

## From behind the couch - 'Alliance'

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### Introduction

Psychotherapy, psychological treatment and psychological techniques are the motherhood and apple pie of psychiatry. No one can be found to say a bad word against them although the word psychotherapy is often preceded with some qualifier such as "sensible" to indicate that the farther shores of the discipline may not have much place in psychiatry. Sadly though psychotherapy and its congeners, unlike motherhood or even apple pie are far from widespread in the practice of many psychiatrists and training in the topic is woefully patchy across the country. In this occasional series I hope to introduce the reader to some key concepts in the field not so much from a scholarly perspective in an academic paper decorated with references (although there will be reading for those with sufficient interest and leisure) but from the perspective of practice. I hope to show how each of these psychotherapeutic concepts can be applied both to the practice of formal therapies and to more general aspects of psychiatric practice.

### Topic 1 - Alliance

The term alliance refers to the maintenance of a certain kind of positive relationship between the patient and their therapist or doctor. We know that the quality of the alliance in psychotherapy is quite predictive of the likely outcome of treatment so that, while a good alliance does not guarantee a good outcome a bad alliance often ensures a poor outcome. Alliance is something of a portmanteau term since it covers aspects both of trust and liking but also of faith in the skill of the doctor or therapist and a willingness to make positive efforts towards furthering the aims of treatment on the part of the patient. Sometimes this last aspect of alliance - the willingness of the patient to put their best foot forward is referred to by the more descriptive term "working alliance". Treatments differ in the extent to which they require anything resembling a working alliance. For example many surgical procedures require only that the patient consents and submits to treatment. Other treatments in medicine require that the patient complies with treatment by which is meant carrying out medical instructions accurately. As treatments become more complex and conditions more chronic the degree to which the patient must be an active agent in the administration of their own treatment increases with diabetes being a classic example.

In psychiatry some treatments such as submitting to depot neuroleptic administration require minimal levels of compliance and little in the way of alliance. However other treatments and particularly those which involve making substantial changes in lifestyle require that the patient be almost entirely responsible for the carrying through of their treatment. As such they resemble fitness training or education far more than they resemble "treatments". In these situations the alliance made between the patient and their doctor is a critical factor in determining the success or failure of treatment.

The making of alliances in ordinary life is not a special skill but something which we all possess however psychotherapists and psychiatrists need to make alliances with people that others shun or who are hostile, ambivalent, distracted or cognitively impaired. The will and the skill to form an alliance with such individuals take training and crucially practice. It can be thought of as comprising three essential parts.

- First – preparation.
- Second – the interaction (s)
- Third – follow up.

Let's see how these stages play out in a clinical situation. In which a man's helpers struggle to maintain a fragile alliance.

Rodger was a large and heavily tattooed man. He walked with a rolling gait and with his arms held out from his side as though he was always ready for a fight. He had suffered several head injuries as a younger man and could be both impulsive somewhat unpredictable and volatile. He used drugs and, at bad times would self harm by slashing himself with tin can lids. Staff in the day hospital had managed to engage him to an extent some months ago but he had become enraged when another patient had started winding him up calling him a stupid fathead. He blundered around the unit like an angry bull threw a chair and made threats to kill the other patient. As a result he was excluded from the unit. Rodger simply could not understand why this had happened and asked to see his key worker to make a complaint.

It would certainly be fair to say that the working alliance with Rodger has all but evaporated. The key worker was faced with the task of explaining Rodger's new situation to him, rebuilding the alliance and possibly defusing an aggressive encounter. She prepared herself in two ways. First she took care with her own safety and the safety of others in the setting. She warned other

people she was seeing Rodger and carried a personal alarm. Her objective was to free her mind from too many anxious thoughts about being assaulted as well as to ensure her physical safety. She also prepared herself by reflecting on Rodger's world imagining it as to him always potentially threatening either physically or psychologically where he felt under threat of being belittled or disrespected in ways he secretly worried but could not afford to admit to himself were true. Last she prepared Rodger by writing to him and telephoning him before the meeting to tell him what was going to happen and why. She made a point of speaking to him in quite formal and respectful terms as "Mr X" and, knowing that he would be very anxious when he arrived she made a point of starting the appointment on time.

