst's ego also splits during the therapeutic process? Does it divide into an "analyzing ego," allied with the patient's observing ego, and an "empathizing ego," attuned to the patient's experiencing ego? Is it necessary to assume that a dissociation occurs in the analyst's ego to explain his ability to alternate flexibly and purposefully between empathic-emotive and cognitive-analytic-interpretive activities? And, if it is not necessary, why do we make this assumption regarding similar phenomena in the patient?

In fact, as Schafer (1976) has argued, the analyst ". . . never really regards [him]self as an apparatus or [his] work as the resultant of forces or the interplay of functions" (p. 119). He is, instead, the "mover of the mental apparatus" he has created, the inventor of the dissociated model of the mind. As such, the analyst never relinquishes his belief in his own personal agency, in the purposefulness of his actions in the analytic situation.

Schafer extended his argument to include a view of the patient as a person, a responsible agent pursuing various (perhaps even contradictory) ends. To conceive of an alliance with a split-off observing ego is to masquerade who it is that really allies with the analyst. Schafer has disclosed the "hidden identity" of this split-off observing ego:

> This split-off agency that makes psychoanalytic work possible is somehow specifically human in that it makes specifically human experiences possible and communicable, and specifically human goals definable, maintainable, and approachable. Implicitly, this relationship-forming agency is a <u>whole person</u> [emphases added]. (p. 119)

Schafer's remarks could apply equally well to the "experiencing ego" as to the "observing ego," for who, except a person, experiences affects in a meaningful way?

Schafer has, I believe, aptly introduced the concept of <u>person</u> as an important term for psychoanalytic theory, but I disagree with the sweeping nature of his critique. Schafer's objections stem from the anthropomorphic and reified nature of traditional psychoanalytic metapsychology. I regard such metaphorical elaboration of abstract terms as, in itself, a largely innocuous activity. (I have, though, objected to some of the illogical and paradoxical formulations deriving from certain of these metaphors, especially in the clinical literature on the therapeutic alliance.)

My brief against the dissociation model is not so much that it leads to anthropomorphic constructions but rather that it posits an untenable bifurcation of patient and analyst as <u>persons</u>. The "part" of the patient that collaborates with the analyst cannot be thought of as wholly separate from the "part" that opposes that collaboration, for all

these "parts" have developed from much the same set of influences.

Rather than partitioning the patient's complex psychological processes, I believe that a more complex view of the person would take into account the total organization of the personality. Observing and experiencing may then be talked about as complex psychological processes which mutually influence each other.

There does not appear to be justification for partitioning the patient into an observing ego that allies with the analyst and an experiencing ego that resists, because these partitions are simply too permeable to support such a compartmentalization!

If the dissociation model fails to give an adequate account of the intra-personal processes within the patient, it is even less adequate as a description of the inter-personal processes between patient and anlyst. It is important to bear in mind that alliances, misalliances, pacts, covenants, treaties, agreements, disagreements, conspiracies, and collusions are all activities that two (or more) persons engage in. Whatever processes occur in the patient and analyst as individual personalities, the therapeutic alliance refers to inter-personal events in the social field of the therapeutic situation.

An adequate model of the therapeutic alliance would have to include an account of the intra-personal processes within patient and analyst; an account of the inter-personal processes between patient and analyst; and an integrative framework linking intra- and inter-personal processes. The ego psychological model of therapeutic dissociation simply fails to provide such a framework.

The theoretical shortcomings of the dissociation model would be

of little consequence were it not for the implications of this theory for clinical practice. In my view, the emphasis on the largely cognitive functions of the split-off observing ego tends to foster an intellectualized approach to treatment, a studied effort to inculcate a reasonable or rational attitude in the patient. As Friedman (1969) has suggested, such efforts ultimately reflect the analyst's wish that he had, not a patient, but another analyst with whom to work. Furthermore, the view of an alliance between observing and analyzing egos ignores the importance of the empathic linkage between the patient's "experiencing ego" and the therapist's "empathizing ego." In my view, the therapeutic alliance involves the total personalities of both the patient and the therapist.

It is difficult to imagine the traditional ego psychological formulation of the therapeutic alliance developing from work with schizoid or obsessional patients, whose ability to stand off from experience and generate intellectual insight into their difficulties is a notorious resistance to treatment. That Sterba and other early ego psychologists were working with a clinical population consisting largely of hysterical patients suggests one reason why they may have laid such stress on objectivity, detachment, and intellectual contemplation. Whatever the original circumstances leading to the formulation of the dissociation thesis, it has had a strong and steady influence on the concept of the therapeutic alliance in psychoanalytic ego psychology. Except for a few early objections to the idea, therapeutic ego dissociation has been accepted uncritically into the literature.

In this chapter, I have re-examined the idea of therapuetic ego dissociation in the light of recent critiques of analytic theory, and

I have come to the conclusion that the dissociation model provides a faulty basis for the conception of the therapeutic alliance.

CHAPTER FOUR

THE ALLIANCE CONCEPT AND THE EMERGING SYNTHESIS OF EGO PSYCHOLOGY AND OBJECT RELATIONS THEORY

Recent trends in psychoanalysis have evidenced an increasing interest in object relations theory. This emphasis on early object relations has developed in response to new clinical and empirical data, arising from (i) direct observations of mother-child interactions (Bowlby, 1969; Mahler, 1968; Spitz, 1965); (ii) clinical experience with psychotic (Searles, 1958), borderline (Kernberg, 1975), narcissistic (Kernberg, 1975; Kohut, 1971), and other traditionally "unanalyzable" or marginally analyzable patients; (iii) psychoanalyses of young children (Segal, 1964); and (iv) the study of group and family processes (Dickes, 1967; Rice, 1965; Miller and Rice, 1967). The transference phenomena and observational data deriving from these clinical and experimental situations have necessitated an understanding of pre-oedipal developmental stages.

Accordingly, many of Melanie Klein's concepts and the larger object relations theory supporting her terminology (M. Klein, 1948; Segal, 1964) have gained acceptance among ego psychologists. Specifically, her notions of "paranoid-schizoid" and "depressive" positions, of "introjective" and "projective" identification, of primitive defensive operations such as "splitting," and of basic object-related emotions such as "envy" and "greed" have gained currency among analysts

working within a classical ego psychological framework (Kernberg, 1975, 1976; Zetzel, 1970; Langs, 1976).

The elaboration of an object-relational viewpoint within the traditional psychoanalytic framework has significant implications for the concept of the therapeutic alliance. In this chapter, I shall examine two approaches representative of this emerging synthesis of ego psychology and object relations theory. The first approaches the therapeutic process and therapeutic alliance in largely developmental terms, and the second approaches the alliance in largely interactional terms. It is, I believe, strikingly ironic that the therapeutic alliance, which originally served to differentiate Freudian and Kleinian approaches to treatment, could later mark the cross-point of their integration!

The developmental-structural approach

Interest in early object relations between mother and infant has led to a view of the therapeutic process in largely developmental terms.

1. Review of pertinent literature

Freud (1913) once remarked that the patient's attachment to the analyst occurs spontaneously in treatment, as the patient links the doctor with ". . . imagos of the people by whom he was accustomed to be treated with affection" (p. 138). Freud did not fully develop the idea, but this passage suggests that the original basis of the patient-doctor "alliance" is this early "caretaking" or maternal relationship.

Others have proposed that, apart from specific neurotic transference reactions, there is a "basic transference" (Greenacre, 1954) of the entire mother-child relationship to the analytic situation. In

Greenacre's view, the repeated contact and total absorption of patient and analyst resemble the ". . . original mother-infant quasi-union of the first months of life" (p. 672).

Stone (1961, 1967) has described a similar phenomenon in his account of "primordial" and "mature" transferences, the former related to the "mother-of-bodily-contact" (i.e., the mother who nurses and intimately cares for the infant) and the latter associated with the "mother-of-separation" (i.e., the mother who fosters the child's increasing autonomy, separateness, and individuation).

Spitz (1956) characterized the patient's dependent and trusting attitude to the analyst as "anaclitic" and the therapist's healing and supporting intentions as "diatrophic." Spitz's anaclitic-diatrophic therapeutic relationship recalls Benedek's (1938) description of the "emotional shelter" which the patient seeks and the analyst provides.

Within this primitive transference relationship, the analyst's role takes on increasingly maternal significance. Loewald (1960) suggested that the analyst's interpretive function helps organize the patient's contradictory psychological states into coherent cognitive-emotive patterns. Such "integrative experiences," Loewald remarked, are ". . . comparable in their structure and significance to the early relationship between mother and child" (p. 24).

Loewald also suggested that the analyst's key purpose is to maintain an empathic vision of the patient's "ego core," an image of the patient's yet-unrealized developmental potential. In this regard, the analyst serves an implicitly parental function.

The implicit mothering functions of the analyst have been

encouraged in the treatment of narcissistic and borderline patients. Kohut (1971), for example, has described the importance of the "gleam" in the mother's eye in the child's development and has suggested a similar attitude in the analyst vis-a-vis a narcissistic patient. Kernberg (1976) also has acknowledged the neutral interpreting analyst's mothering role, implicit in his ability to absorb, withstand, and integrate the patient's chaotic subjective experience and primitive transference.

The resumption of ego development occurring in psychoanalytic treatment has given rise to a view of the treatment process as a kind of psychic rebirth. Gitelson (1962) has described how transference acts as a "developmental drive" which ". . . remobilizes the instincts, and redeploys them for a new developmental beginning" (p. 197).

Winnicott (1958, 1960) has particularly emphasized the possibility of the patient's being born again, as he discovers his "true self" in the context of the "holding environment" provided by the "good-enough" maternal care of the analyst. Winnicott has pointed out the importance of the analyst's <u>managerial</u> (in contrast to interpretive) role. In his management of the treatment situation (e.g., handling matters related to the fee, time limits, and other therapeutic "boundaries"), the analyst serves a largely parental function. To the extent that his conduct is more trustworthy, secure, and consistent than the parent's, the managing-and-interpreting analyst provides a reparative experience for the patient -- in short, a new beginning.

Finally, the "alliance" between patient and doctor has taken on developmental significance too. Fleming (1972), for example, has

described a "working empathic symbiotic alliance" based on the revival of the patient's symbiotic needs for an auxiliary ego. Such a "symbiotic" or "diatrophic" alliance enables the patient to regressively re-experience childhood conflicts and to endure the pain of resolving them in the present, potentially reparative experience with the analyst. In a similar vein, Riggs (1972) has discussed the importance of the therapist's empathic responsiveness in the formation of the therapeutic alliance with more disturbed patients.

