

## THE GENERALIZABILITY OF THE PSYCHOANALYTIC CONCEPT OF THE WORKING ALLIANCE<sup>1</sup>

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**ABSTRACT:** *The psychoanalytic concept of the working alliance is reviewed and elaborated. It is argued that various modes of psychotherapy can be meaningfully differentiated in terms of the kinds of working alliances embedded in them. Moreover, the strength, rather than the kind of working alliance, will prove to be the major factor in change achieved through psychotherapy. Strength of alliance will be a function of the goodness of fit of the respective personalities of patient and therapist to the demands of the working alliance. Past research bearing on these propositions and indicated future research are discussed. Extensions to changes sought in teaching and other group processes are briefly touched.*

Proliferation of psychotherapies has dominated the sixties and seventies. Thirty-six psychotherapies (Harper, 1959) had to be supplemented by an additional compilation (Harper, 1975). Unchecked, this trend would come perilously close to the solipsism, a psychotherapeutic method for each psychotherapist. Not unexpectedly, research in psychotherapy has suffered from an analogous lack of convergence, and with it a disappointing impotence about providing empirical tests of competing claims. As Donald Campbell (1976) suggests, given the wide prevalence of the need for psychotherapy, and the continuing ability of individuals or society to pay for it, the winnowing of this harvest of methods must come from research.

Campbell (1976) speaks to the practitioner, exhorting him or her to engage in systematic follow-up. This essay addresses those prac-

tioners who are also research workers, to call attention to a point of view that can encompass most, if not all, approaches to psychotherapy and can lead toward the needed convergence in research. There has been a promising rate of growth of research and research workers, with encouraging trends toward a coming together on basic issues: I aim to contribute to that movement. Moreover, because of the generalizability of my ideas to all change situations, I hope to stimulate research applications to teaching and to community change processes.

I propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process. The working alliance can be defined and elaborated in terms which make it universally applicable, and can be shown to be valuable for integrating knowledge—particularly for pointing to new research directions. As my initial statement suggests, a working alliance between a person seeking change and a change agent can occur in many places besides the locale of psychotherapy. The concept of the working alliance would seem to be applicable in the relation between student and teacher, between community action group and leader, and, with only slight extension, between child and parent. While I believe such extensions to be fruitful, they are beyond the scope of this paper. I shall confine myself to the therapeutic working alliance, making only brief inferences to extensions to other change enterprises.<sup>2</sup>

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<sup>2</sup> One might extend the idea of working alliances to non-change situations. Although prisons, under reform ideology, have been set up as change situations, most observation suggests that staff and inmates typically arrive at a mutually agreed-upon alliance to get through their relationship with as little upset as possible.

Four propositions provide a conceptual framework for understanding the differences among different theories and approaches to psychotherapy, and point the way for converging investigations.

1) All genres of psychotherapy have embedded working alliances and can be differentiated most meaningfully in terms of the kind of working alliance each requires.

2) The effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance.

3) Different approaches to psychotherapy are marked by the difference in the demands they make on patient and therapist.

4) The strength of the working alliance is a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of patient and therapist.

#### THE THERAPEUTIC WORKING ALLIANCE IN DIFFERENT THERAPIES

The terms of the therapeutic working alliance have their origin in psychoanalytic theory, but can be stated in forms generalizable to all psychotherapies. Two foundations of the working alliance are to be found in the psychoanalytic literature. One of these stems from such views as those of Sterba (1934) on the alliance between analyst and the rational ego of the patient, and of Menninger (1958) on the central importance of the therapeutic contract. The second draws, among others, on Zetzel (1956) and especially on Greenson (1967) for the significance of the real relationship in psychoanalytic work. Fusing these contributions, we can speak of the working alliance as including three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds.

In elaborating on these three aspects, not only will I treat them in the context of psychoanalysis or psychoanalytic therapy, but will attempt to demonstrate their application to other forms of psychotherapy. Research on the working alliance should initially be directed at testing the applicability of these ideas to all varieties of psychotherapy.

