Episode 028: Therapeutic Alliance Part 1

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There are no conflicts of interest for this episode.

This series is dedicated to my mentor, Dr. John D Tarr.

What is a Therapeutic Alliance?

The therapeutic alliance is a collaborative relationship between the physician and the patient. Together, you jointly establish goals, desires, and expectations of your working partnership.

Every interview with a patient, whether it's for diagnostic, intake, evaluative, or psychopharmacology purposes, has therapeutic potential. The treatment starts from your first greeting—how you listen, empathize, and even how you say goodbye.

It's built from a partnership and dialogue, like any other relationship. It's not built from medical interrogation. It's not about pulling medical information to be able to make a diagnosis. We have to make it a positive experience for patient, so they can begin to talk about what's negative in their lives.

The therapeutic alliance is full of meaning, and it uses every emotional transaction therapeutically. If they get angry, sad, or have fear you will abandon them, as a therapist, it's our job to figure out how to help them through that feeling within the relationship. The doctor can express desire for the patient to share, in real time, how the patient is feeling, even about his or her relationship with the doctor.

Why do we care?

We all know that some talk therapists have better outcomes than other talk therapists. What's interesting though, is that some some psychiatrists' placebos worked better than other psychiatrists' active drugs. One study of NIMH data of 112 depressed patients treated by 9 psychiatrists with placebo or imipramine, found that variance in BDI score

(a score that measures depression) due to medication, was 3.4% and variance due to psychiatrist was 9.1%. One-third of psychiatrists had better outcomes with the placebo than one-third had with imipramine.

Another book argues that the therapist is more important to outcome than theory or technique. Many other studies have shown that therapeutic alliance directly correlates to success rates.

What Builds a Therapeutic Alliance?

Research shows there are a few things that grow therapeutic alliance:

Expertness

- Facilitating a greater level of understanding
- When residents are worried they are an imposter, I tell them that humility is good, but realize that you have experience that most will never have, medical school, being highly educated, being around vast different ways of thinking and reflecting on the world...

Consistency

- Structuring your office to run on time.
- Being consistent to respond to refill request, lab results, or patient's questions.

Non-verbal gestures

- Eye contact
- Leaning forward
- Mirroring of emotion occurs naturally when people pay attention to emotion

Maintenance of the therapeutic frame

- A dual relationship (eg, dating) breaks down therapeutic alliance. Patients will test the frame. It can be helpful to say, "There will be positive and negative feelings between us and what will be safe is to talk about them."

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Empathy, attunement, positive regard

- Patient: “Therapist is both understanding and affirming."
- Patient: “Therapist adopts supportive stance.”
- Patient: “Therapist is sensitive to patient’s feelings, attuned to patient, empathic.”
- Research has found that for beginning therapists, setting and maintaining treatment goals is harder
- Research has shown that strength of therapeutic bond is not associated with level of training
- Therapist should appear alert, relaxed and confident rather than bored, distracted and tired

Foundational Concepts of the Therapeutic Alliance

Our profession gives us a privileged glimpse into the human heart and mind. Each patient is idiosyncratic, unique, precious. Each patient has unique strengths which we should place focus on. Some therapists can be in a hurry to find out what's wrong, but we should also want to find out what's right with our patients.

Our own feelings, as therapists, about the session are not intrusions but clues. If you are experiencing boredom, perhaps you are not understanding the main point the patient is trying to explain. Be curious for what you are missing. If you start feeling something different than you did at the beginning of the encounter, notice it. Try to empathize for the patient with what changed.

Our goal is for the patient to feel understood, heard, accepted, felt. To be understood is to be accepted.

A strong alliance will provide a "Corrective Emotional Experience" (Franz Alexander), which means past relational pain and difficulties are worked out in a new relationship. When your subjectivity (your feelings, thoughts, goals) come into contact with the patient's subjectivity, a unique "intersubjective relationship" is formed from your mutual influencing of each other. A new dyad (2 coming together) is formed by looking at new meanings, understandings and connectedness. As a therapist, you are a “participant

observer" as you observe the patient's behavior and also become a "significant other" in their life through your interactions (Harry Stack Sullivan).

Here are Some Things to Consider on a First Encounter with a Patient:

The patient will feel: examined, fear being seen as crazy, fear of not being liked, discouraged, hopeless, helplessness, needy, fear you are a mind reader, or even fear that you sleep with your patients.

In developing this relationship, it's important to understand they can formulate defenses that are adaptive. Try to empathize with that underlying emotion. Starting with what's an adaptive response and solves something, looking for what's maladaptive does not.

The patient may question your competence. They might say you look very young to be a doctor. The appropriate response would be to dig down and see why they are feeling what they are feeling. Say something like,"Perhaps you were looking for someone who looks older; of course you're entitled to worry about how competent I am and how much I may be able to help you."

Therapists are always worried about being ineffectual. It's very natural to feel like an impostor in our position. It's also normal to feel—when someone's angry at us, our mirror neurons lead us to be angry back.

Always face the patient, without desks between you, lean slightly forward, give appropriate eye contact, and do not do excessive note taking (you should be observing at least 90% of the time). Ideally, a clock is positioned behind the patient which can easily be seen by you without making obvious movements.

On Listening: An Active Process

Connection is non-verbal, and is equally as important as verbal communication, sometimes more so.

- Omissions (what is not said) in the patient's stories and memories are important.