Other descriptions of primitive alliance formations include Greenacre's (1954) "narcissistic alliance," based on the inappropriate gratification of the patient's demands; Corwin's (1974) "narcissistic alliance," also based on gratifying primitive symbiotic wishes but tactically necessary for treating very disturbed patients; Searles' (1958) "therapeutic symbiosis," a regressive union necessary for the resumption of ego development in psychotic patients; and Blanck and Blanck's (1972) references to working, therapeutic, and symbiotic alliances.

2. The alliance as a developmental metaphor

Whereas early ego psychologists likened psychoanalysis to the conditions of warfare, these other accounts compare the therapeutic process to development. In terms of this developmental metaphor (cf. the military metaphor described in Chapter One), the analyst's role is likened to that of a mother sensitively and intuitively guiding her child's upbringing -- rather than that of a general directing troops and devising strategems for attacking resistance. Likewise, the patient in this developmental metaphor is like a child seeking in a confused

yet urgent way to find his own unique identity.

The stages of treatment (beginning, middle, and end) take on significance as analogs of the stages of development, so that the first and last phases of treatment rekindle issues of earliest infancy (attachment, separation). In the developmental metaphor of treatment, the therapeutic process as a whole consists in the reparative aspects of the present relationship with the analyst as both an old object (a transference figure) and a new object (a real person).

Technically, the requirements of "goodenough" mothering guide the analyst to find "optimal dosages" (Kohut, 1971) of gratification and frustration that will foster the patient's ego development. Abstinence and neutrality no longer serve as absolute values for the analyst, as these developmental considerations assume importance as technical guidelines.

Finally, the "alliance" between patient and analyst no longer refers to a kind of military pact or treaty to defeat unconscious enemies, but rather refers to the emotional bond or "attachment" between patient and doctor. This dependent bond, similar to the attachment of child and mother, is the influence that keeps the patient in treatment despite his opposition, fear, and resistance. Freud's "aim-inhibited positive transference" takes on much larger significance in the developmental metaphor, in that it is the transference of the entire situation of infancy that makes the analytic situation a place for the patient's psychic rebirth, that inspires the patient's deep faith and hope. The patient's sense of being able to find for himself a separate and unique identity through an intimate relationship with another person is, in terms of the developmental metaphor, the essence of his

wish for cure.

The patient-doctor "alliance" as a developmental metaphor points up, I believe, the contrast between this object-relational approach to the therapeutic process and the traditional ego psychological approach. The contrast between developmental and military images of the therapeutic alliance well conveys the difference between the two theoretical frameworks.

3. Zetzel's genetic-structural analysis of the therapeutic alliance

Following her paper that introduced the term to the literature, Elizabeth Zetzel wrote extensively on the therapeutic alliance (Zetzel, 1958, 1965, 1970). In this series of papers (see Zetzel, 1970), Zetzel attempted to integrate two conceptions of the therapeutic relationship. The first stressed the role of mature ego functions in the therapeutic alliance, and the second emphasized the role of early object relations. They are related by Hartmann's concept of the secondary autonomy of the ego: that is, the mature ego capacities needed for the therapeutic alliance derive, via secondary autonomy, from the earliest dyadic object relationship between mother and child. As Zetzel (1970) commented,

> . . . the basic ego functions essential for later maturation, <u>including the capacity for therapeutic alliance</u> [emphases added], develop during a period when the child is still relatively helpless and necessarily dependent on others. (p. 203)

The genetic basis of the therapeutic alliance relates, then, to pre-oedipal stages of development, when the child engages in essentially dyadic relationship with its mother. Zetzel specified the ego

capacities developing during this period as follows:

> (i) The capacity to maintain basic trust in the absence of immediate gratification.
> (ii) The capacity to maintain self-object differentiation in the absence of a loved object.
> (iii) The potential capacity to accept realistic limitations. (Zetzel, 1965, p. 253)

These achievements, Zetzel elsewhere (Zetzel, 1970) acknowledged, are essentially equivalent to what Melanie Klein had called the "mastery of the depressive position."

Zetzel's view is that the developmental basis of the therapeutic alliance is the consolidation of basic ego capacities during pre-oedipal stages of development. In neurotic patients, these achievements are relatively stable, and appear clinically in the patient's ability to establish and maintain a trusting, secure, friendly relationship with the analyst; to tolerate frustration and anxiety in pursuit of the goals of analysis; and to accept the limitation and lack of omnipotence of both the analyst and the patient himself. The therapeutic alliance thus serves as the basis for the analytic work on the transference neurosis, that is, the repetition of conflicts dating to the oedipal period of <u>triadic</u> relations.

This situation of a clear-cut differentiation between therapeutic alliance, based on pre-oedipal developmental achievements, and the transference neurosis, based on oedipal conflicts, obtains in only a limited number of cases. Zetzel (1970) pointed out that,

> In many character neuroses, borderline conditions and in severe neurotic disorders it may be difficult, if not impossible, to make either a theoretical or clinical distinction between therapeutic alliance as a real object relationship and the appearance of the transference neurosis. (p. 185)

Even in the case of a well-integrated adult neurotic, analysis eventually raises pre-oedipal conflicts, so that the differentiation between therapeutic alliance and transference neurosis is never consistently maintained.

Zetzel's genetic-structural analysis of the therapeutic alliance thus calls attention to the ego capacities developing from the dyadic object relationship and ego identification between mother and child. These achievements, essentially those which Kleinians refer to as the "mastery of the depressive position," eventually become autonomous of their origins in psychic conflict and are activated again by the demands of the analytic situation.

The interactional-adaptational approach

In an extensive series of publications, Robert Langs (1973, 1974, 1975, 1976) has attempted to demonstrate the interactional processes that contribute to, or detract from, the therapeutic alliance. Langs has made extensive use of such Kleinian concepts as introjective and projective identification to explain these interactions. For example, a patient might induce in the analyst a sense of confusion and helplessness, while assuming an air of omnipotence and control over the situation. In this instance, projective identification is both an intra-personal process (a fantasy of putting unwanted parts of oneself into another person) and an inter-personal process (a series of subtle behavioral cues and interactions that induce particular reactions in another person).

Langs has adapted the term "bipersonal field" (Baranger and Baranger, 1966) to describe the context in which these interactional

processes take place. The bipersonal field comprises the two participants of psychotherapy -- patient and therapist -- and the temporal, spatial, and psychological framework of their interaction. For example, the ground rules of treatment (the nature of the task, the schedule of sessions, fee arrangements, cancellation policies) serve to define the "boundaries" of the therapeutic situation. The bipersonal field thus establishes a boundary between patient and therapist, on the one side, and the remainder of the external environment, on the other. Internally, there is a boundary between patient and therapist established by all implicit and explicit rules, taboos, and expectations: for example, the unstated assumption that the patient will not resort to physical violence or that the therapist will not actively seduce the patient.

Langs' view of the therapeutic alliance is that it refers to the basic "agreement" between patient and analyst to pursue certain goals (however these may be defined). This agreement refers not only to the initial contractual undertaking of psychotherapy but also to a myriad of ways in which patient and therapist can work together in a complementary way. Langs has pointed out that patients <u>unconsciously</u> ally with the therapist by providing him with sufficient material (dreams, fantasies, association) from which he might formulate meaningful interpretations. Langs has even included the patient's efforts to <u>cure</u> the therapist of his shortcomings (so that he can then be of help to the patient) as part of the therapeutic alliance. For his part, the analyst supports his initial "agreement" to help the patient with his neurotic problems by providing timely, tactful, accurate interpretations and by maintaining a consistent, reliable therapeutic framework.

The therapeutic alliance thus refers to those interactions which directly or indirectly contribute toward the achievement of a shared therapeutic goal.

In contrast to this therapeutic alliance, patient and therapist may also collaborate to circumvent and undermine the avowed aims of treatment. For example, they may collude in ignoring some important disturbance in the therapeutic framework, such as an unpaid bill of long standing; or, they may each engage in intellectualized speculations as a kind of obsessional defense. Langs has distinguished such "misalliances" from "countertransference" or "resistance" (though these may also be involved), terms which refer to defensive processes arising primarily from one participant and not the other. It is possible, then, for a patient to attempt to seduce the therapist without the therapist's succumbing to the temptation.

Langs' concept of therapeutic alliances and misalliances is not entirely an interactional or interpersonal formulation. His reliance on Kleinian theory is particularly evident in his account of the intra-personal repercussions of these interactional processes. Langs has emphasized that proper alliances serve to reinforce the patient's "introjective identification" with the analyst, that is, his acceptance of aspects of the analyst as part of himself. Therapeutic misalliances, on the other hand, originate from and perpetuate vicious cycles of introjection and projection, thereby consolidating "bad" internalized object relations. For example, a therapist might encourage a patient to discuss sexual fantasies and, when the patient does so, he might react with shock or repugnance. Such an interaction would confirm past experiences with seductive yet punitive parental

figures, hence perpetuating certain neurotic inhibitions in the patient.

Langs' interactional-adaptational view of the therapeutic alliance has included an object relational viewpoint within a primarily classical psychoanalytic framework. He has described the conscious and unconscious processes by which patient and therapist "ally" or "misally" with each other to accomplish therapeutic work. He has demonstrated the inter- and intra-personal aspects of the therapeutic alliance, introducing the concept of the "bipersonal field" as the context of these interactional processes. Finally, Langs has drawn the analyst into the therapeutic alliance not as an analyzing ego but as a whole person with his own realistic and neurotic needs, more or less realized in his therapeutic work. In all these respects, Langs has relied upon object relations theory (specifically Kleinian theory) to overcome shortcomings in the traditional view of the therapeutic alliance.

Overview of developmental and interactional approaches to the alliance

By way of summary, I have presented in this chapter two approaches to the therapeutic alliance that attempt to integrate psychoanalytic ego psychology and object relations theory. The developmental-structural approach considers the therapeutic alliance as the basic attachment or bond between patient and analyst, patterned after the infant's relationship with its mother. The interactional-adaptational approach views the therapeutic alliance as a form of agreement between patient and therapist to accomplish a shared objective.

These formulations of the "alliance" between patient and

therapist issue from two basic metaphors of the therapeutic process. In the developmental metaphor, patient and therapist are "allied" in a kind of union, resembling the attachment of mother and child and following much the same pattern of separation and individuation. In the military metaphor, which Langs' interactional approach recalls, patient and therapist join forces in the pursuit of a shared therapeutic objective.