#### *Agreement on Goals*

The ecology of psychological help-seeking is

such that the patient's goals—or at least the ground work for goals he agrees on with the therapist—are commonly laid in the patient's commerce with other helpers prior to the first meeting with the analyst. The significance of these prior bargains should not be overlooked. Psychoanalytic (perhaps all psychodynamic) treatment rests on the mutual agreement that the patient's stresses, frustrations, and dissatisfactions are to a significant extent a function of his own ways of thinking, feeling and acting. The aim of treatment is to examine, modify or ameliorate his or her own contributions to, or exacerbation of, these pains. The circumstances of life create barriers toward acceptance of such a goal. One could be in such strained economic circumstances that he is suffering from malnutrition, or one may be living under lawless conditions, where the malevolence of others is also life threatening. No one in these circumstances, even without economic barriers toward entering psychoanalysis, could be concerned with a goal which concentrated on changing himself, rather than on these immediate imperatives of maintaining life. Even persons with less dramatic and less realistic external pressures can be and are convinced that the sources of their difficulties are external to themselves. The early stages of psychodynamic modes of therapy are likely to be devoted to exploring current experience and life history, with the therapist seeking to call attention to ways in which the individual shares responsibility for his unsatisfactory experiences.

My curbside survey of psychotherapies suggests that they vary in their emphasis on the central and enduring qualities of the goals that the therapist defines, either explicitly or implicitly<sup>3</sup> as those on which he is willing to collaborate with the patient. Psychodynamic views, especially psychoanalytic views, are directed toward an enduring core of thought and feeling that are seen as determining action and experience. Behavior therapists take a divergent position, doubting the importance, or even the reality, of such central cores and, consequently, directing attention and goals to changing specific acts of the individual in commerce with others or with his physical environment. This situational

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<sup>3</sup> Social psychologists concerned with group process are touching on similar negotiations re goals when they speak of the hidden agenda of group leader and members.

specificity not only highlights differences in the durability of the changes sought, but also shows differences in the scope of the person's life that might be encompassed by therapeutic goals. These range from the psychoanalytic perspective, which sees the individual functioning in so integrative a fashion as to encompass all of his ways of thinking, feeling and acting in all situations, to the behavior position which requires no such set of encompassing functional relations. Therefore, in behavior therapy, goals are more likely to be directed toward very specific, sometimes narrow, segments of the individual's life.

### *Tasks*

Collaboration between patient and therapist involves an agreed-upon contract, which takes into account some very concrete exchanges. The patient must pay for the therapist's skills and efforts. Even more crucial for differences in therapeutic methods are the kinds of tasks assigned to patient and therapist. We all know that psychoanalysis specifies the rule of free association and seeks to highlight attention to the flow of inner experience by the technical specifications of couch, blank screen, and positioning of therapist away from the patient's center of vision. Behavior therapies and other psychodynamic therapies do not insist on attention to the continuous flow of inner experience, but they do require honesty in reporting on one's life and most of them, even some forms of behavior therapy, require self-observation of inner experience. The focus of attention varies; its requirements are not always the same. In behavior therapy, because it is concerned with a functional analysis of a particular set of behaviors, the patient or an associate may be assigned the task of observing and tabulating the frequency and circumstances surrounding a particular action, *e.g.*, assertive behavior. Gestalt therapy, among others, requires attention to action rather than thought content. I am convinced, as are others, that the effectiveness of such tasks in furthering movement toward the goal will depend upon the vividness with which the therapist can link the assigned task to the patient's sense of his difficulties and his wish to change. (In the teaching enterprise, the recent cry for "relevance" represents a search for an analogous linking of goal and task.) This set of assumptions about the change process is impor-

tant, and it is susceptible to empirical verification. One interesting anomaly in this set of assumptions is that there may be modes of therapy—client-centered therapy may be one example—in which tasks are never explicitly specified, and only emerge gradually and ambiguously. In many forms of contract management in behavior therapy, the task assigned is the specific behavior change sought, with the expectation of positive reinforcements controlled by the therapist or another.<sup>4</sup>

The tasks assigned the therapist in alternate methods of psychotherapy also vary. We are all familiar with the many ways of designating these therapeutic tasks; activity-passivity, empathic understanding, communicating, interpreting, self disclosing, etc. These are needed to complete the picture of the sort of collaborative effort that particular varieties of psychotherapy require.

