Therapeutic Alliance Interventions from OQ Clinical Support Tools – An Enhanced Version

Technical Report · April 2018
DOI: 10.13140/RG.2.2.30700.67201

1 author:

John Christopher Muran
Adelphi University
173 PUBLICATIONS **4,027** CITATIONS

SEE PROFILE

Therapeutic Alliance Interventions
from OQ Clinical Support Tools – An Enhanced Version

J. Christopher Muran, PhD
Derner Institute of Advanced Psychological Studies, Adelphi University
Brief Psychotherapy Research Program, Mount Sinai Beth Israel

Below are scripts that elaborate on the therapeutic alliance interventions listed in the Clinical Support Tools Manual – Brief (CST: Lambert et al., 2007, pp. 13-14): ***Note bold & italicized from manual.***

Lambert, M. J., Bailey, R., Kimball, K., Shimokawa, K., Harmon, S. C., & Slade, K. (2007). Clinical Support Tool Manual-Brief Version-40. Salt Lake City, OQ Measures.

Regardless of the specific reasons that a client may have for seeing the relationship as less positive than the average relationship, certain actions have been found to be helpful in repairing or strengthening the alliance. Here we have borrowed extensively from the work of Muran, Safran, and colleagues regarding disarming techniques that can be used to repair a ruptured alliance. A general principle applies: If there is a problem with the alliance, then it will be most likely repaired if the therapist can elicit negative affect from the client, listen to it carefully, and call for elaboration. Above all, do not respond by explaining, justifying, or disagreeing (being defensive); if the patient expresses negative affect, try to empathize [SCRIPT 1-3].

SCRIPT 1:

The research literature shows that ruptures in the therapeutic alliance are quite common and do in fact mark a risk for treatment failure. The research also shows that the repair or resolution of alliance ruptures is associated with treatment success. Some have argued that this finding suggests that rupture-resolution is not just a matter of getting treatment back on track but also can be understood as a change event in and of itself.

Various resolution strategies have been described from clarifying misunderstandings, providing psychoeducation, and changing or reframing treatment tasks and goals, to exploring the experience of the rupture event and associated beliefs of both patient and therapist.

The exploration of a rupture event follows the principle of therapeutic metacommunication, which consists of any attempt to step outside of a difficult patient-therapist interaction by treating it as the focus of collaborative inquiry: that is, communication about the communication process.

In this regard, the research suggests that the critical therapist behaviors in facilitating rupture resolution through metacommunication are:

- To engage the patient in a collaborative inquiry about the rupture
- To invite the patient to express negative feelings
- And to remain nondefensive and open to the patient perspective

SCRIPT 2:

At the explicit level, alliance ruptures involve a disagreement on the ***tasks and goals*** of treatment (that is, how patient and therapist are working and where they are heading) and a deterioration in the affective ***bond*** between patient and therapist (which has to do with the amount of trust and confidence that exists between them).

At the implicit level, ruptures can be understood as marking a tension or breakdown in the negotiation between the respective underlying needs or desires of the patient and therapist.

It can be especially useful to mark ruptures by two specific patient behaviors or communications: That is, *Withdrawal* and *Confrontation* markers.

A *withdrawal* marker is a patient behavior indicating disengagement from an emotional state, from the therapist or some aspect of the treatment.

It includes *patient movements away from the therapist* (that is, withdrawal from the other).

These are movements towards *autonomy and isolation.*

Examples include silences, minimal responses, topic shifts, abstract talk, and storytelling.

It also includes *patient movements towards the therapist* (that is, withdrawal from the self).

These are movements marked by *compliance and appeasement.*

Examples are being overly accommodating or protecting, and begrudging acceptance

A *confrontation* marker is most commonly a direct expression of anger or dissatisfaction by the patient with regard to the therapist or some aspect of therapy but may also be expressed through covert coercions or manipulations.

This entails *patient movements against the therapist*.