Both these approaches use Kleinian object relations theory to describe the developmental or interactional processes that constitute the therapeutic alliance. That analysts working within a classical framework should turn to Kleinian theory is an ironic development in the alliance literature. As I pointed out in Chapter One, the term "therapeutic alliance" originally appeared in the literature in an effort to differentiate Freudian and Kleinian appraoches to treatment.

These technical differences have tended, in my opinion, to polarize ego psychology and object relations theory unnecessarily. The work summarized in this chapter reflects a current trend toward an integration of these viewpoints and points the way toward a formulation of the therapeutic alliance in terms of an ego psychological object relations theory.

CHAPTER FIVE

A REFORMULATION OF THE CONCEPT OF THE THERAPEUTIC ALLIANCE

My critique of the alliance concept has focussed on the untenable dichotomies which traditional ego psychological accounts have set forth. I am referring principally to the distinctions between the transference neurosis and working alliance, and observing ego and the experiencing ego, and Freudian and Kleinian approaches.

I would like now to sketch the broad outlines of a conception of the therapeutic alliance that does not entail arbitrary bifurcations of the total therapeutic relationship and therapeutic process. Theory construction in psychoanalysis being a matter of options, I shall choose to make the therapeutic alliance the central construct of a theory of the therapeutic process.

Rather than conceiving of psychoanalysis as a treatment where a regressive transference neurosis is created and resolved, I intend to conceive of analytic treatment (both therapy and analysis) as a process in which a therapeutic alliance in its fullest form is <u>not</u> a given at the outset of treatment. Instead, alliance formation is a process that takes place, with many vicissitudes along the way, throughout treatment and as a result of treatment. From the standpoint of changes in the patient's behavior within the therapeutic situation, the final achievement of a therapeutic alliance (as I shall subsequently describe it)

marks the final culmination of the analytic process, a point where the patient has achieved a mature and realistic relationship with the analyst.

In taking the therapeutic alliance as the central "vehicle" of the curative process, I am conceptually subordinating the notions of transference and resistance. The concepts of transference -- the experiencing of past relationships with others in the analytic situation -- and resistance -- the clinical manifestations of defensive operations -- still occupy a major place in my proposal. What I view differently is the relationship between transference and resistance, on the one hand, and the therapeutic alliance, on the other. I consider the interpretation and managerial handling of transference and resistance phenomena to be the principal tools by which the therapeutic alliance is fashioned.

In my proposed schema, the "development and resolution of the transference neurosis" and "the achievement of the therapeutic alliance" refer not to separate and relatively autonomous processes, but to different views of the same phenomena. As I view the therapeutic alliance, it is the major instrumentality in the therapeutic process. Its development necessarily draws the patient's history of past object relationships into the therapeutic arena. To avoid redundancy, I shall eliminate the term "transference neurosis," though much of what has traditionally been described as such appears here either under the rubrics of therapeutic alliance, transference, or resistance. What I am proposing is a conception of the therapeutic alliance that integrates into one framework what has been, since Zetzel (1956) and Greenson (1965), described under two as "transference neurosis" and "therapeutic

alliance."

To view patient and analyst as working toward the achievement of a therapeutic alliance, rather than toward the dissolution of a transference neurosis, is to look at the same phenomena but to see them in a somewhat different Gestalt. I shall presently describe in detail the various formations and transformations that constitute the therapeutic alliance. Before proceeding, I would like to state what I consider to be the essence of the therapeutic alliance: it is the bond or attachment between patient and therapist, a form of object-seeking behavior involving both libidinal and aggressive drives, conscious and unconscious processes, and past and present object relationships. This object relation is the basis of the patient's willingness and ability to accept help and work toward the goals of treatment. I shall also describe befow five basic components of the overall alliance concept, and I shall use these as building blocks in later chapters.

1. Integrative observing and experiencing

As described in Chapter Three, analytic work requires a balance and integration of observing and experiencing functions. Observing consists in such processes as attending to, monitoring, remembering, or reporting one's actions. The mode in which such observing actions occur is intimately related to the quality of the person's subjective experience. Cognitive, affective, and physiological processes thus mutually influence the quality of observing and experiencing in the clinical situation.

I might add here that the "observing ego" has a special signif-

icance in terms of object relations theory. Used as essentially synonymous with the superego, the "observing ego" refers to the internalization of interpersonal experiences with the observing parent. As I shall use the term "observing ego," it refers to an internalized object relation, consisting of an image of the self as being observed, an image of the object as observing, and the affective coloring of this observer-observed interaction. (See here Kernberg's [1976] schema.)

Consistent with the general developmental process by which the ego gradually integrates the more primitive and punitive superego, the "observing ego" becomes gradually "depersonified" (Jacobson, 1964). The observing that occurs as an ego-syntonic aim in the therapeutic process reflects this depersonification of the observing ego.

This clarifies further the distinction between observing as an ego or superego function. In the therapeutic situation, the nature of the task (scrutiny of all one's behavior) and the analyst's role (constant visual and psycholgoical scrutiny of the patient) may reactivate the primitive observing ego in even well-integrated patients. In less integrated patients, where the depersonification of the observing ego has never fully occurred, the quality of observing takes on a punitive, shameful, erotic, exhibitionistic, masochistic, or paranoid character. Consequently, there is a departure from an optimal balance and integration of observing and experiencing functions of the ego, complicating the formation of the therapeutic alliance.

A further clarification of the "experiencing ego" is also in order. As I described in Chapter Three, the "experiencing ego" refers to the subjective experience of affect, and hence involves physiological, cognitive, and social processes. Particularly in psychopathology

involving major biochemical or neurological disturbance (e.g., affective illness, schizophrenia, organic brain syndrome), there will be major limitations in the patient's ability to integrate observing and experiencing ego functions. Consequently, the development of a therapeutic alliance will require that the therapist help modify and integrate observing and experiencing functions for the patient: for example, by using a family member to report information, to make note of changes in the patient, etc.

These remarks clarify, I believe, the mechanism by which disturbances in cognition and affect influence observing and experiencing processes in the therapeutic situation.

2. The wish for cure

The traditional view described the patient's prime motivation for treatment as a "rational wish for cure," that is, the rational person's desire to obtain relief from suffering. I pointed out difficulties with this emphasis on rational motivation as the basis of the therapeutic alliance. I shall retain the phrase "wish for cure" as a way of encapsulating the patient's motivation for treatment, a necessary component to any concept of a therapeutic alliance. That "wish" may have both rational, magical, or deviant aspects. A "magical" wish for cure might be a patient's hope that the therapist will effect a miracle cure of his problems. A "deviant" motive might be one like entering treatment to avoid the draft or other covert aims.

How the patient conceives of "cure" and his role in the curative process varies considerably. Unconsciously, to be cured may mean for some patients being blissfully united and merged with the analyst-mother.

For other patients, it may mean a reparative experience with father. I shall be using "cure" primarily to describe what the patient is seeking to restore, preserve, unite, or separate in terms of his relationship with the therapist. This kind of wish for cure necessarily involves non-rational elements.

3. Transference

In general, I shall conceive of transference in terms of projective processes in which characteristics of an internalized object relation are projected onto an external object. Though a bit of a simplification, the term "positive" transference refers to the projection of attributes of a "good" or "ideal" object. All alliances involve some form of transference, though the alliance is not synonymous with or solely based on positive transference. As I shall later describe, certain alliance formations involve both positive and negative transference phenomena.

4. Introjection and identification

Identification is, in some sense, the obverse of transference: it represents a taking in or "introjection" of some aspects of the therapist. This identification process may range from partial, selective, and temporary identifications with aspects of the therapist's role, to massive, indiscriminate, incorporative identifications. In my view, introjective processes are essential to all alliance formations.

5. Reality factors

Instead of using the term "real relationship" I shall refer to various reality factors in the therapeutic situation, such as the phys-

ical setting and framework of treatment, the contractual nature of the service relationship, the therapist's "real" authority and responsibility as a professional person providing a certain kind of service to the patient, and the patient's social status as a client.

I shall also conceive of the "real relationship" as essentially the endpoint of treatment, when the patient has a mature, realistic apprehension of the therapist. "Real" in this sense means that the patient perceives the therapist as a "whole" rather than "part" object. "Real relationship" also refers to the patient's ability to test the reality of the situation, to distinguish between the therapist's role aspects and personal aspects, and to distinguish fantasy from reality. I will specify the sense in which I use the term "real" in later contexts, and will avoid the term "real relationship."

These five terms -- integrative observing and experiencing ego functions, the wish for cure, transference, identification and introjection, and reality -- are the basic components of the overall alliance concept. I shall presently use these in my description of the basic types of therapeutic alliance in the following chapter.

CHAPTER SIX

A TYPOLOGY OF ALLIANCE FORMATIONS

In this and subsequent chapters, I shall elaborate my proposed formulation of the therapeutic alliance in terms of psychoanalytic object relations theory. I intend to show how the therapeutic alliance is the essential feature of the therapeutic process, including within its conceptual scope the notions of transference and resistance.

I shall develop my argument in three steps. First, I propose that the genetic roots of the therapeutic alliance may be traced back to three differentiable stages in the development of object relations -- stages marked by (i) the differentiation of self images and object images, (ii) the integration of gratifying and frustrating object images and loving and hating self images into "whole" self and object representations, and (iii) the consolidation of a definite ego and superego and the formation of an integrated sense of identity.

Second, I propose that there are several types of therapeutic alliance based on the patient's level of personality development. More specifically, each type of alliance formation has, as its genetic basis, one of the stages in the development of object relations mentioned above. I shall attempt to describe three main types of therapeutic alliance: a symbiotic alliance, related to the stage of object relations culminating in self-object differentiation; a therapeutic alliance proper, related to the stage of object relations culminating

in the integration of whole self and object representations; and a working alliance, related to the stage of development culminating in the consolidation of ego identity and ego and superego integration.

Third, I propose that the patient's level of personality development determines, within broad limits, the type of alliance formation likely to occur in psychoanalytic treatment. Specifically, I shall suggest that psychotic patients are capable of forming a symbiotic alliance; borderline patients, a therapeutic alliance (narrowly defined); and neurotic patients, a working alliance (narrowly defined). A central part of my proposal is that each of these alliance formations raises core conflicts for the patient, so that the process of alliance formation is itself curative.

