Psychotherapeutic Alliances

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Using the empathic method in psychotherapy inevitably means understanding the expectations of both client and therapist in a therapeutic relationship, expectations that shape tacit psychological contracts and de-facto alliances. Breaking or fulfilling these de-facto alliances significantly contributes to the success or failure of the psychotherapy. For example, when a client and his/her therapist have divergent expectations, misunderstandings generally occur that may create client feelings of not being empathically understood, or foster stalemates and/or unexpected, messy terminations. Inevitably, unclear misalliances and less-than-anticipated outcomes, disappoint clients and psychotherapists, and help generate a belief that psychotherapy is, at best, marginally worthwhile. Importantly, a pattern of psychotherapeutic failures or less than satisfactory outcomes resulting from misalliances, will undermine the success of a psychotherapist's practice.

Detecting de-facto psychotherapeutic alliances requires an ability to discern the unspoken goals of a psychotherapeutic relationship. This discernment does not depend on an "objective" diagnosis of a patient, based on symptoms and psychopathological categories, but on the implicit assumptions under which the sessions are functioning. Such a concept of alliances that are open to change by mutual consent as a psychotherapeutic relationship develops has been around for a long time. For example, it was implied when Freud (1913) conceived of psychoanalysis going through "beginning," "middle" and "termination" phases, with different tasks in each of them. In a modern psychotherapy practice, it is now

possible to think of co-transferences evolving through several alliances before termination is reached, alliances that point to a much broader understanding of psychotherapy than the valuable concept of "therapeutic alliance" that Zetzel (1956) introduced into psychoanalysis.

During psychotherapy, the alliance generally resides in the background of the relationship. The need to monitor such alliances has been accentuated by ongoing theoretical changes in psychoanalysis, the emergence of intensive psychoanalytic psychotherapy, the growth of a strong counselling movement, and the gradual adoption of the generic term "psychotherapy" to cover all types of psychological healing. These accumulated changes have broken down the barriers of discrete psychotherapeutic modalities and created the need for an inclusive theory of treatment alliances to help understand the variety of requests for therapeutic help, especially in private practice. For example, clients seeking brief or weekly counselling with specific goals, may be significantly helped without needing repairs to their self-organization that require years of psychoanalysis or intensive psychoanalytic psychotherapy. On the other hand, such counselling experiences will be experienced as inadequate if these are expected to produce significant, permanent personality changes. This means that satisfactory results from a broad range of psychotherapy services largely depends on the client and psychotherapist mutually arriving at a clear agreement about the expectations of the alliance under which they are working. Sometimes such alliances are only understood well along into the therapeutic effort, and unfortunately, if ever.

What follows briefly describes psychotherapeutic alliances that may operate in the background of psychotherapy. These are the (1) magical, (2) working, (3) therapeutic, and (4) structuralizing alliances.

1. Magical alliance.

Not all clients in distress begin by seeking a magical change and the alliance that goes with it. But if they are seeking a magical alliance, clients usually do so in response to distress as a result of disjunctions with the "world." -- a person or an institution. What is meant by "person," is a relative, boss, neighbour, etc.; what is meant by "institution" is a government, religious, social or commercial organization. In seeking a magical alliance, a client assumes that the world needs to change, not the client. Extending this assumption, the client hopes that the psychotherapist will change the world "out there," by so doing relieve his/her distress, and so avoid the need for internal, personal change. This expectation grants omnipotent powers to the psychotherapist, who experiences the client's idealization as a defense (Gedo, 1981; Kohut, 1971, p. 75) and not an idealizing transference. This idealization's defensive function is evident from the expectation that the idealized therapist will omnipotently change the world without changing the client. In comparison, under a sustained Kohutian idealizing transference, the client is motivated to do the changing.