These are movements marked by *aggression and control.*

Examples include complaints about the therapist, therapy activities, and therapy progress.

Also, confrontations can include coercions like being overly friendly or seductive.

SCRIPT 3:

Withdrawal and confrontation markers can also be understood as reflecting different ways of coping with the dialectical tension between two fundamental human motivations:

The need for agency versus the need for relatedness.

Ruptures mark a breakdown in the negotiation of these needs with another.

Thus a withdrawal rupture could be understood as the pursuit of relatedness at the expense of agency.

A confrontation rupture could be understood as the pursuit of agency at the expense of relatedness.

Accordingly, the resolution of a withdrawal rupture then involves a movement towards agency: *The common progression consisting of moving through increasingly clearer articulations of discontent to self-assertion, in which the need for self-agency is realized and validated by the therapist.*

And the resolution of confrontation rupture involves a movement towards the need for relatedness: *The common progression consisting of moving through feelings of anger, to feelings of disappointment and hurt over having been failed by the therapist, to contacting vulnerability and the wish to be nurtured or taken care of by the therapist.*

Rupture resolution can be understood then as an opportunity to learn how to negotiate these needs with another.

- ***Pay careful attention to the amount of agreement between you and your client concerning the overall goals of treatment and the tasks necessary to achieve those goals*** [SCRIPT 4]:

SCRIPT 4:

Given the importance of patient and therapist agreement on treatment tasks for the development of therapeutic alliance, it can be useful for therapists to begin treatment by exploring patients' preconceptions about how therapy works and what the therapeutic process involves, as well as their hopes regarding what will be accomplished in therapy. In situations where there is an apparent disagreement between patient and therapist about how they should work together, an attempt should be made to explicitly negotiate these differences.

With regard to the agreement on treatment goals for the alliance, it is similarly important for therapists to work with patients at the outset to help them to articulate what their goals are for the treatment. The objective here is not to establish a set of unchangeable goals that will guide the treatment from beginning to end, but rather to initiate a dialogue about goals from the outset and to ensure that the patient and therapist are on the same wavelength.

Bear in mind, disagreements about the tasks and goals of therapy can occur through the course of treatment and should be viewed as not only as critical risks for treatment failure but also as critical opportunities to explore and understand patient expectations and beliefs about themselves and others.

- ***Reframe the meaning of tasks or goals*** [SCRIPT 5] ***and/or modify tasks and goals*** [SCRIPT 6]:

SCRIPT 5:

Reframing the meaning of therapeutic tasks and goals in terms that are acceptable to the patient is a type of joining intervention commonly used by strategic and systemic approaches. For example, a patient who was receiving a cognitive-behavioral treatment for social anxiety was initially reluctant to complete any between-session assignments that involved increasing social contact because of a fear of rejection. When the therapist reframed the meaning of the assignment as one of "putting yourself into the anxiety-provoking situation in order to self-monitor your cognitive processes," the task no longer felt as risky, and she was willing to attempt the assignment. A patient in psychoanalytic treatment experienced his therapist's attempt to analyze his defenses as judgmental and unaccepting. When the therapist was able to frame the goal as one of increasing self-awareness and self-acceptance, rather than one of change, the alliance improved. It is critical for this type of intervention not to be delivered in a manipulative fashion. This requires that the therapist be able to genuinely view the reframe as a valid way of construing things, rather than as a white lie.