### *Bonds*

The goals set and collaboration specified appear intimately linked to the nature of the human relationship between therapist and patient. For example, two persons will be more concerned about liking or disliking each other if they are proposing to settle into a working relationship of several years duration, meeting three or more times a week, than if their relationship is expected to terminate in three months or less. Some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed. Our examinations of such features of therapeutic work need to be more pointed. For example, the kind of bond developed when a therapist gives a patient a form and asks him to make a daily record of his submissive and assertive acts and of the circumstances surrounding them, appears quite different from the bond developed when a therapist shares his or her feelings with a patient, in order to provide a model, or to provide feedback on the patient's impact on others. One bond may not necessarily be stronger than the other, but they do differ in kind.

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<sup>4</sup> A good example is the treatment of depression by asking and even rehearsing the patient to engage in behaviors designed to elicit positive responses from others.

Another nuance in the therapeutic bond might be defined by the difference between a caretaker and a consultant. Some modes of psychotherapy have much more of a take-charge element built into them. Interestingly, two otherwise quite different approaches to psychotherapy, behavior therapy and psychoanalysis, are similar in containing a strong element of taking responsibility, as does rational-emotive therapy. The free association rule, sometimes implicitly, sometimes explicitly, asks the patient to replace his attention toward his specific hurts and self-dissatisfactions with a free-floating set, and tells the patient that the therapist will at least temporarily take over the executive functions for him. The exaggerated emphasis on the status of the behavior scientist clearly casts the behavior therapist in a major executive role. At the other extreme, the very ideology of client-centered therapy tends to mute the responsibilities of the therapist and highlight those of the patient.

#### STRENGTH OF WORKING ALLIANCE AND EFFECTIVENESS

The newness of the idea that the strength of collaboration between patient and therapist may have more to do with the effectiveness of the therapy than the particular methods chosen ensures that there will be little direct evidence available to test the proposition. Using Ryan's (1973) measure of patient collaboration with psychoanalytically-oriented therapists, Sarnat (1975) found better than chance relations between independently rated levels of collaboration and judgments of outcome, as well as the occurrence of premature termination. Horwitz (1974) reviewed the process and follow-up data in the long-term Menninger Clinic study of forty-two patients, half of whom had been treated by psychoanalysis, and half by psychoanalytically-oriented psychotherapy. His most striking conclusion, contrary to expectation, was that there were no marked differences in outcome according to treatment mode, but "that a major contribution of this study is the indication that the therapeutic alliance is not only a prerequisite for therapeutic work, but often may be the main vehicle of change." Thus, all of the sources of direct data are founded in therapy from a psychoanalytic persuasion. A broader ranging confirmation would have to depend on the prior demonstration of the applicability of a

generalized measure of the strength of the working alliance to varieties of psychotherapy and to testing its relationship to outcome in these varieties.

There are, however, two lines of inquiry which provide indirect evidence supporting the proposition that outcome is a function of the strength of the working alliance. One line of evidence comes from the work on the influence of expectations on therapeutic outcome by such investigators as Frank (1961, 1964), Goldstein (1962), Orne (1968), and Strong (1968). Some of these concerns with expectations have treated them as subjects for manipulation, *e.g.*, through artificial attributions of status or expertness to the therapist. The conceptual framework of the working alliance, in emphasizing the need for consensus, directs attention to the process of reaching agreement, and gives less attention to the manipulation of expectations (Goldstein, 1962; Strong, 1968). It seems certain that both parties, change seeker and change agent, come with sets reflecting faith, hope, and experience—in group dynamics parlance they are spoken of as hidden agenda—which must be openly encountered in the forging of a strong alliance. Frank and his associates at Johns Hopkins (Frank, 1961; Hoehn-Saric *et al.*, 1964) have demonstrated the facilitating effects of Orne's (Orne & Wender, 1968) proposed patterns for inducing mutuality of expectations with regard to goals and tasks in individual and group therapy. As indicated earlier, the patient's readiness to collaborate in a psychodynamically oriented goal may be a function not only of his personal characteristics, but of the nature of his environmental pressures and supports. I suspect that the reason Lerner (1972) was able to report that her therapists succeeded in psychodynamically oriented therapy with lower class, economically deprived patients, was that her social-worker therapists owed as much, both intellectually and emotionally, to Jane Addams as to Freud. This means that they were first willing to be concerned and involve themselves with their patients' "mundane" problems of keeping alive and achieving minimum creature comforts before turning attention to goals aiming at changes in their thoughts and feelings.