Another seeking of a magical alliance is evident where a client presents with an expectation of an instantaneous or fairly immediate change. Generally the wish for a magical change may be expressed through the seeking of a magical act such as a sacrament, or a prayer, or a technique such as in Cognitive Behavioral Therapy, or a

pill such as an antidepressant, that magically produces change in the client without involving the client's self-agency and engaging the client's self-organization. The client seeking a magical alliance wants the disconcerting symptoms removed without changing the person who is expressing the symptoms.

For example, in the major studies from 1987 until 1997 that Elly Lilly Pharmaceutical Company used in its application to the U.S. Food and Drug Administration for approving the sale of Prozac, 8,731 moderately depressed patients completed the trials. Out of these, 40% improved who took antidepressants for six weeks, but 30% improved with just a sugar pill (placebo). This placebo effect is a measuring of the power of a magical procedure. So in seeking psychotherapy, it needs to be acknowledged that a client often has a magical expectation that can often be used for the good of the patient. At the same time it needs to be recognized that in utilizing magical expectations, a therapist runs the risk of intensifying despair if the magical act does not work, and using up the patient's hope.

In my functioning as a Minister of Counselling on the staff of a large (3000 member) church in the U.S., I often accepted the magical alliance requested by a parishioner/client. Over a period of three years a number of the parishioners who came for counseling, asked me to pray for them, which I did, and then they left with their defenses seemingly shored up, and I never saw them again. For some, this brief, magical form of helping can be cost-effective treatment. Another client, after making an appointment, asked me to pray for her, explaining that she was discouraged by the heavy demands being placed on her at the time. Feeling that this client was not ready for a therapeutic exploration that engaged her self-organization, after I prayed for her,

she became calmer, thanked me, and left after twenty minutes. Over the next eighteen months she returned a number of times for prayer, but each time stayed longer and shared more of herself. On the last of these prayer request sessions, the client requested regular weekly sessions with a view to exploring more of herself. Recognizing there had been an encouraging, progressive shift from a magical to a working alliance, I agreed.

Magical alliances are generally manageable and worthwhile if brief, relatively infrequent, share some self-narrative and begin spontaneously moving towards a working relationship. The longer the sessions continue on a regular basis under a magical alliance without a movement towards a working alliance, however, the more likelihood there is of a client becoming despairing or being traumatized and the psychotherapy failing. Under such circumstances, the client's defensive idealization of the psychotherapist and the assumption that the "world" ought to meet the client's needs, should be explored. Responding to the ingrained magical expectations of a (structuralized) defensive idealization is different from the idealizing transference, which Kohut recommends not interpreting to a client. And even with heavily structuralized defensive idealizations, a clarification of the client's tacit expectations often results in movement towards a working alliance, and, sometimes leads to a therapeutic alliance. Here is an example.

Ms. L, a young, part-time store worker, sought psychotherapy because of a depression (loss of appetite, nausea, an inability to sleep), obsessional "bad thoughts," and a wish to suicide. She was intensely focused on her body, which she perceived as

"weird and grotesque" because she felt a "layer of dirt under her skin," and because her legs delusionally shrunk or swelled before her very eyes.

Ms. L's mother was usually emotionally unavailable to L, but when she was available, L experienced it as cruel or lustful. Distressingly, L's mother was interested in men, L's elder sister, and her stepfather. L was also shamed by her stepfather's lecherous comments about her large breasts, or his allusions to her being a "fat cow." When a distressed L complained, her mother took the stepfather's viewpoint and claimed that L was creating a storm in a teacup. These humiliating family interactions contributed to L's anorexic disorder for which she had previously sought once-a-week psychotherapy, but which terminated after a few sessions. Some time later, she saw a new psychotherapist.

In the third session of the new psychotherapy, L excitedly reported that she had been feeling hungry and had started to eat again. Decreases in L's eating symptoms, and the hope this generated, suggested the possibility of an idealizing transference to the psychotherapist, especially as she had also been able to sleep better. Then the sessions focused on L' sister, with whom she periodically had spiteful disagreements and fights since they were young girls, involved throwing food, pulling hair, and attempting to strangle each other

L and her sister's latest conflict concerned L's bedroom, located as a bungalow at the rear of the parent's house. The sister wanted to exchange her house bedroom for L's bungalow, so she and her new boyfriend could live there. L became angry when her mother sided with her sister over the bungalow – as she had on many

other issues in the past. L also revealed that her sister, a drug addict, had borrowed over $1,000 from her and never repayed it. And when L was a sick teenager, her dominating sister not only pressured L into taking antidepressants.