Brief literature review

I consider my proposals to be consistent with certain trends in the literature on the therapeutic alliance. A controversial issue about the alliance concept is whether its genetic roots derive from oedipal or pre-oedipal stages of development. Greenson's (1965, 1967) description of the "working alliance" as a relatively mature, sublimated, task-oriented relationship between patient and analyst presupposed ego capacities consolidated principally during the oedipal stage of development. Likewise, Anna Freud (1962) argued that the patient's capacity for self-observation, insight, sacrifice, reciprocity, and loyalty in object relationships has its roots in the passage of the oedipal stage of development. (Parenthetically, the conflicts aroused by the oedipal situation also, in Anna Freud's view, contribute to the formation of the

transference neurosis.)

In a later chapter, I summarized Zetzel's developmental model of the therapeutic process. Zetzel claimed that the basic ego capacities required for the therapeutic alliance derive from pre-oedipal stages of development. In particular, the capacity for basic trust, self-object differentiation, and the acceptance of realistic limitations derive from the earliest, dyadic, pre-oedipal, mother-child relationship.

Still others (Langs, 1973; Novick, 1970) have suggested that all stages of development contribute to the patient's capacity to form a therapeutic alliance. Novick, for example, pointed out that each psychosexual stage contributed a different kind of ability or motive to ally with the analyst: from the oral stage derived trust; from the anal stage, a desire for autonomy; from the phallic stage, inquisitiveness; and from the genital stage, pleasure in achievement. In a similar vein, Langs suggested that the patient's ". . . primitive and magical wishes for help from an omnipotent, immediately-relieving therapist" (p. 265-66) were a product of pre-oedipal stages of development, while his more realistic ideas of how the therapist can help derive from oedipal and later stages.

In short, there is support in the literature for considering both pre-oedipal and oedipal stages of development as contributing to the development of ego functions and object relations necessary for the therapeutic alliance.

Recently, there have also been several attempts to distinguish between various kinds of therapeutic alliance. Dickes (1967) suggested

that the therapeutic alliance derives from many sources, including positive transference and magical expectations about treatment. The working alliance, though, issues primarily from the patient's more rational and realistic expectations, motives, and beliefs about treatment. Langs (1976) affirmed this distinction between the therapeutic and working alliances, stating that the therapeutic alliance encompassed both rational and irrational, conscious and unconscious, transference and nontransference components, while the working alliance referred only to the conscious, rational, reality-based, nonneurotic factors contributing to the patient's willingness to cooperate with the analyst. Finally, Luborsky (1976) has proposed two different types of "helping alliances": in a "Type I" helping alliance, the patient experiences himself as the passive recipient of the therapist's help; while in a "Type II" alliance, the patient experiences himself as an active participant in a "joint struggle" to overcome his neurotic difficulties.

These recent suggestions all support the potential usefulness of distinguishing between different types of therapeutic alliance. They also intimate that there are different genetic origins to these different kinds of alliance formation. Based on these trends, I came to the conclusion that patients whose level of ego development showed predominant disturbance in pre-oedipal stages were likely to form a very different kind of therapeutic alliance than those better-integrated patients whose conflicts are largely oedipal in nature. Rather than consolidate all pre-oedipal issues into one poorly defined stage, I considered a more differentiated model of personality development potentially more useful.

Consequently, the model of object relations development I shall

use is a distillate drawing chiefly from Kernberg's (1976) textbook on object relations theory, but also from the work of Mahler (1968), Erikson (1963), Melanie Klein (1948, 1952), and Jacobson (1964). Such a framework may aptly be called an "ego psychological object relations theory" (Kernberg, 1977).

In what follows, I shall attempt to develop the first two steps of my overall proposal. I shall set forth a description of three main types of alliance formations -- calling them symbiotic, therapeutic, and working alliances -- and relate these to stages in the development of object relations.

Three types of alliance formation

Each type of alliance formation refers both to a process of therapeutic change, and to a basic framework within which that change may take place. I shall attempt to describe how each alliance fosters a certain basic stability in the therapeutic relationship while at the same time generating certain tensions and conflicts, the resolution of which produces change.

Type I: Symbiotic alliance

The symbiotic alliance forms on the basis of the most primitive kind of object relationship, prior to the differentiation of self images and object images. In this type of alliance, the patient experiences a blissful union with the analyst as an omnipotent, magical, all-loving, need-satisfying object. These pleasurable experiences consolidate a nuclear, though still-undifferentiated "self-object" from which differentiation of self and object may eventually occur. The regressive "lower limit" of this symbiotic alliance is the point where the patient

withdraws into an autistic world, experiencing the analyst as part of a chaotic and persecutory environment. The symbiotic alliance allows for a rudimentary form of object relationship to develop between patient and therapist, on the basis of which further differentiation of self and object images -- and hence further personality development -- can take place. The progressive "upper limit" of the symbiotic alliance is the point where the patient is able to maintain differentiated images of self and object within a loving, gratifying, pleasurable relationship.

The genetic origins of the symbiotic alliance date to Stages 1 and 2 of Kernberg's developmental model: Stage 1, covering the first month of life, is the stage of "normal autism," preceding the emergence of the "'good' undifferentiated self-object constellation" (p. 59); and Stage 2, covering the second to eighth months of life, is the stage of "normal symbiosis," when the basic good self-object constellation emerges and eventually differentiates into self and object components. This stage roughly corresponds with Mahler's autistic, symbiotic, and differentiation subphases of the overall separation-individuation process. Erikson's (1963) description of basic trust also appears compatible with this model, as does Melanie Klein's description of the "paranoid-schizoid position."

The activation of this stage of development in the treatment situation involves primitive forms of transference and identification. (These terms are used advisedly, considering the lack of differentiation between self and object in a symbiotic alliance.) The nature of the patient's "positive transference" in a symbiotic alliance takes the form of a blind hope and magical faith in the analyst and a willingness

to become absolutely dependent on the analyst as an "auxiliary ego." Searles (1965) has described these primitive transferences in his description of "therapeutic symbiosis," an idea which I am adapting here rather closely under a slightly different name.

Several types of internalization processes may occur under the aegis of a symbiotic alliance. "Oral incorporative" modes of internalization may be prominent, in that the patient fantasizes that in listening to the analyst's words he is greedily taking in his milk. Introjective processes may also take place which do not involve oral incorporative fantasies. Repeated pleasurable experiences with the analyst provide opportunities for the patient to "take in" the analyst via the ego apparatus of primary autonomy, specifically, perception and memory. Finally, the experience of merger is itself a form of "primary identification" (Jacobson, 1964).

The reality of the analytic situation helps consolidate the symbiotic alliance. The therapist's warmth, friendliness, consistency, presence, and availability serve to create a stationary point in the patient's chaotic and fragmented object world. The regularity of meetings consolidates more and more coherent representations of self and object in largely pleasurable interaction. Furthermore, the intermittence, rhythm, and recurrence of sessions provide experiences of temporary loss and restoration of the object, and these experiences foster eventual differentiation of self and object.

An illustration of the formation of what I am calling a "symbiotic alliance" appears in Mahler's (1968) description of the stages in the treatment of psychotic children. Mahler describes the therapist's task as establishing "primitive communication" with the child who cannot

experience any direct relationship with another person. Mahler describes how the therapist acts in a nonintrusive and attentive way to the child, so that the child accepts the therapist as a soothing presence. The therapist allows the child to use the therapist's body as an extension of himself, for example, letting the child use his arm as a tool to reach an object, or as a pillow to lean against. The therapist might also engage in "parallel play" with the child, humming a song or banging on the table in rhythmic unison. The singing of simple songs associated with particular activities allows for the pleasurable recognition of sameness and continuity in relation to the therapist and provides a basis for variation and novelty. Even during a child's tantrums, the therapist might attempt to lessen the intensity of the child's rage by commenting, in a sing-song and soothing voice, "'Don't hurt Violet. She's a nice girl.'" (p. 199) In all these ways, the therapist attempts to establish a beginning symbiotic attachment (or symbiotic alliance) with a child who is yet unable to experience the therapist as a separate and distinct human object.

This clinical illustration points out that a symbiotic alliance cannot always be presumed as a given at the outset of treatment, but may represent an intermediate stage in the work with a psychotic patient -- the initial stage being the child's autistic withdrawal from human contact and the later stage being the child's attachment to another person who is represented as psychologically distinct from the self.

The formation of a symbiotic alliance may also raise core conflicts and anxieties in the patient, related to fears of annihilating (and being annihilated by) or engulfing (and being engulfed by) an

external object. These conflicts focally concern experiences of frustration or deprivation and the consequent fragmentation such experiences generate in the patient's object world. Unlike more advanced types of alliance formation, the symbiotic alliance does not require that the therapist call attention to the patient's hostility, distrust, or rage, since focusing on such "negative transference" would tend to forestall the consolidation of the good self-object. In accordance with the reality testing principle of the "pleasure ego," the frustrating experiences with the therapist are experienced as part of the external world, while the gratifying experiences are part of the self (or self-object). Until the patient can differentiate self and object within this nuclear good self-object, the therapist's chief technical concern is to enter into an empathic and pleasurable symbiotic relationship with the patient -- what I have termed the "symbiotic alliance."

Type II: Therapeutic alliance proper

What I shall term the "therapeutic alliance proper" resembles the "symbiotic alliance" in that the patient's attachment to the therapist is basically anaclitic. Unlike the symbiotic alliance, the therapeutic alliance proper presumes the ability to differentiate self and object. This ability may simply reflect the patient's level of development upon entering treatment, or may be the result of successful formation of a symbiotic alliance. In other words, the formation of a Type I alliance may be a necessary prelude for the formation of a Type II alliance.

The core of the therapeutic alliance proper is the patient's ability to form an attachment to the therapist as a "whole" object. The formation of this second type of alliance requires the integration of the gratifying and frustrating aspects of the therapist and the loving and hating aspects of the patient himself into whole self and object representations. Reparative drives, which Hannah Segal (1964) has defined as ". . . the wish and the capacity for the restoration of the good object, internal and external" (p. 92), are central to the formation of a Type II alliance. These reparative wishes, as Segal has described them, are ". . . the basis of the ego's capacity to maintain love and relationships through conflicts and difficulties" (p. 92). As a central aim in the patient's motivational hierarchy, reparation enables the patient to endure the emotional onslaughts of treatment and the inevitable frustrations, conflicts, and animosities encountered in relation to the therapist. The acceptance of the analyst as a largely benevolent (though not magical) help-giving figure, despite his limitations and shortcomings, and the patient's own related acceptance of himself as worthy of receiving help, are essential features of this therapeutic alliance proper.

