Relationship Between Pretreatment Variables and Working Alliance in Psychotherapy: Parental Representations, Ego Functioning, and Psychopathology as Predictors

by

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PREVIEW

Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University New York

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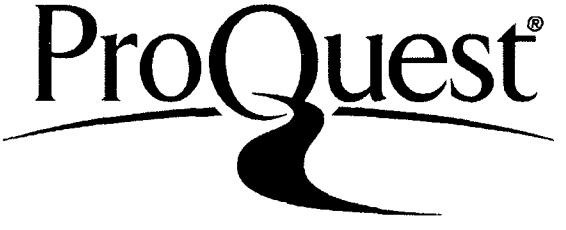

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ABSTRACT

Relationship Between Pretreatment Variables and Working Alliance in Psychotherapy: Parental Representations, Ego Functioning, and Psychopathology as Predictors

by

Dana Barowsky

The working alliance between patient and therapist is consistently documented as a significant predictor of psychotherapy outcome. Despite this finding, little is known about the patient pre-treatment variables that contribute to a positive working relationship. Among the variables that patients enter treatment is their attachment status, level of ego development, and pre-existing symptomatology. This study sought to understand the association between these variables and patients' perception of the early working alliance with young adults in an outpatient counseling center. To measure attachment status, Beth Hart's (1991) Internalized Parental Representations Scale (IPR) was administered at time of intake. Level of Ego Development was measured using Jane Loevinger's (1983) Sentence Completion Test which was also administered at time of intake. Diagnostic status and pre-existing symptomatology was assessed using the Personality Assessment Inventory (PAI). Patient's perception of the early working alliance was determined through their responses on the Working Alliance Inventory (WAI) which was given out following the third psychotherapy session. Results indicated no relationship between working alliance and attachment status and level of ego development. A significant negative relationship was documented between working alliance and depression, borderline features, paranoia, and somatic complaints. Implications, limitations and directions for future research are discussed.

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CHAPTER I

Introduction

The working alliance, most generally defined as the collaborative relationship between patient and therapist, has been proposed as one of the most critical aspects of the therapeutic process. Substantial research has documented the relationship between the working alliance and psychotherapy outcome, regardless of the specific treatment approach. Despite the importance of the working alliance, little is known about the pretreatment individual differences that contribute to patients' ability to form positive therapeutic relationships.

Patients enter psychotherapy with a range of backgrounds, experiences, and levels of functioning; it is likely that these differences affect their capacity to form positive working alliances. Given that the relationship between patient and therapist requires intimacy and trust, object relations and attachment theories support that patients early childhood experiences and internal representations of primary caregivers would contribute to their ability to form positive attachments with the therapist. Additionally, because positive alliances are dependent on viewing the therapist as an objective and rational helper, patients level of ego functioning can serve to facilitate or hinder their ability to work collaboratively with a therapist. Furthermore, patients present in therapy with a range of psychopathology, some of which are characterized by symptoms that make it difficult for them to engage productively with other individuals. Thus it is reasonable to assume that particular diagnoses and symptomatology may play a role in patients' capacity to develop positive working alliances.

This study will examine the relationship between internal parental representations, ego development, symptomatology, and the capacity to form a positive working alliance among patients in psychotherapy at an urban university outpatient clinic.

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CHAPTER II

Literature Review

Theoretical Approaches to the Working Alliance

Currently, the terms "working alliance," "therapeutic alliance," and "helping alliance" are used interchangeably in the psychotherapy literature. While there are slight variations among definitions, the terms generally refer to the collaborative relationship between patient and therapist and they take account of both individuals' capacity to negotiate a treatment contract. (Bordin, 1979; Luborsky, 1976; Strupp & Hadley, 1979). The development of this theoretical construct spans almost a century and has its origins in early psychodynamic theory.

The importance of the therapist-patient relationship can be traced back to Freud who first discussed the relationship between healer and client as being "the vehicle of success in psychoanalysis" (1913, p.106) In his paper, *On Beginning Treatment* (1913), Freud spoke of rapport as being essential in the beginning stages of therapy and wrote that "the first aim of treatment is to attach the person of the patient to the person of the therapist" (p.139). In his understanding of this alliance, Freud differentiated between the reality-based and collaborative aspect of the relationship and the more distorted and neurotic component of the patients' attachment to the therapist, termed transference. Positive transference, which includes the positive feelings that the patient has towards his analyst, was said to originate from trusting elements of parental relationships and was viewed as the motivation for collaboration with the analyst (Freud, 1958).

In the years following, the bond between the patient and therapist was further explored in the psychodynamic writings of Richard Sterba. In his paper, *The Fate of the Ego in Analytic Therapy* (1934), Sterba emphasized the rational aspect of the therapeutic relationship. Like Freud, Sterba viewed the success of therapy in light of the patients' positive transference and

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identification with the therapist. More specifically, Sterba aligned with the ego-psychology movement that was then in full swing and he introduced the term "ego alliance". By this, Sterba referred to the alliance between the analyst and the rational ego of the patient. According to Sterba, it was necessary for the patients' ego to dissociate so that the component that is reality focused splits from that part that is driven by instinctual and defensive energy. By identifying this mature and rational ego with the analyzing ego of the therapist, the patient was then able to work for success in therapy.