SCRIPT 6:

In this type of intervention, the therapist attempts to work on tasks and goals that seem relevant to the patient, rather than exploring factors underlying disagreements about tasks and goals. Whether or not the therapist and patient explicitly negotiate what the tasks and goals of therapy will consist of, there is always an implicit negotiation about how the patient's problems will be viewed and worked on. The therapist's ability and willingness to accommodate the patient by working in terms that are more meaningful to him or her can play a critical role not only in building the alliance in the immediate context, but also in helping the patient to develop a more generalized trust in the possibility of getting his or her own needs met in relationships with others. In some situations the decision to switch to a task that is more meaningful to the patient subsequently leads to a willingness on the patient's part to engage in other tasks that are initially viewed as more meaningful by the therapist. For example, treating a patient's phobia at a symptomatic level may help the patient develop sufficient trust to engage in the task of self-exploration later on. Accepting that it is difficult for a patient to explore her feelings and reducing the frequency of feeling-oriented questions may help her to feel sufficiently safe to explore her feelings at some later point.

- ***Work with resistance by retreating when necessary and explaining that the patient's resistance is understandable*** [SCRIPT 7]:

SCRIPT 7:

One common form of allying with the resistance involves framing the patient's defensive avoidance of painful feelings as adaptive. For example, take the case of a middle-aged woman who sought treatment in part because of her difficulty establishing a long-term romantic relationship with a man. As she approached her 40s, the pressure to have a child before her childbearing years were over intensified, along with her fear of never finding a mate. In treatment, a central issue that emerged was her fear of abandonment and her resulting difficulty in sharing feelings of need with other people and letting them in. In one session she began to explore her feelings of isolation and fear of spending the rest of her life alone in a particularly poignant fashion, and for the first time in treatment began to cry. She then became self-conscious, remarking that she was being melodramatic, and proceeded to talk about her situation in a more distant, intellectualized fashion. The therapist drew her attention to the avoidance and acknowledged its adaptive value: That it may be necessary for her to keep some distance from the painful feelings for the time being. Sometimes this results in a return to the painful experience itself. Regardless, allying with the resistance rather than challenging can help patients to at least access avoided aspects of experience.

A second form of allying with the resistance involves validating mistrusting and despairing aspects of the self. In situations where patients have difficulty accessing more trusting and hopeful parts of the self, therapists may find it useful to spend considerable time allying with the more mistrusting and despairing aspects of the self. This process can gradually transform the situation so that patients can ultimately bring the more hopeful aspects of the self into the treatment. For example, a patient despaired about the possibility of being helped by the therapist, maintaining that he did not feel trusting enough to talk about important and embarrassing concerns. The therapist responded that it was appropriate for the patient not to trust her since she had not yet earned his trust. She thus empathized with the underlying mistrust. Furthermore, she maintained that for the patient to experience his mistrust in the context of the therapeutic relationship right now was "the work of therapy" and that there was nothing that he should be doing other than what he was doing.

- ***Provide a therapeutic rationale for your techniques, actions, and/or*** behaviors [SCRIPT 8]:

SCRIPT 8:

One of the more basic interventions for addressing alliance ruptures consists of outlining or reiterating the treatment rationale. When therapists detect strains in the alliance, they can check to see if patients are clear about the rationale, and if not, they can reiterate it and clarify any misunderstanding. One means of doing this is microprocessing tasks, or exercises assigned to patients in order to help them develop a concrete understanding of the type of internal processes that play a role in therapeutic change. For example, patients in cognitive therapy can be asked to report on their automatic thoughts in session or between sessions by keeping a thought record as a way of helping them learn to self-monitor and to illustrate how cognitive therapy works. Although conveying a therapeutic rationale to the patient is accorded a central role in the cognitive-behavioral tradition, it is typically given less emphasis in other traditions, but we are now seeing notable exceptions in the psychoanalytic and humanistic traditions: for example, scripted explanations of how free association works and of how focusing on emotional experience is therapeutic.

- ***Discuss the here-and- now therapeutic relationship with your client*** [SCRIPT 9]:

SCRIPT 9:

The focus should be on the here-and-now of the therapeutic relationship and on the present moment, rather than on events that have taken place in the past (i.e., either in previous sessions or at different points in the same session). There is a tendency for both patients and therapists to deflect the focus from the here-and-now of the therapeutic relationship because it is too anxiety-provoking. Commenting on what is happening in the moment facilitates the process of mindfulness for patients. To the extent that therapists are able to comment on whatever is happening in the moment, it will become easier for patients to develop a grounded experiential awareness of both their actions and the internal experiences associated with those actions. It also helps to challenge their existing relational schemas by drawing their awareness to any therapist actions that are discrepant with their expectations.