The lower limit of this second type of alliance is the point where self and object images begin to refuse, indicating that a psychotic regression has taken place. Under ordinary circumstances, the level of personality development associated with a Type II alliance renders such severe regressive trends unlikely. The "upper limit" of this Type II alliance is the point where integration of self images and object images of opposing valence has been achieved. (The full achievement, though, of a stable and consolidated ego identity requires a further advance

in the development of object relations, as described in the next section on the "working alliance.")

The genetic roots of this second type of alliance formation date to Stage 3 in Kernberg's model of object relations development, which begins at the eighth month and continues to the third year. This stage includes the differentiation of self and object images of both a positive libidinally-toned nature and a negative aggressively-toned nature, and the eventual integration of "good" and "bad" self and object images into a total self and object concept. This stage also corresponds with Mahler's description of the stages of separation-individuation (practicing, rapprochement, separation-individuation proper) and with Melanie Klein's description of the depressive position and mastery of depressive anxiety.

Transference and identification processes are central in this type of alliance, as in all three types of alliance. The patient's positive transference -- for example, his idealization of the therapist's abilities, character, and efficacy -- may serve to consolidate an alliance at the outset of treatment but eventually must yield to the accumulating evidence of the therapist's human limitations. This second type of therapeutic alliance does <u>not</u> depend, then, on the patient's sustaining an illusory, mythological belief in the therapist, but, just the contrary, on his accepting (without devaluation or contempt) the therapist's defects in understanding, knowledge, character, health, and psychological well being. Under favored circumstances, these realistic perceptions can be integrated within a largely positive or libidinally-toned transference. Less favorably, but not altogether incompatible with the formation of a Type II alliance, the patient may

have a manifestly hostile or "negative" transference disposition, where for various reasons more libidinally-toned affects remain latent. Under such circumstances, the gradual acceptance of the analyst's competence, integrity, soundness of judgment, strength of character, and benevolent intentions (despite his manifest shortcomings) is essential in the process of alliance formation.

Identification and other internalization processes play a similar role in the formation of a Type II alliance as in a Type I alliance. The frequency and duration of sessions provide numerous opportunities for the patient to internalize both gratifying and frustrating experiences with the therapist. Consider, for example, the sequence of daily sessions. The patient may experience each interval between sessions as an object loss or deprivation. Because of his relative incapacity to sustain an image of the therapist as gratifying during such temporary crises as weekend separations or illnesses, the patient experiences his relationship with the analyst as frustrating and hateful at such times. The next session restores the object in reality and the analyst's continuing interest and concern for the patient show that he has not been destroyed in reality as he has been in fantasy. Over a lengthy treatment, these repeated experiences of loss and redemption help the patient integrate the frustrating and gratifying experiences with the therapist. The greater degree of integration in the patient's internal representation of the therapist helps sustain the patient through these temporary separation crises, as he now has a more securely internalized image of the therapist as a helpful figure (even if he is not immediately available at all times). This series of transformations in the patient's experience of the analyst

illustrates what I mean by the process of alliance formation: the series of interactions by which the treatment situation modifies the patient's fantasies and brings about a change in the character of his experience of self and others.

The integration of "good" and "bad" self and object images does not occur simply through the passage of time, of course. The formation of this second type of alliance encounters formidable sources of conflict, anxiety, and consequent defensive operations. The realization that the patient has attacked the very same analyst upon whom he desperately depends raises considerable anxiety, so that the patient may endeavor to split the gratifying and frustrating experiences with the analyst. In this respect, splitting of self and object images is a prime defensive operation manifesting itself clinically as resistance. What I claim the patient to be resisting is the formation of a therapeutic alliance, which would require integration of love and hatred. Consequently, the therapist's interventions that confront and interpret the patient's defensive splitting serve, in my view, to enhance the therapeutic alliance. In this respect, interpretation of transference and resistance is instrumental in the formation of the therapeutic alliance.

A subtle form of resistance which may masquerade as therapeutic alliance occurs when the patient attempts to make "manic" reparation: for example, some kindly words at the last minute of a session as a way of magically repairing damage done to the object. Such "pseudo-alliance" formations may also appear as the patient's presumably "sincere" resolve to work harder in treatment, not miss sessions, and really cooperate with the therapist. Such maneuvers may actually be

attempts to appease the therapist by telling him what he wants to hear as a way of preventing further scrutiny into areas of conflict. The therapist who fails to note the "as-if" or sham quality of these seeming alliances and acquiesces to the patient's covert demand for absolution, simply feeds into the patient's pathological object relations. The patient may experience such interactions with the therapist as a triumph, having so easily seduced the therapist into mistaking pretense for reality. The consequent devaluation of the analyst in fantasy may then stir fears of retaliation, followed by other manic efforts at reparation, and so on, in a vicious cycle.

While it is difficult to distinguish genuine from sham alliance formations, a true therapeutic alliance is likely to appear more in the patient's behavioral expressions of a determination to overcome conflicts and difficulties with the therapist (for example, securing a job to pay for an extra session) than in mere verbal declarations of a wish to cooperate.

Type III: The working alliance

Of the three types of alliance formations, the "working alliance" refers to the most mature, sophisticated kind of attachment between patient and therapist and the most rationally-attuned agreement about the means and ends of treatment. The working alliance presumes the achievements that are the outcomes of treatment conducted under the aegis of either the symbiotic or the therapeutic alliance. That is, the working alliance takes as given that the patient will be able to differentiate self images and object images, and to integrate loving and hating aspects of self and object. The working alliance represents,

then, a form of "whole" object relations.

The core of the working alliance is the patient's drive to attain a stable, consistent, and unique identity, marked by the age-appropriate integration of sexual and social roles.

The regressive lower limit of the working alliance is the point where splitting of good and bad object and self images begins to occur. The upper limit is the point where the patient has attained full integration of personal identity, and this achievement generally culminates in successful termination of treatment.

The genetic roots of the working alliance, in the specific sense I am using the term, do indeed date back to the oedipal stage of development. In terms of Kernberg's model, the genetic basis of the working alliance would be Stages 4 and 5: Stage 4, covering the period from three to six years of age, involves the development of the definite ego, superego, and id as structures comprising self and object representations; Stage 5, covering the post-oedipal years and beyond, involves further integration of the superego, increasingly realistic self knowledge, and a greater harmony between internal object relations and external reality. These developments correspond roughly with Erikson's later stages of the life cycle, when initiative, industry, identity, intimacy, generativity, and integrity represent favorable outcomes of an ongoing series of developmental crises. In other words, the working alliance culminates in the integration of an identity that is fully appropriate for the patient's age and sex.

This account of the working alliance follows certain features of the classical model, though I am not in any sense withdrawing my previous critique of that model. The ego psychological model of the

alliance has always contained an embryonic object relations approach, inasmuch as positive transference, identification with the therapist, and the "real" relationship have figured into its formulations. These notions take on a somewhat different significance, though, in the context of the typology of alliance formations I am presenting.

Positive transference in the working alliance still manifests itself as a sublimated and sustained friendly feeling for the analyst and as such is an ingredient in the rapport between patient and therapist. This variety of transference is less crucial, though, in motivating the patient to cooperate, for the patient capable of entering into a working alliance has the maturity and sense of reality to cooperate in the performance of a task that serves his own best interests.

Similarly, identification with the therapist is, in a Type III alliance, a more partial and selective process. The patient is capable of internalizing aspects of the therapist's role, such as his reliability, honesty, courage, incorruptibility, and conscientiousness. Aspects of the therapist's social as well as professional roles are apparent to the patient, and these may provide a kind of touchstone against which the patient assesses his own roles. For example, a male therapist inevitably provides a male patient with aspects of his identity as a man.

Where my formulation of the working alliance differs from more traditional accounts is that I believe there are conflicts and obstacles to its formation, in the treatment of even the best integrated (yet neurotic) patient. Unresolved oedipal rivalries and propitiations may enter into the patient's ability and willingness to work collaboratively

with the therapist, for such an arrangement may evoke memories and affects related to other experiences of working with, but subordinate to, another person. Conflicts, anxieties, and defenses that have traditionally been discussed as transference neurosis are, in this model, considered as resistances to the formation of a working alliance. Hence, the resolution of these conflicts and defenses helps in the formation of the working alliance.

The working alliance affords the patient an opportunity to work collaboratively in a task-oriented relationship and this arrangement both draws upon and develops the patient's capacities for reciprocity, loyalty, fidelity, sacrifices, and sublimation. In addition to the specific benefits afforded by the therapist's helpful interpretations, the very working relationship itself provides an opportunity to develop a capacity for mature love, work, and play in the shared pleasures and sustained hard work demanded by the analytic task.

Pseudo-alliances may also appear in this type of alliance formation, too. The patient's hard-working posture -- his conscientious reporting of dreams, his punctuality, his seeming cooperation -- may be attempts to deny hostility. Once again, surface compliance does not necessarily signify that the patient and analyst are engaged in a working alliance. The detection of such masquerades can, of course, lead the way to extremely useful work, perhaps related to the patient's tendency to be submissive and passively aggressive to those in authority. As in all three types of alliance formations I have described, attention to disturbances in the alliance points up significant areas of transference, resistance, and countertransference.

I have sketched here in broad outline three types of alliance formation -- symbiotic, therapeutic, and working -- and I have linked each with differentiable stages in the development of object relations. In the following chapter, I shall discuss types of alliance formation characteristic of neurotic, borderline, and psychotic patients.

CHAPTER SEVEN

THE THERAPEUTIC ALLIANCE IN CLINICAL PRACTICE: DIAGNOSTIC CONSIDERATIONS

As described in Chapters One and Two, the traditional ego psychological conception of the therapeutic alliance stresses the relatively mature and healthy ego functions required of the patient at the outset of treatment. The diagnostic implication of this viewpoint is that only neurotic patients are capable of forming such an alliance, while borderline and psychotic patients are not.

For some time now, the "widening scope of indications for psychoanalysis" (Stone, 1954) has been a catch-phrase for the application of psychoanalytic treatment methods (with or without modification of the classical model) to this very category of patients who are incapable of forming a therapeutic alliance.

This trend toward an expansion of the range of indications for psychoanalytic treatment poses a dilemma for the traditional conception of the alliance: If, on the one hand, the therapeutic alliance presumes a high level of maturity and personality integration at the outset of treatment, how can patients lacking such integration form an alliance? On the other hand, if such patients do not and cannot form a therapeutic alliance, then what is the basis for their participation in a psychoanalytic form of treatment?

I have attempted to resolve this dilemma by positing several

different types of therapeutic alliance, each presuming a different level of personality integration. In this way, I have tried to avoid making unwarranted assumptions about the patients' ability or motivation to work actively in their own treatment, without then restricting the scope of psychoanalytic treatment to better-integrated neurotic patients.