After a score of sessions, L arrived late one day and, with tight-lipped face, stared at the female therapist. There was silence. When the therapist eventually commented that L looked like she was about to burst, L countered with, “No, I don’t feel anything. I feel squashed, but I would rather not talk about it. I have nothing to say. Talking isn’t getting anywhere.” She then quickly added, “I need to come only fortnightly or monthly because I need to save money as a deposit on a flat.” She then added, “Talking my arse off isn’t getting anywhere. I don’t have anything to talk about with you. I can sit at home and think about things myself.”

At first the therapist thought there had been a disjunction in the previous session, but when she tried to explore this possibility, the client didn’t think so, and mentioned that she came into treatment hoping that her problems at home would be fixed, but she was still “waiting.” Because nothing had changed at home, she was convinced that talking about it and thinking about it didn’t help. For L, psychotherapy had failed because it had not automatically (magically) changed her home situation and her bullying sister.

At this point the psychotherapist understood that the client’s therapeutic agenda was the key issue. The client wanted change, had expected that talking about her home problems would magically change her mother and sister, and did not understand that psychotherapy indirectly changes the external situation through an

internal change in the client herself. Agreeing that the home situation needed to change, the psychotherapist indicated that in order to achieve this, L needed a new strategy. It was explained that by expecting her mother and sister to change, L was actually increasing their power to frustrate her. On the other hand, if she focused on changing her own expectations, she could reduce the control that her sister or mother had to frustrate or bully her, and therefore, indirectly change the situation. The therapist explained that L's former strategy aimed at changing the situation, not herself. In the new strategy, changing herself not only changed the situation, but also enhanced her sense of self-agency. After saying this, the psychotherapist noticed that L's face reflected feelings of hope.

Psychotherapy that relies on change through understanding the client's point of view, only works when clients accept the challenge to reveal themselves. When the nature of any psychotherapeutic alliance is not understood, and clients seek a magician to manipulate the situation "out there," or to manipulate their symptoms without engaging their self-agency, they usually quickly terminate sessions, convinced that the psychotherapist is as powerless a magician as the client.

Mrs. C, a divorcee in her fifties, is a second example of a person seeking a magical alliance. She presented with agoraphobia and depression, and a recent divorce after discovering her husband had been having an ongoing affair. C had a history of depression. She had post-natal depression after the birth of her two children, but had been susceptible to depression from her early childhood, and had offered the observation that she had been emotionally detached throughout her life.

In describing her parents, C made it clear that she had always accommodated the various roles they imposed on her, and consequently, had meagre experiences of self-agency. Her doting mother had dressed her like a doll. The father wanted her to be musical; so from the age of ten she practiced the piano daily, hated it, and felt ashamed knowing that her father was downstairs listening to her mistakes. As she grew into adolescence, she replaced her shy mother as her father's dance partner, a role she came to loath.

With the development of such an accommodating peripheral self-organization and a detached nuclear self-organization, C sought a magical alliance in the psychotherapy to change her circumstances, and not change herself. At the sixth session, she told the psychotherapist that she was forcing herself to attend the sessions because she found nothing works. She then shared the image of a model scene in which someone was waving a magic wand and all her bad experiences went away. When asked about possible meanings, however, she refused to associate to the image.

This refusal indicated that the client was not willing to work at the goal of understanding her thoughts, feelings and behaviour, and supported the idea that she was covertly functioning on the assumptions of a magical alliance. In effect C had created helplessness in the psychotherapist similar to her own helpless feelings, in effect, creating an archaic form of twinship. Unless this twinship experience is eventually explained and explored with the client, client frustrations generally increase and the psychotherapy sessions are discontinued.