The focus should be concrete and specific, rather than general. Whenever possible, questions, observations, and comments should focus on concrete instances. Concreteness promotes experiential awareness, rather than abstract, intellectualized speculation. Thus, for example, if in the context of exploring what is happening in the therapeutic relationship, the patient says, “I tend to back away from expressing negative feelings,” the therapist can ask, “Are you aware of avoiding expressing negative feelings right now with me?” When providing therapeutic feedback, rather than saying, “You tend to speak in a very abstract way,” the therapist can say, “What you’re saying right now seems kind of abstract to me.” When patients’ attention is directed to the concrete and specific, they can make their own discoveries rather than feeling they must “buy into” the therapist’s version of reality. This type of concreteness and specificity helps them to become observers of their own behavior. It thus promotes the type of mindfulness that fosters change.

- ***Give and ask for feedback on the therapeutic relationship*** [SCRIPT 10]:

SCRIPT 10:

Feedback can be understood in different ways. There is the structured approach associated with cognitive therapy whereby each session devotes some time to soliciting feedback from the patient regarding the treatment process and the therapeutic relationship. There is also a more process-oriented approach that can be applied when encountering an alliance rupture or treatment impasse. This is exemplified by the principle of therapeutic metacommunication, simply defined as communication about the communication process. Metacommunication involves any attempt to invite a collaborative inquiry about the patient-therapist interaction as it is happening in the here-and-now. It can begin by focusing on the patient experience with questions like "What are you feeling right now?" or observations like "You sound angry to me." It can also focus on the interpersonal field with questions like "What's going on between us?" or observations like "It seems like we're in some kind of dance in which we're being very careful not to step on each other's toes." And sometimes it can focus on the therapist experience with questions like "Do you have any thoughts about what might be going on for me right now?" or self-disclosures like "I'm aware of feeling really defensive right now." It is important when engaging in communication that the therapist remain curious, nondefensive and open to elaborating on understanding the rupture with the help of the patient. The rupture results from the interaction between patient and therapist and thus can only be resolved with contributions from both.

- ***Spend more time exploring your client's experiences*** [SCRIPT 11]:

SCRIPT 11:

Ruptures are windows into the internal world. They represent opportunities to expand therapist understanding and patient awareness of beliefs and expectations concerning self and others. It can be important in the face of a rupture that therapists don't just try to change things to make things better. Taking time to understand the details of experience associated with a rupture can be therapeutic in itself. The therapeutic relationship can be a very useful laboratory for exploration and change. Often such explorations will involve therapists, and not only patients, confronting their own beliefs and expectations. In other words, therapists require the courage to confront themselves.

- ***Pay attention to subtle cues that there may be a problem with the alliance*** [SCRIPT 12]:

SCRIPT 12:

Alliance ruptures are not always conspicuous. We have distinguished between two types of patient communications that mark a rupture: Withdrawal and Confrontation markers. Previously, we have described these rupture types in detail. There are two additional types that are more subtle and will highlighted here. The first, withdrawal from self, involves any movement away from an emotional state in order to appease the therapist (thus a movement away from self and towards the therapist). Withdrawal from self may manifest as expressions of overcompliance, or begrudging acceptance of whatever the therapist asks or suggests. This can result in a so-called *pseudo-alliance* between patient and therapist. What the therapist should attend to in regard to such ruptures is any sign of hesitancy on the patient's part or any uneasy feeling within the therapist. In other words, therapists should use their own internal experience as an emotional compass of what may be happening in the therapeutic relationship. The second subtle rupture type is the confrontation characterized by control rather than aggression. Patient behavior that may be experienced as overly friendly or overly managing of the session dialogue are examples of this type of confrontation. These behaviors may be quite subtle, making it critical for therapists to attend to their own experience as a guide to whether something not obviously detectable does not quite feel right.