My proposal of three basic types of therapeutic alliance aims at having a wider application than the traditional model. Instead of taking the situation of an adult neurotic in psychoanalysis as paradigmatic, I have had in mind a broad spectrum of treatment situations, including children and adolescents as well as adults, patients with borderline and psychotic personality organization as well as neurotics, and supportive and expressive psychotherapy as well as psychoanalysis proper.

My focus in this chapter is on the application of my model to neurotic, borderline, and psychotic patients.* Some of the considerations relevant to this classification of patients are these: What kind of alliance are patients with neurotic, borderline, and psychotic personality capable of forming? What difficulties are likely to arise with these patients in the process of alliance formation? What are the potential benefits of the alliance in terms of personality integration?

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*When I use the term "neurotic patient" or "borderline patient," I mean "patient with a neurotic personality organization." The shorter but less accurate phrase is simply a convenient shorthand. I will also be adopting rather conventional diagnostic classifications and labels. Though no classificatory schema is without its problems, I am relying most heavily on Kernberg's (1975) descriptive and structural diagnostic framework.

In the previous two chapters, I have postulated that the therapeutic alliance in general comprises five elements: observing and experiencing ego functions, a wish for cure, transference, identification or introjection, and reality. The three types of alliance I have outlined -- symbiotic, therapeutic, and working -- represent different amalgamations of these components. These various elements and their interrelationship change over the course of treatment, and these vicissitudes constitute the process of alliance formation. Under favored circumstances, each type of alliance will eventually culminate in a successful termination of treatment.

I may now add the third step in my overall proposal. I maintain that there is a specific link between the patient's personality structure and the type of alliance likely to appear in treatment. Patients with neurotic personality organization are capable of entering a working alliance (Type III); patients with borderline personality organization, a therapeutic alliance proper (Type II); and patients with psychotic personality organization, a symbiotic alliance (Type I).

Lest it appear that I am minimizing the therapist's participation in the process and outcome of alliance formation, I hasten to add one addendum to this proposal: Whether or not a patient succesfully establishes the type of alliance of which he is capable is ultimately the responsibility of the therapist. Following arguments set forth by Kaiser (1955), I maintain that the failure to establish an alliance reflects in the end the therapist's errors in diagnosis, technique, and overall strategy. My current focus here, though, is on the patient and the impact that the process of alliance formation has on his overall personality integration. This focus is justifiable, I believe, since

the aim of treatment is change in the patient, not the therapist.

Neurotic personality organization

I shall begin with the conventional description of the "working" alliance in patients with neurotic personality organization. Such patients typically manifest "intact" reality testing abilities; use "higher-order" defensive operations such as repression; and have focal conflicts related to the oedipal stage of development, following the consolidation of the definite ego and superego.

Consequently, neurotic patients are typically capable of sustaining a realistic grasp of the treatment situation and flexibly shifting the focus and mode of their attention from internal processes to external realities (for example, to compare a fantasy against reality). The neurotic patient may repress certain fantasies and impulses concerning the analyst without engaging in a fundamental "splitting" of self and object representations, as is typical of borderline patients. Hence, the relationship with the therapist may evoke conflicts of a triadic, oedipal nature without a loss of reality testing ability, primitivization of defensive operations, or gross distortion of the external relationship with the analyst.

A consideration of two basic neurotic personality types -- hysterical and obsessional -- will help clarify these general remarks:

1. Hysterical personality

Patients with hysterical personality are capable of forming a working alliance, because they readily form a bond or attachment to the therapist and generally cooperate with the requirements of treatment. There are, nevertheless, complications in the alliance formation

of even hysterical patients, the most "analyzable" of all the diagnostic classifications.

Because of the extensive use of repression as a defense, the balance of observing and experiencing will depart from an optimal level of integration. For example, instead of verbally reporting sexual fantasies about the analyst, the patient might have a series of brief romantic involvements, perhaps with older men. While the general vivacity of hysterical patients favorably supports their entry into an alliance with the therapist, the reliance on repressive defensive operations inevitably detracts from their ability to accomplish the work of observing and experiencing analytically.

The quality of the hysterical patient's object relations reflects similar areas of core conflict which detract from an otherwise stable working alliance. A vignette from the treatment of an hysterical patient will illustrate this point:

> Miss L. entered treatment with an attractive male therapist, toward whom she quickly developed an affectionate, though not consciously erotic, feeling. During his summer vacation, she experienced longing for him and genuinely missed him and the help he was able to provide her in just a few months of treatment. Within a few more months of treatment, she began to have fears and distrustful beliefs about him. She wondered whether he, like any other man, was primarily interested in her sexuality. The focus of treatment then turned to her difficulties in trusting men, her own seductiveness and coquettishness, and her denial of sexual feelings toward the therapist.

This vignette points up, I believe, how a neurotic patient is capable of experiencing longing, affection, and gratitude for the therapist (core conflicts for borderline patients), while at the same time having circumscribed conflicts related to oedipal themes -- in the case, to

trust in male-female relationships -- that appear as complications in the process of alliance formation. Extrapolating the vignette somewhat, we might expect that effective interpretive work on the patient's difficulties in trusting men might lead to a deepening of the working alliance, allowing a fuller recognition and articulation of repressed fantasies, fears, anxieties, and other affects involving the therapist. Had the therapist bypassed the disturbance in the alliance with his patient, these crucial issues related to trust would have "gone underground," the patient might have become more and more concealing in treatment and might have cancelled sessions or terminated.

While the quality of the hysterical patient's object relations generally supports a stable alliance with the therapist, core conflicts related to oedipal themes typically complication the working alliance at certain times during treatment. These developments are critical episodes in the treatment, and their successful resolution secures and strengthens the working alliance.

2. Obsessive personality

Patients with predominantly obsessive personality are also capable of entering a Type II or "working" alliance. Their reality testing and judgment are sound, and these abilities provide a hold on their sense of the reality of the therapeutic situation. Problems nonetheless arise. The reliance on isolation of idea and affect as a prominent defense detracts from the optimal integration of observing and experiencing. In contrast to the hysterical patient's vivacity, the obsessive patient tends to be highly intellectualized and cerebral. Consequently, the focus of attention in treating obsessive patients is on the recogni-

tion and expression of affects, especially those involving the therapist.

Despite some aloofness and coldness, the obsessive patient is generally capable of maintaining a stable, task-oriented relationship with the therapist. The emphasis on the accomplishment of work -- a key element in the obsessive style (Shapiro, 1965) -- has certain obvious benefits for the establishment of a "working" alliance, though the denial of feelings of warmth and affection detracts from the achievement of the alliance in its fullest sense, which requires both intimacy and detachment in the pursuit of a shared objective.

Complications in the development of the working alliance arise from the obsessive patient's core conflicts in object relations. Submission and defiance, and related affects of rage and fear, may arise with regard to the working arrangements between patient and therapist. A vignette may help clarify this point:

> After an initial period of skepticism and hesitation, Miss D. began psychotherapy. She worked conscientiously in sessions and between sessions, accepting rather fully her responsibility to contribute to her own treatment. She developed over time a fondness for the therapist, and she showed an empathic concern for the therapist as a person, accurately noting changes in the therapist's own professional and personal development. Her gradually deepening involvement in treatment entered a critical phase when, in reporting an incident, she asked the therapist if he was familiar with a particular book. She was not satisfied with the therapist's reflective response ("Why do you ask?") and protested that the information would be useful to her. The therapist's explanation of the rationale for not directly telling her the information also proved unsatisfactory. The patient angrily accused the therapist of blocking the treatment and thwarting her, using therapeutic "one-upmanship" to keep the patient in a subordinate position. After three sessions devoted to this issue, the patient stated that she felt the therapist had tried to make a genuine effort to explain his position and, though she still objected to this approach, she could understand it and accept it. The next

> session, the patient remarked that she found herself more interested than ever in her treatment, that two sessions did not seem adequate time to express herself, and that she would like to come more often.

Like the previous vignette, this excerpt from the treatment of an obsessive patient reveals the quality of object relationship that supports the working alliance (fondness, empathy, gratitude) and the core conflicts that present critical moments in the treatment. The very process of overcoming these conflicts, in both their inter- and intrapersonal aspects, strengthens the patient's ability and willingness to form an alliance with the therapist. I also believe that the disturbances in the working alliance with these patients reflect particularly crucial aspects of their psychopathology. Resolution of these difficulties improves the quality of the working alliance and this improvement is itself a significant therapeutic benefit.

Borderline personality organization

I shall now consider the characteristic problems in establishing and maintaining a therapeutic alliance (Type II alliance) with patients manifesting a borderline personality organization (Kernberg, 1975). The wide range of disturbances in ego functions and object relations exhibited by these patients poses formidable problems for the therapist. According to my proposed classification of alliance formations, such patients are incapable of forming a task-oriented relationship with the therapist, for such a "working" alliance requires mature forms of trust, reciprocity, affections, and gratitude. The typical patient with a borderline personality structure has severe difficulties in just these areas. I hope to show here the utility of my proposal that such patients

can develop an alliance of a somewhat different, less mature type -- what I have termed the "therapeutic" alliance proper. To anchor my discussion clinically, I shall discuss the process of alliance formation with patients exhibiting several types of severe character pathology, usually associated with borderline personality organization.*

1. Narcissistic personality

The very nature of the therapeutic relationship -- involving the giving and receiving of help -- raises areas of core pathology for the narcissistic patient. To acknowledge personal limitations, to rely upon another person for help, and to accept that help gratefully, touches upon the narcissistic patient's conflicts concerning dependency and trust and arouses unconscious emotions of rage, envy, and hatred (Kernberg, 1975). Yet, the narcissistic patient's experience of fragmentation in the "self experience" (Kohut, 1971) impels a search for a need-satisfying, soothing external object. As the medium by which help is given and received in treatment, the therapeutic alliance raises the central dilemma for the narcissistic patient: the wish to receive help in the form of relief from narcissistic tension, on the one hand, and the fear of destroying the possibility of that help out of hatred and envy, on the other.

The process of alliance formation with narcissistic patients is an arduous one. The patient's search for a need-satisfying object is,

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*In Kernberg's (1975) diagnostic schema, character pathology and personality structure refer to related, but different, clinical phenomena. Personality organization or structure refers to the differentiation and integration of the total personality, and may be classified as neurotic, borderline, or psychotic. Character types refers to relatively stable behavioral dispositions or constellations of "traits," like hysterical, obsessive, narcissistic, etc.

to some extent, met by his initial entry into treatment. In the initial stages of treatment, the patient's tie to the analyst is largely a fantasied relationship, based on a narcissistic form of object relatedness, where the patient either experiences the analyst as an extension of his own gradniose self or experiences himself as an extension of the idealized analyst. Defensive operations such as splitting and denial may help preserve this idealized relationship with the analyst from attack and so may, to a limited extent, protect the incipient formation of an alliance.