A third example of a client's expectations of a magical alliance is of a middle aged Mr. G, who sought psychotherapeutic help when his wife threatened to leave him. As Mr. G's behaviour pattern consisted of heavy drinking and gambling, his wife had struggled for years to financially "make ends meet." When the psychotherapist offered twice-weekly psychotherapy, Mr. G accepted, and resolved to stop consuming alcohol. He succeeded in his abstinence until the Xmas vacation period, when he returned to heavy drinking.

When the psychotherapy sessions recommenced, Mr. G revealed that he had seen a hypnotherapist and, when this had been ineffective, had attended a weekend marathon psychotherapy group, which also had not helped. The psychotherapist then pointed out that the client had been motivated to find a "quick fix" and that these attempts, while laudable, had not succeeded because they did not involve changes to the structures of his deeper (nuclear) self. In effect, Mr. G had sought a magical alliance in hope of producing instant change without the flowering of transferences and the processes of micro-structuralizations.

(b) Working Alliance

Greenson (1965) introduced the term "working alliance" into the psychotherapeutic lexicon. He recognized the importance of a working alliance because of experiences with unanalysable or interminable patients who, despite the development of a traditional transference neurosis, never made significant personality changes. In conceiving of this, he acknowledged his debt to Zetzel's (1956) "therapeutic alliance" and Stone's (1961) "mature alliance," which he thinks are

similar concepts, as does Kohut (1971, p. 30). Greenson, however, prefers the concept of working alliance because it "has the advantage of stressing the vital elements: the patient's capacity to work purposefully in the treatment situation" (p. 202).

As used in this paper, the concept of working alliance is broader than Greenson's usage. Greenson linked his concept to the patient's goal of overcoming his/her illness. In this paper, the concept of work has been extended to include more circumscribed goals that focus on better functioning rather than illness. As there are clients with a reasonably sound self-organization who seek a selfobject experience in psychotherapy when confronted with a new or potentially overwhelming situation, the working alliance here includes the goals of prophylactic treatment to prevent fragmentation or helping a client discover a better solution to a situational problem. Kohut's (1971) idea of a "transference of creativity" (p. 316), a selfobject experience that facilitates a concrete creative expression or act, could be conceived as a working alliance because it does not seek to repair a damaged nuclear self, but focuses on sustaining a person during a draining period of creativity. If, during the process of creative experiences structural repairs occur, this is a bonus that may move the working alliance into a therapeutic alliance.

Working alliances are very much involved when a client seeks counselling with a specific goal, such as processing grief feelings over the death of a loved one or the loss of an object (anyone or anything) to which one had been significantly attached. Working alliances are involved when counselling focuses on fears that arise in specific situations, such as facing exams or coping with illness, or dealing with

complex work conflicts. Other examples consist of persons with marriage difficulties or situations that require difficult decision-making. Psychotherapy, using such goal-oriented counselling, presupposes a working alliance where some selfobject experiences may occur in achieving various specific goals, but where the overt goal is not the transformation of the transferences.

Mr. J is an example of a working alliance that involved 30 sessions spread over two years, during which the relationship failed to move into a therapeutic alliance. He came to the psychotherapy as a result of a referral from his wife's psychotherapist, because he had drunkenly kissed a woman at a party and had incensed his wife. This kissing event, however, reflected Mr. J's lack of satisfaction in a twenty-year marriage. Serving in the Federal police, he had been on track for a senior command, but had resigned so that his wife could finish her training as a dental surgeon of outstanding promise.