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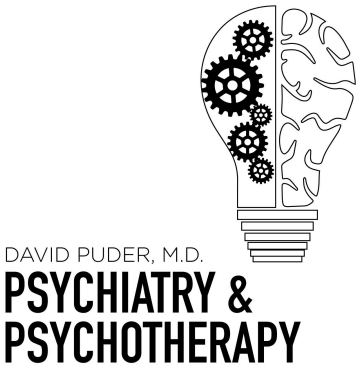
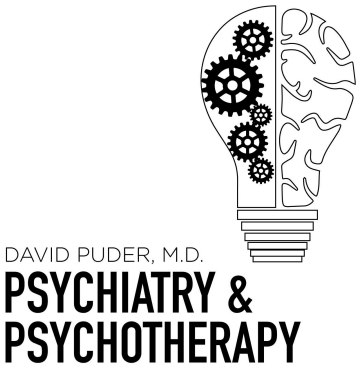


- Point out common patterns you hear.
- If every time you say something to the patient he says "no, that's not it" then point out that to the patient.
- Be aware when asking "why" questions, you are likely going to arouse the same defensive emotional reactions that occurred when the patient as a child was asked "why did you do that?" by the parent. At times, "why" can communicate disapproval. For example you ask, "Why do you feel that?" And they say, "I DON'T KNOW! Are not you the doctor!"
- Dr. Tarr has some good advice on nonverbal communication: "I participate. I respond. I react to my patient and to his verbal and nonverbal communications. At the same time I observe what's going on, what the patient is saying and what he is not saying. I am particularly attuned to evidences of anxiety, to what I am feeling and thinking, and where, if anywhere, the interchanges are going. I am wondering how best to formulate for this particular patient what I observe that may help him feel understood and responded to."
- Observe that defenses (sublimation, reaction formation, intellectualization), although they reduce anxiety, may misrepresent reality.
- Assume an attitude of "reverie," like a good maternal object, receiving toxic stuff from patients and then giving it back to them in a detoxified form (Wilfred Bion).
- Create a "holding" place for patients in which patients have a transitional or play space (Donald Winnicott).
- Listen in a way that notes what the patient is trying to say about your relationship.
    - Patient: "I feel lonely even when I am with people." Doctor: "Do you feel lonely here with me now?" Patient: "No, I feel you understand me somewhat." Doctor: "I want to know if there are any times where you feel more lonely in our sessions, it will help me to understand what is going on between us."
- Listen to their moment to moment change in emotions.
    - Try to enter a bit into their feeling, be present with them, mirror the emotion/feeling, use their own words, ask them to find their own words.
    - If you don't get why they are sad, then stay with it, ask them more questions, have them deepen your understanding of it.
    - Once they feel you truly understand the effect will change. When people feel heard, deeply understood, it is pleasurable.



- Shame- patient looks down
  - "I can understand why talking about this must be difficult."
  - **"**Perhaps as you talk about this you feel…"
  - Try to find the adaptive function: "I hear switching to a new doctor is hard, I think that is a common experience, I think it is adaptive to be hesitant at first in what you share, we are just meeting."
- Anger/Frustration:
  - "Would you say that as you mentioned this you feel frustrated."
  - Find the adaptive function: "your anger here seemed to have the goal to protect you and your family" "your anger likely kept you alive!"
- Sadness
  - "Perhaps you are feeling sad as you say this?"
  - Find the adaptive function: "it makes sense that you feel sad here, I think crying and feeling sad shows how much you valued your dad and therefore the loss hurts that much more."
- Disgust
  - "I am wondering if you feel disgusted by this?"
  - "I hear you feel disgusted…" (ask with a questioning tone).
  - Find the adaptive function: "Feeling disgusted by how your sisters turned on you and cast you out of the family makes sense, it sickens you to see the level of their resentment and bitterness."
- Fear
  - "I hear a deep concern or perhaps fear regarding this."
  - "Might there be a deep concern or perhaps fear regarding this?"
  - Find the adaptive function: "After your traumatic event, it makes sense that you would no longer want to put yourself in that situation, it sounds like you are trying to protect yourself."

Listen to the patient's goals, purposes, aspirations, fears, hopes, values, meanings.

How do you Create and Maintain a Working Alliance:

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Be sensitive to empathic strains and prevent them from developing into empathic ruptures.

Ask for feedback. Reflect on the "we" aspect of the encounter. If the intervention/participation failed to have the desired result then look at what went wrong with the communication.

- “As we were talking together when did you really feel we were on the same page?”
- “When did you feel we were understanding each other?”
- “When did you feel we were communicating meaningfully?”
- “When were you feeling disappointed?”
- “When did you fell I was not responding enough?”
- “When did you feel frustrated, misunderstood, or impatient?”

Be able to define and predict interpersonal conflicts that may cause a disruption of the shared empathic relationship. Set the groundwork for openness.

For example:

Doctor: "Tell me about your past psychiatrist? “What worked and what were your disappointments with your past psychiatrist?"

Patient: "He was kind of a jerk."

Doctor: "Can you tell me more about that?"

Patient: "He always would just stare at this computer, and often answered his pager during sessions."

Doctor: "Thank you for sharing that, I will stop typing and finish this later, I hope that if you ever have any feedback for me you will know that I will want to hear it, even if it is negative, and will appreciate knowing your experience of things."

Patient: “Ooo I was not talking about you.”

Doctor: “Ok, nevertheless it is a good reminder to not be focused on the computer, but if you are bothered by things or frustrated it will be helpful to know.”

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The therapeutic alliance is an incredibly powerful relationship, and if it is managed with care, it can affect positive change in a patient's life.

In future episodes on therapeutic alliance I will dig deeper into specifics of it, and pull upon the depth of my mentorship from Dr. John Tarr.