The therapeutic alliance with narcissistic patients does not depend on the prolongation of this need-satisfying, symbiotic relationship with the analyst. On the contrary, such a "symbiotic alliance" -- appropriate for the treatment of psychotic patients -- would be counter-therapeutic in the treatment of narcissistic patients. As I described in the previous chapter, the process of alliance formation in a Type II alliance requires the progressive integration of loving and hating aspects of the self, and gratifying and frustrating aspects of the object.

Accordingly, to achieve a therapeutic alliance with narcissistic patients requires consistent efforts to clarify, confront, and interpret the patient's attempts at destroying or devaluing the help-giving and -receiving nature of treatment. The patient may then come to a more realistic appraisal of his own need for help and the therapist's ability to provide it, and this development may be, as Kernberg (1975) has described it, ". . . the starting point . . . for the recuperation of normal infantile and mature dependency and self-evaluation" (p. 289).

A critical point in the process of alliance formation with

narcissistic patients occurs toward the latter stages of treatment, especially if there has been some improvement in the patient's overall condition (Kernberg, 1975). A vignette will illustrate:

> A severely disturbed patient made significant improvements over the course of one year of a lengthy treatment. When asked to account for changes, the patient cited various efforts he had made to socialize with others, assert himself, and express his feelings more openly, without once mentioning the therapist's helping role.

In this case, while the patient did not actively depreciate the therapist, the omission of any recognition of the therapist's help reflects a difficulty in experiencing gratitude. Extrapolating this vignette, we may imagine the strides that would be required for the patient to acknowledge that he had received help from the therapist. Such a recognition would bring the patient face-to-face with his lengthy history of having attacked and depreciated the therapist, both in reality and in fantasy. He might then experience for the first time true concern for the therapist, perhaps empathizing with the therapist's feelings of frustration, exasperation, or anger. Along with these painful recognitions would come a feeling of guilt for having damaged the therapeutic object in the past. Unlike the guilt that drives the patient to neurotic suffering, this awakening of concern and empathy for the object would intercept a particular vicious cycle of attacking (and then fearing retaliation from) the therapist, and would prompt genuine efforts at reparation. The patient's need to defeat the therapist and to spoil any help he might get would also lessen, in this hypothetical case. In short, the progressive development of the therapeutic alliance builds upon and improves the general quality of the patient's object

relations. The full achievement of a Type II alliance would mark the end-point of a certain phase of treatment -- perhaps enabling the patient to first enter a more mature working alliance in a full-scale psychoanalysis.

One other source of difficulty in establishing a therapeutic alliance with narcissistic patients concerns the quality of their observing-and-experiencing functions in analytic treatment. To examine one's own actions carefully exposes the narcissistic patient to painful affects of shame, embarrassment, humiliation, or disgrace. Consequently, the patient may withdraw from the therapist psychologically or may conceal information, as he experiences the therapist's observing presence as more shaming and humiliating than understanding and accepting. These difficulties in ego functioning may best be understood, I believe, in the context of the patient's pathologically narcissistic object relations where, as a child, the patient experienced the observing parent as intolerably frustrating, shaming, or intrusive. The failure to develop internalized tension-regulating personality structures leaves the patient particularly needful of the therapist's auxiliary observing-and-experiencing ego. Part of the process of alliance formation, then, is the narcissistic patient's gradual acceptance of the therapist's observing presence as helpful rather than shaming.

This discussion of alliance formation with narcissistic patients points up, I believe, both the problematic nature of this process and also the centrality of the issues raised by the alliance for these patients. Alliance formation involves a series of transformations in the quality of the patient's relationship with the therapist. The

beginning of this process is the patient's search for a symbiotic, magical, need-fulfilling relationship and the endpoint is his acceptance of a more realistic, differentiated, and reciprocal one. The emergence, development, and full achievement of a Type II therapeutic alliance marks these changes in the maturity of the patient's relationship with the therapist.

2. Schizoid and paranoid personality

The problems in alliance formation with other patients exhibiting borderline personality organization closely resemble those encountered with narcissistic patients. Generally speaking, other personality types within the borderline spectrum have even greater disturbances in the ego functions and object relations needed for a Type II alliance. Patients with schizoid or paranoid personality, for example, may undergo psychotic regression in an unstructured treatment, while a better-integrated narcissistic patient would not. In terms of my proposed typology, the regressive potential of borderline patients with schizoid or paranoid personality threatens the stability of a Type II alliance, which presumes an ability to maintain self-object differentiation.

Once again, the central problem in forming an alliance with these patients involves their pathological object relations. Kernberg (1975) has indicated one such typical transference-resistance to the formation of an alliance with borderline patients: "To establish a therapeutic alliance with the therapist becomes equal to submission to him as a dangerous, powerful enemy . . ." (p. 82). A vignette from the psychotherapy of a borderline patient with predominantly paranoid

features will illustrate this problem:

> A patient entered therapy upon the recommendation of his counselor at a methadone clinic. The patient experienced this recommendation partly as an expression of the counselor's benevolent interest in the patient, but also as a punitive gesture and command. All of the patient's relations with others shared this intensely ambivalent, masochistic quality. He lived at home with his mother (in fact, slept in the same bedroom), even though he experienced her as dictatorial and intrusive. He worked lengthy hours for a boss he considered a slave-driver. He wanted to detoxify from methadone, yet feared that, if he wanted to go back, the counselors at his clinic would sadistically withhold medication from him. At the same time, he considered taking methadone as a form of enslavement. Initially, the patient appeared to experience relief at the therapist's ability to articulate and understand the nature of these binds. Using some supportive measures (such as advice-giving), the therapist encouraged the patient to apply for financial assistance in order to return to school, where it seemed the patient had received some gratification before dropping out. When, after much work, the patient was able to successfully negotiate financial aid, he came to session for the first time optimistic and excited about his life. Soon afterward, he began missing sessions or coming extremely late, and verbalized a fear that he would become "addicted" to therapy. The therapist pointed out how this fear arose after receiving something good and helpful from the treatment, which the patient experienced as a way of inducing him into a dependent relationship where he would be exploited yet unable to leave at will. This pattern of missing sessions persisted over several weeks, and the therapist eventually interpreted the patient's actions as a provocation to the therapist to terminate the patient's treatment, as a way of resolving the patient's conflicts around trusting and depending on the therapist. Being thrown out of treatment, the therapist commented, would confirm a pattern the patient was used to (being abused and kicked around). Some improvement in the patient's participation in and attendance to treatment was noted after drawing attention to this disturbance in the therapeutic alliance.

This vignette details some of the difficulties in establishing a therapeutic alliance with borderline patients and also shows the importance of an interpretive focus on transference-resistances which block the patient's ability to accept the therapist's help.

Borderline patients exhibit poorly integrated observing-and-experiencing functions because of their chronic use of primitive defensive operations such as splitting and projective identification. The borderline patient's subjective experience is characteristically chaotic and empty, anger and dysphoria being the main or only affects (Gunderson and Singer, 1975). To take notice of contradictory affects, especially those related to the therapist, arouses considerably anxiety. Consequently, observing and experiencing functions have to be carried out more and more by the therapist, with little active participation from the patient. The therapist's ability to integrate the patient's subjective chaos provides, we might way, auxiliary observing-and-experiencing functions.

The nature of the alliance with a borderline patient is qualitatively different from that of a neurotic patient. The borderline patient expects magical help, nurturance, and intuitive understanding from the therapist. He is apt to blame the therapist when things go wrong in his life, much as a child blames its parent for not protecting it from falling. This externalization of responsibility is not only a defensive process but is also a consequence of the dependent tie to the therapist, hence an aspect of the therapeutic alliance (though not a welcome one). The borderline patient's "negative therapeutic reaction" to accepting help poses a formidable obstacle in the formation of a therapeutic alliance. A therapeutic strategy consistent with the model

I have presented involves setting appropriate limits on the patient's self-destructive behavior, so that the patient cannot use self-destructiveness to torture the therapist. Given a therapeutic framework that safeguards both the patient and the therapist (legally, professionally, emotionally), it is then possible to direct the interpretive focus to disturbances in the therapeutic alliance. In this way, sound management of the boundaries and framework of treatment goes hand in hand with interpretation of pathological object relations interfering with the patient's ability to accept and make use of the therapist's help.

Entering into a Type II therapeutic alliance raises for the borderline patient core problems related to dependency and trust. I have suggested that the process of alliance formation consists in a transformation from a need-satisfying symbiosis to a relatively more mature and realistic attachment to the therapist. Along the way, the therapist may have to take a very active role and greater responsibility for the patient's welfare than he would in a working alliance with a better-integrated patient. Favorably, the umbrella of support this "therapeutic" alliance provides will enable the patient to integrate certain defensively segregated self and object images, resulting in an overall improvement in his personality functioning.

Psychotic personality organization

Patients with psychotic personality organization are capable of entering a symbiotic alliance. On the basis of a symbiotic alliance, the patient may eventually be able to differentiate self and object images, resolving the psychotic personality structure. The basis of

the symbiotic alliance is the patient's experience of the therapist as merged with the self in a pleasurable, comforting, protecting symbiosis. I will discuss this alliance formation in the treatment of two kinds of patients with psychotic personality structure:

1. Manic-depressive patients

The elation, depression, or irritability of patients with manic-depressive psychosis presents serious obstacles, of course, to any form of alliance with the therapist. The therapist's ability to be consistently soothing, despite the fluctuations in the patient's mood, provides a nucleus around which a focussed attachment may occur. (Mood-equilibrating medication may aid this process.) A vignette may illustrate this point:

> An extremely irritable patient with a manic-depressive illness consistently "snapped" at any hospital staff member attempting to help her. One such episode involved a dispute with a social worker about having money on the ward. The social worker explained to the patient why it was not in the patient's best interest to have money on the ward and a procedure by which she could obtain her money when she wanted it. This relieved the patient's agitation. Other staff had told the patient that it was a ward rule before this interaction with the social worker, and this had particularly agitated the patient.

While only one incident, this kind of interaction might provide an irritable patient with a soothing, tension-relieving interpersonal experience. As the patient undergoes many shifts in mood over treatment, the therapist's consistently helpful attitude and his provision of adequate safeguards against the patient's expression of depressive or manic impulses helps consolidate a symbiotic alliance.