In the initial sessions, Mr. J made it clear that he was not seeking marital counselling, but wanted someone to listen as he processed his feelings and made a decision. As Mr. J told his story it was obvious that he hungered for friendships to compensate for his wife's excessive workload and her incapacity for intimacy with him. He had gradually developed friendships in a group of mothers who, like him, took their children to school. He sometimes had coffee with them and shared warmth and understanding, the very quality he felt lacking in his marriage, but his fearful wife insisted that he not associate with these women, and this led to many arguments. One time the wife smashed a chair in rage; on another she had confronted several of the "Koffee Klutch" women at a social gathering, and made an ugly scene in which she

demanded that they keep away from her husband. In desperation, the wife even demanded that Mr. J and she seek marriage counselling when she realized that his personal psychotherapy was not persuading him to conform to her "orders."

The more that Mrs. J became aware that Mr. J was defying her, the more disturbed and outrageous her behaviour became. At another party where most of the school parents were present, Mrs. J embarrassingly accused three of the "Koffee Klutch" women of wanting to steal her husband from her. This outrageous behaviour associated to Mrs J's fear of losing her husband, revealed that her competent, professional peripheral self masked a desperate nuclear self that needed Mr. J to function as a nurturing selfobject. Apparently Mr. J had always functioned as a selfobject for his wife, but on becoming more depleted from lack of reciprocity and emotional availability, he was now searching for ways to be nourished and prevent fragmentation.

Mr. J's psychotherapy attendance pattern revealed the nature of the alliance. He would come for three or four weekly sessions, feel better, and not schedule another session for several months to see if his improved feelings would lead to an improved marriage. When the marital interaction did not improve, he would return to the psychotherapy. His major focus was the marriage. Under pressure from his wife, he eventually agreed to some conjoint sessions with a marital therapist, but these sessions ended when Mrs. J refused to explore the marital interaction. She had expected the marital therapist to ally with her in pressuring Mr. J to cut off his associations with the school's "Koffee Klutch," but when the therapist took a neutral

stance Mrs. J no longer wanted conjoint sessions. They were back to their marital standoff.

To cast this standoff as a power conflict misses the selfobject dimension. Of course Mrs. J wanted status quo, if this was possible, but she failed to grasp that this was no longer a viable option. For her husband to continue functioning as her selfobject without any reciprocity, made him more fragmentation-prone than in the past and, hence, no longer able to function as the selfobject she needed, whether he wanted to or not. The only way he could stay in the marriage was through friendships, a secret affair, or ongoing psychotherapy that met his selfobject needs so he could continue to function as a selfobject for his wife. Even if he opts to have regular psychotherapy sessions, if these are aimed at keeping him cohesive and preserving the marriage, such working alliances aim at maintaining the "status quo" rather than a therapeutic goal of healing a defect in Mr. J's self-organization.

(c) Therapeutic alliance

A therapeutic alliance aims at resolving repetitive transferences and transforming narcissistic transferences, to repair a patient's self-organization. Such repairs are sought when neglectful, wounding, or traumatic past experiences have crippled a client's ability to respond with effectiveness and enjoyment to the tasks of adulthood. The key to a therapeutic alliance is the client's desire to heal self-organizational defects and an agreement with the psychotherapist to help in this process. Stated another way, in a therapeutic alliance, both client and therapist are

committed to attempting to alter a client's nuclear self-organization, not just the client's accommodating peripheral self-organization.

A therapeutic alliance could be conceived as a special working alliance, where psychotherapeutic work focuses on repairing the past, generally through the emergence of transferences. These may be Freudian transferences, where early experiences with significant others interfere with present relationships, (now referred to as repetitive transferences)(Stolorow, 1992, p. 24), and the narcissistic transferences that are recognized as hungers for idealization, mirroring or twinship (Kohut, 1971, 1984; Lee and Martin, 1991).

Once these transferences emerge in psychotherapeutic sessions, their modification becomes the major goal of the psychotherapy. The therapeutic alliance involves agreeing to modify these transferences, through understanding and explaining them to the client's satisfaction. In agreeing to this alliance, the client can be viewed as becoming a patient.