The other stream of indirect evidence comes from the research of client-centered investigators, particularly from Rice and her collaborators (Rice & Wagstaff, 1967; Rice, 1973;

Rice & Gaylin, 1973). Their strategy consisted of developing a linguistic measure of client-expressive style, which reflected how thoroughly he or she was entering into the self-experiencing task stipulated as both process and goal in this kind of therapy. Their research demonstrates that those clients who initially exhibit the greater capacity to respond in that manner are judged to have improved most. Interestingly, Sarnat (1975) found little overlap between this client-centered measure and a psychoanalytically-oriented measure of client collaboration developed by Ryan (1973). At the same time, both measures showed predictive value for the outcome of psychoanalytically-oriented treatment. But the client-centered measure was only significant with a number of interviews partially out; the reverse was true for the psychoanalytically-oriented index of collaboration.

In addition, she found that Ryan's measure, unlike the client-centered measure of voice quality, was predictive of whether or not premature termination occurred, in itself a reflection of strength or weakness of the alliance. These results might suggest that although some elements of the client-centered alliance do fit psychoanalytically-oriented psychotherapy, they do not fit well enough to forecast either early termination or the deeper changes achieved in longer term processes.

#### THE PERSONAL DEMANDS OF DIFFERENT WORKING ALLIANCES

The third and fourth propositions deal with the personal demands of different working alliances and strength of the alliance as a function of fit. Since differentiation of the evidence for these two propositions must rest on the design of measures of each type of working alliance and on measures of strength to be applied to each, measures largely undeveloped, our review of the available evidence will not be readily separated into support for one or the other. Therefore, the review of available data and research needed will be discussed under this one heading.

Most of the data for inferring the demands of working alliances bear on the characteristics of the client or patient. Social class differences in the treatment that patients receive may, in part, reflect an influence of a combination of situational pressures and psychological sophistication on the person's readiness to enter into a psycho-

dynamically-oriented alliance. The aforementioned situational orientation of the behavior therapist is likely to echo the concerns of the economically-stressed person and the world view of less educated persons, thereby making it easier for such persons to enter into the therapeutic contract offered by behavior therapists. Indeed, I am inclined to believe the generalization that it takes specific acculturation for a person to accept psychodynamic goals and the connection between the tasks assigned and the achievement of those goals. The focus on the body, contained in bioenergetics, may be another example of goals and tasks that more readily correspond to the man in the street's level of understanding, especially the tendency to substitute somatic symptoms for psychological discomforts.

The patient's readiness to accept a particular goal of treatment may turn out to be intimately linked to capacities or dispositions, which in turn are related to how easy it is for him to collaborate in the particular mode of treatment directed toward that goal. I have already cited the stresses of the patient's life and subculturally-conditioned norms for coping actions as two possible influences on the kinds of goals that patients will find meaningful. When the stresses created by fright about depersonalization, hallucination, delusion or other experiences of being out of control and out of touch exceed those experienced as originating outside the person, he is likely, up to a certain point, to understand and accept a goal and a method oriented toward his inner experience.<sup>5</sup> But beyond that point, his fear may be so great as to induce him to flee from such a confrontation. He can, in fact, only enter into a collaboration designed to deal directly with the fright. The take-charge element in the therapist's part of the task arrangements may be a vital factor in the extremely frightened patient's entering into a particular therapeutic collaboration. Ryan (1973) found that indices of hope ascertained through independent interviews and level of development of object relations, as inferred from early memories, were related to the strength of the working alliance manifested at the start of psychotherapy. This points to the possi-

<sup>5</sup> For a review of the complicated, indirect evidence linking anxiety and other indices of psychic pain positively with outcome and negatively with early termination, see Bordin, 1974, pp. 194-199.

bility that enduring dispositions play a part in the ease with which certain alliances are entered.