- ***Allow the client to assert their negative feelings about the relationship*** [SCRIPT 13]:

SCRIPT 13:

Courting assertion is essential for therapists, especially with regard to alliance ruptures. To begin with, it is important for therapists to understand that they are not necessarily in a privileged position of knowing what is going on in the therapeutic relationship. There are ways in which they unwittingly contribute to ruptures, and hearing the patient's perspective is integral to understanding in a fuller sense. Assertion of negative feelings is an essential aspect of rupture resolution, whether with regard to withdrawal or confrontation ruptures. The common progression in withdrawal rupture resolution consists of moving through increasingly clearer articulations of discontent to self-assertion, which is often marked by avoidant operations. To facilitate the resolution process, it is important for therapists to be inviting and open to patients' negative sentiments. In confrontation rupture resolution, patients' initial expressions of anger towards the therapist are frequently mixed with anxiety and avoidance due to fear of the therapist's rejection or retaliation. The initial task for the therapist is to encourage patients to stand behind their anger before feelings of disappointment and vulnerability can emerge. Therapist openness and nondefensive responses to patient assertion of negative feelings can be critical for providing a corrective emotional experience.

- ***Accept responsibility for your part in alliance ruptures*** [SCRIPT 14]:

SCRIPT 14:

Therapists should always accept responsibility for their contributions to the interaction. Bear in mind that as therapists we are always communicating more or less than we are consciously aware and are thus contributing to patients' responses. The task is thus one of working in an ongoing fashion to clarify the nature of our contributions. In many cases, the process of explicitly acknowledging one's contribution to the patient's experience and response can be a particularly potent intervention. First, this process can help patients to become aware of inchoate feelings that they are having difficulty articulating, in part because of their fear of the interpersonal consequences. For example, acknowledging that one has been criticizing a patient can help him or her to acknowledge the resulting hurt and resentment. Second, the process of explicitly acknowledging one's contribution to the interaction can validate patients' conscious and unconscious perceptions of what is taking place and help them to trust their own judgment. Since patients often accurately perceive ways in which therapists contribute to the interaction, but have difficulty articulating their perceptions, the process of explicitly acknowledging one's contribution as a therapist can play an important role in decreasing the type of mystification that has been common in the patient's interpersonal relationships. Third, by validating the patients' perceptions through this type of acknowledgment, therapists can reduce patients' self-doubt, thereby decreasing their need for defensiveness and paving the way for the exploration and acknowledgment of the patient's contribution to the interaction.

- ***Explore with your client their fears about asserting their negative feelings about the relationship*** [SCRIPT 15]:

SCRIPT 15:

In exploring a rupture experience, and particularly when expressing negative feelings, patients can become anxious and avoidant. Their anxiety and avoidance can mark a fear of being rejected or abandoned by the therapist because of what they expressed. They can also experience fear of retaliation by the therapist after confronting or expressing disappointment in the therapist. This is a significant part of the rupture resolution process that can result in a return to exploring the rupture experience, but also it can provide a therapeutic benefit in and of itself – by making patients more aware of their anxieties and avoidant behaviors.

- ***Give more positive feedback*** [SCRIPT 16]:

SCRIPT 16:

Therapists should try to approach ruptures with the attitude that these events represent therapeutic opportunities, despite the attendant emotional challenge. They can convey this to their patients both implicitly and explicitly. Therapists should see ruptures as windows into the patient's internal world and opportunities to expand awareness and to provide a corrective emotional experience. Thus they should provide positive feedback about the expression of negative feelings regarding the therapeutic relationship, whether in the form of anger, disappointment, discontent or anxiety. They should acknowledge the difficulty in negotiating negative feelings as a form of validation and encouragement.