As the psychotherapeutic literature is full of examples of the treatment of patients who manifest repetitive transferences or narcissistic hungers, I refer the reader to the cases involving the narcissistic transferences in The Psychology of the Self: A Casebook (1978) and the cases on the repetitive transferences as described by Stolorow and Atwood (1992). My example is Peggy (Lee, 2003), a humiliating,

> middle-aged patient who, after ringing the doorbell, was greeted by
> a female psychotherapist saying "come in, come in" as Peggy
> entered a hallway. With annoyed face and irritated voice, Peggy

> responded, "Don't say 'come in, come in' when I am already 'in'." Feeling slightly irritated and humiliated, the psychotherapist ushered the patient into her consulting room.
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> After Peggy sat in the patient's chair, she looked around the room, noting its paintings and pictures. Focusing on shelves overflowing with books, she commented, "I don't like the untidy look of bookshelves stuffed to overflowing." Aware of her growing anger in response to the patient's criticisms, the psychotherapist asked why the patient was seeking help and was told she had "relationship difficulties." (p. 1).

In the initial months of the psychotherapy, a pattern of humiliating behaviour and social isolation emerged during a working alliance, an alliance in which Peggy helped the psychotherapist understand how she felt and why. Eventually, however, an awareness of the extensiveness of her humiliating behaviour and loneliness motivated her to change her need to humiliate others, and led to forming a therapeutic (healing) alliance.

Clients often present with goal-oriented problems of a working alliance. If they have been severely damaged by early experiences, however, transferences will eventually emerge that point to the need for a therapeutic alliance, but it often takes empathy, patience and skill for the psychotherapist to help patients see that changing self-defects involves intensive, long-term treatment, and not an easy fix. K, who was a single, female client in her thirties, presented for treatment seeking relief from

severe phobias that involved most areas of her life. By the sixth session, K indicated that she was uncertain about where they were heading. Her therapist realized that K was really asking a question about the nature of their alliance, and that K, who had been anxious in the sessions, was asking if her fear could be modified.

Her psychotherapist explained that the immediate goal was to turn the psychotherapy sessions into as safe an environment as possible. After K agreed that feeling safe was a very important component to her psychotherapy because she had "always gone through life not feeling safe, " her therapist took the step of allying herself with K's therapeutic goal. She asked, "If the therapy could significantly make you feel safer, would you deem the psychotherapy worthwhile?" When a hopeful K answered "Yes," the therapist responded, "Although I can't guarantee anything, I want you to know that I will work with you to the best of my ability to help you achieve this end." With a pleased look on her face, K indicated that if they could only partially, but permanently ameliorate her feelings of insecurity, the psychotherapy would be very worthwhile. The next session the therapist realized that the therapeutic alliance was confirmed when K reported that since the last session she had felt the calmest for a long time.

(d) Structuralizing alliance

A structuralizing alliance, as used here, is an agreement to continue the sessions until the therapeutic gains are permanent. The term structuralization is used in two ways: as a general explanation for therapeutic gains becoming permanent, and as a describing of specific processes that enhance the permanency of changes to a

client's self-organization. As an explanation for permanent gains in psychotherapy, the concept of structuralization preceded the recent neuroscience research that is now discovering specific processes to support this general explanation. One example is Kandell's research into the sea snail, Aplysia Californica, which withdraws its gills when touched.

Kandell conducted learning experiments with the snail. After repeated touching of its gills, the snail learns to withdraw them more rapidly. Examination of the synapses of the startle reflex circuit in these "taught" snails revealed an increase in neurotransmitters. Then Kandell increased the gill touching to make the Aplysia withdraw its gills for longer and longer periods of time until he found that instead of increase in neurotransmitters, there was evidence of protein synthesis and the growth of new dendrites and synapses. As Abel (1995, p. 302) says, "on the cellular level the switch from short-term to long-term based memory facilitation is a switch from process-based memory to a structural based memory."