Many of the other characteristics required to meet the demands of various therapeutic tasks, such as psychological-mindedness and preferences for work styles, may also influence the likelihood that a person will find certain therapeutic goals meaningful.

Turning attention more fully to the differential demands of alternative treatment methods, and the characteristics of the patient which influence his ability to comply with the tasks associated with that collaboration, I go beyond the trait of psychological-mindedness because, while it seems important, it also seems ambiguous. Many of the characteristics I will mention appear to be partial referents of what may be represented by psychological-mindedness as a collective term. As I suggested earlier, virtually all methods of psychotherapy require the patient to observe her- or himself. The varieties of psychodynamic therapies are similar in focusing on the feedback that the person gets from his thoughts, feelings and bodily experience of his actions, but may, nevertheless, differ. Thus, while all psychodynamic therapies make considerable demands for introspection and self-observation, some may make more insistent demands for oscillation between observation and action. Other modes, or other features of the same therapy, may demand oscillation between experiencing and abstracting and generalizing. Rice and Gaylin (1973) found that those who responded to psychotherapy with a turning inward of attention and energy and directed it toward self-exploration were marked by such Rorschach indices of flexibility and creativity as the total number of responses, the proportion featuring determinants other than form, and the number featuring complex organizations. Sarnat (1975) obtained partial replications within psychoanalytically oriented therapy.

As I look at various psychodynamic and behavior-oriented treatment, I find evidence that the vividness with which a patient is able to recapture experiences and to create fantasied ones is a requirement for successful treatment. All of these, the vividness of memory and fantasy, fullness of self-observation, abstracting and generalizing, and oscillation seem to me ready targets for psychological measurement and research. Investigation leading to the understanding and measurement of such processes will

in turn foster more incisive examination of the interaction between patient characteristics, performance in the tasks assigned in psychotherapy, and its outcome.

Research on attrition has already demonstrated a firm connection between performance on intelligence tests and the likelihood of premature termination. Whether such findings are functions of the fact that most of the psychotherapy under investigation relied on the verbal facility of the patient for communication, or are functions of the more subtle features which link intellectual and emotional functioning is still to be proved.

The division of responsibility between therapist and patient as a feature of collaboration appears likely to tap into the patient's anxieties about dependency, and the ways that he copes with them. The counter-dependent person is likely to find the client-centered emphasis on his responsibility very congenial, at least as a beginning. The demystifying elements in behavior therapy might also appeal to the counter-dependent. Yet research by Cairns (1961, 1962) and Stewart & Resnick (1970) suggest that counter-dependents are difficult to condition. My own ideas about dependency (Bordin, 1965) suggest that the relations of the conditions of the working alliance to anxieties about dependency are likely to prove complex. I am convinced that the bonding aspects will be particularly important from the very beginning for the overtly dependent person but, while possibly interfering at first, will be necessary at later stages for the counter-dependent as well.

Differences in preferred work styles (many of which are intimately related to character formation) might be expected to influence differential readiness for varieties of therapeutic collaboration. Braatøy (1954) has suggested that hysterics will take more readily than obsessive-compulsives to an emphasis on body position and movement, which is so prominent in Gestalt and bioenergetic approaches. Since this suggestion contradicts Perls' evident conviction that his methods are particularly valuable as an antidote to the latter groups' preoccupation with words and with intellectualizations, systematic examination of the vicissitudes of attention to the body with obsessive-compulsives will be of particular interest. Tolerance for ambiguity and uncertainty would seem to be another fruitful area for investigation, and some work on it has been done

(Bordin, 1966; Schneider, 1953; Temerlin, 1956). Here we would need to look at possible differences according to whether it is an unclearly defined task, the wide latitude offered by the task, or the anonymity of the therapist which is the source of ambiguity.

The idea that the bonds between patient and therapist have a significant positive role in psychotherapy is sufficiently new to leave us with a relatively undeveloped set of specifications regarding it. In his extremely interesting analysis of the role of the therapeutic alliance in the outcome of psychotherapy in the Menninger project, Horwitz (1974) discusses the patient's capacities to see the therapist as a good object as an influence toward establishing a strong working alliance. Presumably such capacities are intimately related to hopeful and trustful states and dispositions. It is extremely likely that we are not just dealing with static conditions, and it is likely that these conditions are responsive to the adaptive responses of the therapist. Horwitz deals with such alternatives when he speaks of the possibility that, in particular instances, a more effective and stronger working alliance could have been achieved through inpatient as compared to outpatient treatment.