In 1956, the term "therapeutic alliance" was introduced by Elizabeth Zetzel and it referred to the positive and affectionate attachment of the client to the therapist. While Zetzel agreed with Freud and Sterba regarding the importance of interpretations of transference in battling neuroses, she felt in order for such an intervention to be effective, it must occur within the context of a sound therapeutic relationship. Thus, Zetzel was one of the first authors to conceptualize the therapeutic alliance as separate from the transference relationship. According to Zetzel, the therapeutic alliance preceded the initial therapeutic meeting and was rooted in the patients early developmental experiences, specifically, the mother-child relationship. Those that entered therapy with solid object relations were viewed as fundamentally capable of establishing stable, trusting relationships with the therapist and were ready to participate in the therapeutic work. Those however with poor object relations required that the therapist attend to his basic needs and anxieties in order to develop a trusting therapeutic relationship before the work could begin.

An alternative conceptualization of the therapeutic alliance was introduced by Carl Rogers (1957) in his client-centered approach to therapy. Unlike earlier models which stressed the patient' contribution to the work in therapy, Rogers emphasized the therapist-offered conditions that were instrumental in initiating personality change. According to Rogers, it was the therapists' ability to provide the client with an environment of unconditional positive regard,

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congruency, and empathy that was necessary and sufficient for promoting change. Therefore, Rogers differed from Zetzel in his belief that the alliance was therapeutic in and of itself, rather than a prerequisite for the success of psychotherapy.

What was missing from Rogers (1957) conceptualization was delivered by Greenson's (1967) extension which included the patients' contribution to the alliance. Greenson introduced the term "working alliance" which he viewed as one of three nonmutually exclusive components of the therapeutic relationship; the other components being the real relationship and the transference. Although not totally separate from the transference relationship, the working alliance he felt was based on "the relatively non-neurotic, rational rapport which the patient has with his analyst" (p.157). Like Zetzel, Greenson felt that at least a portion of alliance was based on rational rapport developed between analyst and patient in contrast to the less conscious, irrational, elements. According to Greenson, the working alliance is established by the analyst showing compassion, concern, and therapeutic intent, and it is this part of the alliance that allows for successful analysis of the transference neurosis.

In 1979 controversy developed regarding the validity of the therapeutic alliance construct. Most notably, Charles Brenner (1979) argued that it was "neither correct nor useful to distinguish between transference and the working alliance" (p. 137). He felt that there was no such phenomenon as the alliance and that the entire relationship of the client is merely an expression of transference. Within Brenner's framework, a patient's collaborative effort was viewed as a wish to gain the approval of a nurturing parental figure, rather than alliance, and should be interpreted as such. In his paper, Brenner wrote, "In my opinion, it is not being more or less human that is most important. What is most important, I believe, is to understand correctly the nature and origin of one's patients' transference reactions however one behaves" (p. 148). Thus, he felt that focusing on the alliance was counterproductive to the goals of therapy, which in his view should emphasize interpretation.

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Over the past decade, several researchers have continued to reconceptualize definitions of the working alliance and to develop instruments designed to measure this alliance. One of the most significant contributions to alliance research came from Edward Bordin's (1979) pantheoretical definition of the working alliance. Building on Greenson's (1967) concept of the real relationship, and Rogers (1957), focus on the healing process of the therapeutic relationship, Bordin extended the traditionally psychoanalytic definition to all change-inducing relationships. Additionally, he emphasized the concept of mutuality and collaboration between the patient and therapist. According to Bordin, the working alliance is characterized by the therapists and the patients mutually endorsing and valuing the goals that are the target of the intervention (goals), the in-counseling behaviors and cognitions that form the substance of the counseling process (tasks), and the complex network of positive personal attachments between the client and the counselor (bonds). While different change agents would place different degrees of emphasis on the bond, task, and goal components, Bordin's working alliance is generalizable to all types of orientations and interventions. Bordin's (1979) article triggered a wave of research developments, moving the field toward empirical study of alliance. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), which is based on Bordin's pantheoretical conceptualization, remains the most widely used instrument in international alliance research.

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Working alliance and psychotherapy outcome. In this day and age, where treatment is dictated by managed care companies, research regarding empirically supported treatments is at the forefront. While psychotherapy has proven to be efficacious across various theoretical orientations, (Lambert & Ogles, 2004; Leichsenring & Leibing, 2003; Lipsey & Wilson, 1993; Luborsky, Singer, and Luborsky, 1975; Seligman, 1995; Shedler, 2010; Smith, Glass, Miller, 1980) little is known about the active ingredients and the mechanisms of change. As such, the Division of Psychotherapy of the American Psychological Association has organized a Task Force on Empirically Supported Therapy in order to actively explore process variables. In their