Psychotherapy's initial interest in structuralization came through Freud's concept of internalisation. In Mourning and Melancholia (1917), Freud noted that following the death of a spouse ("object decathexis"), identification with the dead spouse increased. He explained that this increased identification reflected the internalising of the deceased. Freud thought that internalisation was a defense against the pain of the loss and a way of permanently retaining the memory of the loved one through internal structuralization. As Strozier (2001, p. 199) reminds us, Freud's internalisation took place in a gradual fractionated way.

Kohut (1971), following Freud's ideas on internalisation and not Klein's views on introjection as a macro-internalization, introduced the terms "transmuting internalizations" and "micro-internalizations" as his way of describing "the withdrawal of object-instinctual and narcissistic cathexes from object imagoes" and its replacement by the "formation of psychic structure" (p. 49). He gives the example of a patient whose idealization of the psychotherapist is gradually reduced through the minor disappointments of the therapeutic relationship, but concurrently the patient's ideals grow stronger. Kohut referred to this process as resulting from optimal frustration; enough frustration to encourage the internalizing process; not enough frustration to enrage the patient and produce rejection and the aborting of the internalization.

In the twenty five years since the death of Kohut, self-psychology theory first broadened the concept of internalization to include other processes than optimal frustration, and then dropped the term internalisation altogether. It was encouraged to do this by the work of Loewald (1960), Schafer (1972), and Stolorow, Atwood and Orange (2002). In its decreased use of the concept of internalisation, self-psychology has abandoned Freud's approach to structuralization via internalizations, as it now sees structuralization as a process constantly taking place whenever learning occurs.

The concern of this paper is with the agreement between patient and therapist around the issue of structuralization, that is, the structuralizing alliance. In intensive psychotherapy, if such an alliance arises, it generally does so after the patient has experienced significant changes in self-states that were negotiated as a part of the therapeutic alliance. In traditional psychoanalysis the ideas of a therapeutic alliance

and structuralizing alliance are linked together in undergoing psychoanalysis, where the structuralizing phase was designated as "working through." However, as Kohut (1980) indicates, "the border lines between psychoanalysis proper and psychoanalytically informed psychotherapy…in practice…cannot always be drawn sharply" (p. 535). This is because psychoanalytically oriented psychotherapy also can move into a structuralizing alliance so as to reinforce the gains of the therapeutic alliance and produce permanent change. This was evidenced in the Menninger study of 42 patients, where the progress of 22 who had undertaken psychotherapy (the other 20 were in psychoanalysis) was relatively permanent twenty plus years after treatment (Wallerstein, 1986).

In reflecting between psychotherapy and psychoanalysis, Kohut (1980) thinks that the key to the difference lies in the goals of the treatment. He says that "in contrast to psychoanalysis, our aim in psychotherapy is primarily the improvement of functioning and well-being [therapeutic alliance] and only secondarily structural change" [structuralizing alliance] (p. 535). This is because the transferences only receive attention in order to develop sufficient structures "to enable the selfobject transference to shift from the therapist to other selfobject figures in the patient's life, and to enable him to make better use of the selfobject support that he can obtain from appropriate people in his surround" (p. 535). An example of this is seen in the case of Kool (Goldberg, 2000, pp. 25-44) where the analyst thought the case was a failure because he mistakenly thought he was in a structuralizing alliance. Although there was sufficient structuralization for the patient to leave the psychotherapy, the patient's continued cohesion depended on the patient's experience of his girlfriend as a selfobject. So, for Kohut, the crucial question in the healing process in

psychoanalysis or psychotherapy is the adequacy the structuralization to produce a permanent approach. Once structuralization begins it is enhanced by a continuing the psychotherapy for a significant period after it is openly acknowledged as a structuralizing alliance. Here is another case example.

L had been severely traumatized through sexual abuse as a child and on presenting for psychotherapy, frequently resorted to dissociation when her interactions raised fears of being retraumatized. Her highly sensitized tendency to dissociate had played havoc with her life and crippled her capacity to respond adaptively in family or employment. One of the major components of her therapeutic alliance was the modification of her need to dissociate through experiencing an idealizing selfobject experience with her therapist. In four years of twice-a-week psychotherapy she had a number of periods where she was dissociation-free for a few days, tasting the experience of change, but by becoming excited by the hope this progress engendered, she would dissociate again out of fear of fragmentation because of the sustained stimulation.