Two important caveats: First, this positive attitude should be genuinely felt and expressed. Any artificial or disingenuous expression will probably lead to further rupturing. Second, when faced with patients' despair, therapists should be careful not to become overzealous champions of hope. This can be polarizing and push patients to defend their hopelessness. This polarization is often the result of the therapist's own fear of despair. Better to try to tolerate and understand patients' despair. From this position hope can be rekindled.

- ***Process transference and be aware of countertransference*** [SCRIPT 17]:

SCRIPT 17:

Therapeutic metacommunication can also serve as an organizing principle for processing transference and countertransference. In contrast to some takes on transference interpretation and countertransference, the orientation recommended by this principle is on near-experience, what is transpiring on the here-and-now of the therapeutic relationship, trying to unpack the details of the patient-therapist interaction, including implicit beliefs and associated patterns of behavior. Making links to outside relationships, to significant others, is de-emphasized, as these can run the risk of blaming the patient for the rupture. There is a good deal of research to support this risk. The therapist should be seen as a contributor to the rupture and as NOT in a privileged position of knowing. The therapist requires the patient to contribute to a conversation about the rupture to truly understand what happened. In other words, the rupture should be understood as co-constructed and as something that can only be co-resolved.

- ***Discuss therapist and therapeutic style match*** [SCRIPT 18]:

SCRIPT 18:

Matching patients to therapists and various therapeutic models is complicated matter. There are different ways to address this question. Here I will focus on interpersonal implications, especially because we're considering problems in the therapeutic alliance. It is important for therapists to consider the therapeutic implications of their interpersonal stance, whether that stance is determined by the therapist's personality or their chosen treatment approach. This stance has significant implications for the negotiation of the therapeutic alliance. Research suggests that the therapist's affect and affiliative position elicits a matching or complementary stance in the patient, and vice versa: Friendliness begets friendliness, hostility begets hostility, dominance begets submission, and so forth. Thus, for example, a friendly-dominant personality would pull for friendly-submission (and vice versa). Every personality has a particular disposition, and personality disorders have even stronger dispositions, on these dimensions. The personality dispositions of therapist and patient can pose challenges and contribute to alliance ruptures. In a similar sense, certain therapeutic models dictate particular interpersonal dispositions for therapists. For example, a cognitive therapist would frequently assume a more friendly-dominant position than a person-centered therapist. Something for therapists to consider is what therapeutic implications their interpersonal stance has for a given patient personality (whether dictated by their personality or their therapy model). For example, a very structured treatment might be regulating or enabling for a given patient or in a given time during the course of therapy. It can certainly be useful for therapist to explicitly discuss the question of match with their patients.

- ***Discuss shared experiences*** [SCRIPT 19]:

SCRIPT 19:

In this form of feedback, the therapist comments on what may be a shared experience as a lead into exploring any patient feelings, perceptions, or attitudes that may be associated with the interaction. For example, the therapist might say: “It feels to me as if the two of us are playing chess.” Or “It feels to me like the two of us are being very cautious with one another right now.” Or “I have a sense that both of us are being very polite right now.” Or “It feels to me like we’re both being very tentative right now.” Or “It feels to me like I’m constantly intruding, and you’re trying to politely keep me out.” If the observation resonates with the patient’s experience, the therapist can ask him or her to further elaborate on the therapist’s experience of the interaction. Conversely, if it fails to resonate, the therapist can ask the patient to try to put into words his or her own experience of the interaction.

The implicit message should always be one of inviting the patient to join the therapist in an attempt to understand their shared dilemma. During periods of therapeutic impasse, patients typically feel alone and demoralized. The therapist becomes one in an endless succession of figures who are unable to join with the patient in his or her struggle. The therapist becomes another foe rather than an ally. The therapist begins the process of transforming the struggle by framing the impasse as a shared experience.