2. Schizophrenic patients

A few brief remarks about the formation of a symbiotic alliance with schizophrenic patients may help clarify my discussion. Schizophrenic patients represent problems in forming an alliance *in extremis*. Their global disturbance in cognition, affect, and behavior grossly complicates the integrated observing-and-experiencing necessary for analytic treatment. It is therefore necessary for the therapist, as I mentioned earlier, to supply supplementary ego functions. The need for auxiliary observing-and-experiencing ego functions provides a rationale for many therapeutic measures commonly used in treating schizophrenic patients, such as pharmacotherapy, family therapy, and group therapy.

A regressed schizophrenic patient may accept the therapist's help in very primitive ways. A vignette will illustrate:

> A patient was unable to eat because of her bizarre thoughts about food. She accepted food when fed by her therapist, verbalizing her distorted perceptions of the food with each bite.

Equally, a schizophrenic patient may *reject* the therapist's help in a primitive way, too. For example, one patient refused to get out of bed to see her hospital therapist, and another patient threw a chair at a therapist in frustration. Such episodes represent ruptures in the symbiotic alliance and may well prove irreparable, especially when the therapist's own countertransference reaction is extreme.

> After a patient threw a chair at him during session, a therapist arranged to have an attendant stand guard during sessions. He also arranged to have the patient placed in pajamas and remain in the Center of a ward. These safeguards, in themselves not unusual, lasted for over a month, during which time the patient became progressively more withdrawn and lethargic.

While providing safeguards for a schizophrenic patient is important for both the patient's and therapist's safety and security, it is important to understand the meaning of these precautions for the patient. Where they are perceived (consciously or unconsciously) as helpful, then the alliance is enhanced. Where they are perceived as punitive (as in the vignette above), then it is not.

To summarize my discussion of the diagnostic considerations of the alliance concept, I have proposed a relationship between various types of alliance formations and the personality structure of the patient. I have attempted to describe the characteristic difficulties and potentialities of alliance formations with neurotic, borderline, and psychotic patients. The overall thrust of my presentation has been to show the relationship between various transferences and resistances and the process of alliance formation. Rather than presenting separate developments in treatment, the resolution of these transference-resistances and the achievement of the therapeutic alliance go hand in hand. I have also maintained that the achievement of a Type III or working alliance with neurotic patients, a Type II or therapeutic alliance proper with borderline patients, and a Type I or symbiotic alliance with psychotic patients, is the central vehicle in the "cure" of their core psychopathology.

CONCLUSION

In the preceding pages, I have presented a view of the therapeutic alliance that issued from an examination of its historical and theoretical premises. My critical position focussed on the dichotomies posited by the traditional conception of the alliance between (i) aim-inhibited positive transference versus erotic positive or negative transference; (ii) the therapeutic or working alliance versus the transference neurosis; (iii) the observing ego versus the experiencing ego; (iv) Freudian ego psychology versus Kleinian object relations theory; (v) oedipal versus pre-oedipal origins of the alliance; and (vi) neurotic versus borderline and psychotic patients.

My proposed reformulation of the alliance contradicts each of these dichotomies, yet builds on the basic foundation of the traditional model. I depart from the ego psychological conception by making the alliance concept the central notion in my theory of the therapeutic process, conceptually subordinating the notions of transference and resistance and eliminating the term "transference neurosis." Instead of a dichotomy between transference neurosis and working alliance, I have considered alliance formation as the basic feature of the therapeutic process, the instrumentality or "vehicle" of cure. Instead of a dissociation of observing ego and experiencing ego, I have stressed their mutual interaction and optimal integration in the therapeutic process. Rather than limiting the alliance concept to neurotic patients, I have broadened it to apply to borderline and psychotic patients.

Instead of presuming mature ego development at the outset of treatment as a requisite for alliance formation, I have described three different types of alliances -- symbiotic, therapeutic, and working -- each of which presumes a different level of personality organization. Finally, rather than using the alliance concept to differentiate Freudian and Kleinian approaches to treatment, I have relied on an integrative ego psychological object relations theory as the basic framework of my proposal.

In short, I have drawn distinctions between terms generally regarded as synonymous (therapeutic and working alliance, positive transference and therapeutic alliance). I have integrated concepts usually viewed as polarities (observing ego/experiencing ego). I have eliminated terms widely considered as absolutely definitive of the analytic situation (transference neurosis, real relationship). I have taken an aspect of treatment most analysts regard as at best of peripheral significance and of non-specific benefit and made it the essence of the treatment process -- the therapeutic alliance. And I claim that these conclusions grow out of an essentially conservative, hopefully logical approach to my material.

I would like, in conclusion, to address myself to certain objections that the reader may entertain to these proposals:

1. A radical departure

One objection is that my proposal represents an unwarranted and radical departure from the classical conception of the analytic situation. Psychoanalysis without a transference neurosis is not psychoanalysis at all but yet another hybridization and off-shoot of its

approach.

In answer to this objection, I might point out that my focus on the therapeutic alliance is consistent with a distinguishing feature of the analytic approach: its emphasis on the patient-doctor relationship as a recapitulation of past object relations. My view of the therapeutic alliance as a complex transference phenomenon incorporates this crucial psychoanalytic insight.

The concept of the transference neurosis also highlights the patient-doctor relationship, but it places it in a strange light: It is an artificial illness and resistance to treatment, yet also the vehicle of cure. It is an obstacle to the analyst's work, yet the chief instrumentality of his success. It is also difficult to understand what enables the patient to resolve his transference neurosis without positing something like a therapeutic alliance, and it is difficult to describe the outcome of that resolution without referring to something like a real relationship. Furthermore, it is problematic whether borderline and psychotic patients in psychotherapy develop a transference neurosis, which then limits its clinical applicability.

In contrast, the therapeutic alliance as I have described it highlights the help-giving and -receiving nature of treatment and its task-oriented aspects, without losing sight of the difficulties inherent in this special form of human attachment. The therapeutic alliance suggests a goal that the therapist can endorse and the patient can strive for, which the idea of a transference neurosis does not. And, finally, as I have broadened the idea, it is applicable to a full spectrum of clinical situations.

2. Old wine in a new bottle

Another objection is that I have proposed nothing new, since treatment consists in the same process of resolving transference and resistance and maintaining a sound therapeutic situation. All such a proposal does, then, is take the old wine of the transference neurosis and place it in the new bottle of the therapeutic alliance.

I am not altogether at variance with this objection. My intent has been to provide a conceptual framework for describing what analysts and other therapists have been doing all along when they have been successful in their efforts at helping patients. Considering that the therapeutic alliance is essentially the container of that process, it is not an inapt metaphor to call it a new bottle. I might also add that it is sometimes necessary to allow a vintage wine to breathe from time to time, and a new decanter may well serve that purpose. I do maintain that my approach to the therapeutic process as essentially one of alliance formation is a novel re-arrangement of familiar terms and concepts. I also believe that this conceptualization is a useful way to look at clinical data and to formulate therapeutic strategy, tactics, and techniques.

3. Regression, conflict, and repetition

Another objection to my proposal to make the alliance concept the central construct of a theory of the therapeutic process is that I then minimize the extent of the patient's regressive, conflictual, and repetitive behavior -- phenomena which are clearly underscored by the transference neurosis.

This objection might well be raised against the traditional

alliance concept, which does indeed link the adaptive, progressive, conflict-free, and autonomous aspects of the patient-therapist relationship with the alliance and the neurotic, regressive, conflictual, and defensive aspects with the transference neurosis. In eliminating the transference neurosis/working alliance dichotomy, I have attempted to include both the regressive and progressive, conflictual and non-conflictual, repetitious and novel aspects of this relationship under one rubric.

Accordingly, each type of alliance I described defines certain upper and lower limits to the patient's ego functioning within it. The integrity of these limits -- an indication of the patient's personality structure -- is in part secured through the relationship with the therapist. Some regression is necessary for therapeutic progress, but a "barrier" to that regression is also important. The alliance concept I have described includes these regressive trends as part of the overall progressive aims of treatment.

I have also described in some detail the conflictual nature of the therapeutic alliance for most patients. While there is ideally a progressive expansion of the conflict-free areas of functioning for the patient, the alliance always engaged areas of conflict. Invariably, there are crises of trust, rapport, cooperation, and respect. These crises mark critical episodes in the formation of the alliance.

Finally, the alliance concept involves both repetition and novelty, as the therapist is both an old object for the patient (via transference) and a new object. The process of alliance formation, as I have attempted to describe it, consists in a series of interactions in which the present relationship with the analyst potentially modifies

this legacy of the past. It is, to be sure, a "corrective emotional experience" for the patient, but one that has been achieved by maintaining a sound therapeutic framework and interpretive stance -- not by attempting to mimic the behavior of a good parent.

In short, regression, conflict, and repetition have a definite place in my view of the therapeutic alliance, though I have attempted to describe their role in a more balanced way than does the traditional model.

4. A false sense of harmony and common purpose

One last objection I might take up here is also, I believe, the most fundamental: To emphasize the importance of the therapeutic alliance is to minimize the extent to which patient and therapist do not share a common goal. It presents a view of patient and therapist as in greater harmony than clinical reality warrants. Such a concept can create naive expectations in the therapist about his patient's involvement in treatment, overlooking the depth and extent of the patient's resistance to treatment and his motivation to block, oppose, and ultimately defeat the therapist.

Again, this objection might well be raised against the traditional conception of the alliance, based on an alliance with a split-off healthy segment of the personality.

In my model, I have portrayed patient and analyst as having a variety of aims or goals, some congruent with each other, others competing or contradictory. I do not assume that patient and therapist have very much in common at the outset -- just enough that they can interact in some way. The development of the alliance refers, in a way,

to the expanding congruence between what the patient wants and what the therapist is prepared to give. The model I have proposed is neither optimistic nor pessimistic about the prospects of patient and therapist forming an alliance in pursuit of a common therapeutic goal. What I have attempted to provide is a framework for understanding what happens when they do and where the difficulties might lie when they do not.

Freud (1937) encouraged analysts to pursue their understanding of the obstacles to treatment rather than building fanciful models of how cure takes place. I have attempted to include a consideration of what these obstacles are and how they are overcome, and I have made use of the concept of the therapeutic alliance to explain how that process occurs. While my evident concern has been that such a formulation of the alliance concept might prove either too radical or naive, my hope has been to present a formulation that will be useful, suggestive, and affirmative.

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