L's major concern shifted from the question, "Can I change?" to "Can I sustain the changes for more than a few days?" The therapist responded to this later question by pointing out that there had been a pattern in her dissociation-free experiences; the first few being for a day or so, and now they lasted for three or more days. As this observation made L very excited, that evening she became very distressed, dissociated, could not calm down from the increased hope of further change, telephoned, and had an extra calming psychotherapy session the next day.

Some sessions later, L "slipped into her absent space" again. In a terrified state, she reported that there was a black space that contains something terrible, something involving her mother, and that it did not feel safe. In contrast to this black condition, L felt safe with the therapist, but reported the "blackness" returned when the therapist (female) went on vacation. She then mentioned that her doctor had told her about taking off a little boy's plaster cast, and the boy told everyone that the doctor had fixed him.

The psychotherapist's association to the story of the little boy's broken arm was that the patient was asking to negotiate a structuralizing alliance. The patient felt mended while she was attending psychotherapy sessions, that is, the temporary support of the plaster cast, but was asking if the changes would last when she terminated the psychotherapy, when the plaster cast was taken off? So the psychotherapist asked if L wondered if her increasing freedom from dissociating would become permanent. When the patient confirmed that this was a concern, the psychotherapist said that making the gains permanent generally depended on reinforcing the intensive, twice-weekly sessions long enough, once changes had been made. The therapist then reaffirmed her commitment to continue the psychotherapy until that was achieved. What this offered L was not a watertight guaranteed result, but a guaranteed alliance with a high chance of success, based on experience. L's acceptance of this alliance was then demonstrated by her continued attendance at sessions.

In the months that followed two incidents reflected the importance of this alliance and the need for more structuralization. The first was when L said at the end

of the Friday session, “See you Monday,” and the therapist reminded her that Monday was a public holiday and there would be no sessions. The shock of being reminded led to L’s feelings of vulnerability, disconnection and a distressful weekend dissociating, but from which she recovered in a few days. The second was when her single, live-at-home daughter, left on a month’s trip. In the past, her daughter’s absence for this length of time would have terrorized her, but this time she only experienced a “normal” amount of sadness. L then shared an image of being let out of a cage where she is no longer trapped, and having good feelings of freedom. Then she reported that for the first time she felt these positive feelings could not be taken from her, that is, they were becoming permanent. This suggested increasing structuralization, facilitated by bringing the structuralizing alliance into the foreground of the psychotherapy sessions.

Further confirmation of the work of structuralization came out several months later. For the first time in the four years of treatment, L asked to use the bathroom and when she returned to the consulting room, she reported that “things are different.” She had spent a wonderful day with her daughter and toddler granddaughter, and had shared with her daughter much from the past, including her own sexual abuse as a child, and her divorce because, with her husband involved with pornography and prostitutes, she feared her two daughters would be molested by him. In turn, her daughter shared that neither she nor her sister had been abused. Then L indicated that when she was undecided about sharing her childhood abuse with her daughter, she heard the therapist’s voice say in a calm, matter-of-fact way, “Why not tell her?” In response the therapist explained how psychotherapy is able to continue inside the

head, and how development of such a capacity meant that meeting for actual sessions would eventually not be needed.

Conclusion

Successful outcomes in psychotherapy depend upon understanding the alliance under which the psychotherapy is conducted, and recognizing the shifts that occur in such alliances during the course of the psychotherapy. This means that successful psychotherapy not only needs a psychotherapist who can empathically understand the subjective state of the patient, but one who has skills in negotiating appropriate alliances with that patient. Such negotiating skills are best learned, not from books, nor from examples in a paper such as this, but from a psychotherapist's prolonged immersion in personal psychotherapy, and a supervisory relationship that focuses on the person's own cases.

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