The key worker began by asking Rodger what he felt about the meeting and what was on his mind. Starting with the patient's perspective and seeking to understand things from their point of view is a critical element of forming an alliance. It communicates to the patient that alliance is a two way affair. Rodger began angrily about the whole business and started to wind himself up about the person who had been rude to him and also about the unfairness of being excluded. The key worker agreed that it must feel very unfair to him. Rodger went on crossly that he was always given the "prick tease" invited into places and then chucked out. The key worker agreed that Rodger was often chucked out of things and asked him why he thought that had happened. Rodger said people were down on him and they all picked on him.

In terms of the alliance Rodger and his key worker are already doing better than before. Rodger is able to speak about what is on his mind and the key worker is able to hear it without becoming defensive or frightened. However this is not yet working alliances because the Key worker has not done much other than agree with Rodger's perspective in as far as it seems correct.

So now the key worker said that he wondered if Rodger had ever thought patients and staff were frightened of him. Rodger bridled and said angrily "there you go you are all the same I don't care about them what about me. No one asks how I feel." The key worker had moved too quickly and the alliance, already fragile has collapsed again. So the key worker said. "I have done the same thing as other people do to you, you always feel you get told off and no one ever listens to your point." Rodger agreed and again warmed to his theme describing the way in which he was always being put down and treated unfairly. As he became more vehement he stood up and began to pace around the room gesticulating. At times he would refer to "them" putting him down but on other occasions he would say "you". The key worker said, "When you walk around and raise your voice I get frightened of what you might do and it is hard for me to listen to you properly when I feel scared." Rodger looked startled and sat down abruptly saying rather defensively "I am not going to do anything"

The key worker's response which was neither threatened nor defensive but tried to state plainly the effect that Rodger's behaviour was having explicitly referred to the way in which some behaviour can threaten the alliance. The key worker then went on to explain that although Rodger did not feel that his behaviour was threatening other people interpreted it that way. This allowed the key worker to mention the incident in the day hospital again and to say that people had been frightened of Rodger. At this point the Key worker felt Rodger had taken the point and so he suggested they meet again to talk about it some more next week. Notice that the key worker did not try to "close the deal either clinically by, for example making a contract for good behaviour with Rodger or managerially by seeing if Rodger was satisfied by how his complaint had been heard. This was because the key worker judged that these moves might threaten the alliance again and a further outburst could wipe out Rodger's memory of his new understanding of himself as potentially frightening others and his new understanding of others as frightened.

The key worker followed up on the meeting with Rodger in a number of ways. First by feeding back to the staff at the day hospital, By doing this the key worker was helping them to repair, even in Rodger's absence, their sense of an alliance with him and maybe preparing the ground for Rodger's return. The key worker also telephoned Rodger later in the week to find out how he was timing the phone call to a time when Rodger would normally have been in the day hospital. The Key worker began the call by saying "I was thinking about how you might feel today". By doing this the key worker conveyed to Rodger that Rodger was in his mind even when Rodger himself was not in the room and that Rodger is an object of concern to him. Giving patients the sense of being "held in mind" is crucial to fostering the alliance. When medical staff gives a sense that they do not have the patient in mind there is almost always a severe rupture in the alliance as for example when the doctor starts reading the patient's notes while they are in the room.

## Conclusion

The story of Rodger and his key worker may seem to some over simple. In such natural seeming interactions the skill is cleverly disguised. Although the Key worker appeared spontaneous and appeared not to be considering his words he was in fact weighing them very carefully. He chose language that was appropriate to Rodger's intellectual level. His statements were brief and contained only a single point. Thus the key worker matched Rodger's cognitive level. The Key worker also managed the feeling tone in the room very carefully intervening to calm but not truncate potentially explosive feelings and ultimately promoting a little nugget of increased knowledge about the relationships between Rodger and other people. By maintaining an alliance and by carefully moving it into being (even if briefly) a working alliance the key worker managed a little step of progress with Rodger.

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**COMPETING INTERESTS**

None Declared

**AUTHOR DETAILS**

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For those who would like more: Cognitive Behaviour Therapy for challenging Problems. Judith Beck, Guildford press New York 2005, Chapters 4,5,6

For the very keen: Safran J. D. & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy*, 43, 286-291.

**FOLLOW UP READING:**

For those who want a basic text: Oxford Textbook of Psychotherapy, Glen O Gabbard Judith S. Beck & Jeremy Holmes, Oxford University Press 2005

**NEXT ISSUE: MANIPULATION**