While there has been some exploration of the influence of personal conflicts and neurotic dispositions on ineffective therapist performance, investigations of the relation of his personality characteristics to the therapist's willingness and ability to perform certain tasks, and to the kinds of bonds established, are rarer. There is weak evidence of involvement of Rorschach (Allen, 1967; Mueller & Abeles, 1964) and MMPI (Bergin & Jasper, 1969; Bergin & Solomon, 1970) indices in empathic sensitivity. The scattered, indirect, and complex evidence bearing on how personality factors influence the therapist's readiness to like or care for his patient, his willingness to disclose his feelings and past experiences, and his activity and passivity in therapeutic relationships has been reviewed elsewhere (Bordin, 1974) and will not be repeated here. That review reveals the fallowness of the ground.

To the extent that psychotherapy is a significant feature of their life's work, we may assume that psychotherapists, whatever extrinsic satisfactions they seek, are drawn by the gratifications intrinsic to their work. Current views of psychotherapy no longer confine considera-

tion of the therapist's personal satisfactions to the negative aura of countertransference or other such concepts. This emphasis on positive influences of satisfaction would lead me to expect that differences in working alliances embedded in the varieties of psychotherapy will be found to be reflected in personal differences in the therapists drawn to each variety. These differences will mirror the kinds of satisfactions they might be expected to seek, their preferences for work styles, and certainly, their capacities to meet the demands of the particular kinds of alliances. Many of the humanistically-oriented psychotherapies call for much greater self-disclosure. Behavior therapies tend to be less explicit, but those that place heavy emphasis on the therapist as technician would seem to mute self-disclosure. One would infer that the working alliance in such behavior therapies placed lighter demands on therapist empathic skills, since attention is directed toward overt behavior rather than the covert processes of thought and feelings. Yet the recent (as yet unpublished) research by Sloane, reported by Bergin & Suinn (1975), produced evidence that three behavior therapists received higher empathy ratings than three analysts, all of whom were involved in a comparative study. I leave this seeming anomaly to future investigators. What enduring results have come out of research on the A-B scale, as an index of differential effectiveness with schizophrenic patients, derive, I am certain, from the fact that the scale is founded in a set of responses that have been shown to be functionally related to vocational choice (Chartier, 1971; Razin, 1971).

The perspective of the working alliance leads me to the conclusion that the matching of the therapist and patient in terms of personality will be most precisely understood in terms of the mediating effects of the demands of that working alliance, which simultaneously meets the needs of patient and therapist. Whether, for example, similarity or complementarity is to be expected will depend on the relations of the demands on the patient to those on the therapist and how well fitted each is by that particular alliance.<sup>6</sup>

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<sup>6</sup> Though not interpreted in working alliance terms, the research of Mann and his collaborators (Mann *et al.*, 1970) on the influence of the interaction of teachers' and students' styles on the classroom process would be an example of its application to the teaching-learning situation.

A NEW IMPETUS TO ASSESSMENT  
AND DIAGNOSIS

In recent years there has been a marked disaffection with assessment and diagnosis among those immersed in psychotherapy, perhaps most evident among psychologists. There are undoubtedly many reasons for this development: aversions to static designations, concern over threats to civil rights associated with some labels, etc. Psychologists, whose discipline was most involved with the development and validation of various devices and procedures for personality assessment, were demoralized by much negative evidence on the validity of these methods and lost interest; also because such methods did not seem, on the face of it, of any use in making treatment decisions.

I believe that I have shown that the application of the terms of the working alliance leads to much more specific formulations about the function of specific personal characteristics of both patient and therapist. I am hoping that this greater specification will provide a source of guidance and inspiration to the personalists among us to stimulate a renewed effort at investigating these personal characteristics so that we can understand them, and through that understanding discover more efficient and pointed methods of assessing them.

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