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ifies necessary, but not sufficient, elements. Adler[14] observed that patients with borderline and narcissistic difficulties may not be able to establish a mature working alliance until much later in a successful treatment. Others who typically work with more disturbed patients have noted that establishing a therapeutic alliance may be one of the primary goals of the treatment and that there may be different phases of alliance development as treatment progresses. Gunderson[15] observed the following alliance stages in the course of conducting long-term psychotherapy with patients with borderline personality disorder:

> 1) Contractual (behavioral): initial agreement between the patient and therapist on treatment goals and their roles in achieving them (Phase I); 2) Relational (affective/empathic): emphasized by Rogerian client-centered relationships; patient experiences the therapist as caring, understanding, genuine, and likable (Phase II); 3) Working (cognitive/motivational): psychoanalytic prototype; patient joins the therapist as a reliable collaborator to help the patient understand herself or himself; its development represents a significant improvement for borderline patients (Phases III–IV). (p. 41)

Progression through these stages, if successful, typically takes a number of years. The implication is that to reach a point at which work leading to substantive and enduring personality change can occur may require a lengthy initial alliance-building period. As Bach[16] noted,

> Perhaps the primary problem in engaging the difficult patient is to build and retain what Ellman (1991)[17] has called analytic trust. These difficult patients have generally lost their faith not only in their caregivers, spouses, and other objects, but also in the world itself as a place of expectable and manageable contingencies. (p. 185)

ALLIANCE STRAINS AND RUPTURES

While a strong positive alliance can predict a successful treatment outcome, the converse is also true: problems in the treatment alliance may lead to premature termination if not handled in a sensitive and timely manner. Evidence has shown that strains and ruptures in the alliance are often related to unilateral termination.[18] Thus, negotiating ruptures in the alliance is another issue that has garnered increasing attention in the psychotherapy literature.

Disruptions in the alliance are inevitable and occur more frequently than may be readily apparent to the clinician.[10] One study[19] asked patients to report thoughts and feelings that they were not expressing to their therapists. Most things that were not discussed were negative, and even the most experienced therapists were aware of uncommunicated negative material only 45% of the time. It has also been suggested, however, that therapist awareness of patients' negative feelings may actually create problems. Therapists, rather than being open and flexible in response, may at times become defensive and negative or may become more rigid in applying treatment techniques.[20]

Safran and Muran[10] outlined a model specifying two subtypes of ruptures: withdrawal and confrontation. Withdrawals are sometimes fairly subtle. One example is a therapist who assumes the treatment is progressing but may be unaware that a patient is withholding important information out of lack of trust or for fear of feeling humiliated. Other types of withdrawal behaviors include such things as intellectualizing, talking excessively about other people, or changing the subject. Withdrawal behaviors may be more common in patients who are overly compliant at times, such as those with dependent or obsessive-compulsive personality disorder or those who are uncomfortable about interpersonal relations, such as patients with avoidant personality disorder.

Confrontations, on the other hand, are usually more overt, such as complaining about various aspects of therapy or criticizing the therapist. Some may be rather dramatic, such as a patient who storms out of session in a rage or leaves an angry message on the therapist's answering machine. Confrontation ruptures are likely to be more frequently experienced with more brittle patients such as those with borderline, narcissistic, or paranoid personality disorders. In any event, clinicians are best served by being alert to ruptures and adopting the attitude that they are often excellent opportunities to engage the patient in a collaborative effort to observe and learn about the patient's own style.[21]

ALLIANCE CONSIDERATIONS BY DSM CLUSTER

For ease of discussion, the following section is organized by DSM-IV-TR[22] personality disorder diagnostic clusters to address particular alliance-relevant issues associated with each. However, there is increasing evidence that the DSM categories and clusters do not ade-

Table 1. Alliance-relevant aspects of each personality disorder style

Personality disorder trait cluster	Alliance challenges	Points of possible engagement in treatment
Schizotypal	Suspiciousness/paranoia Profound interpersonal discomfort Bizarre thinking	Possible motivation for human connection
Schizoid	Social detachment Emotional aloofness	Underlying neediness and sensitivity
Paranoid	Expectations of harm or exploitation Hypersensitivity to perceived criticism Inclination to withdraw or attack	Underlying need for affirmation
Borderline	Unstable emotional and cognitive states Extremely demanding Proneness to acting out	Relationship-seeking Responds to warmth and support
Narcissistic	Need for constant positive regard Contempt for others Grandiose sense of entitlement	Responds over time to empathy and affirmation
Histrionic	Attempts to charm and entertain Emotionally labile Unfocused cognitive style	Relationship-seeking Responds to warmth and support
Antisocial	Controlling Tendency to lie and manipulate No empathy or regard for others Use of pseudoalliance to gain advantage	May engage in treatment if in self-interest or if Axis I symptoms cause sufficient distress
Avoidant	Expectation of criticism and rejection Proneness to shame and humiliation Reluctance to disclose information	Responds to warmth/empathy Desire for relationships in spite of vulnerabilities
Dependent	No value placed on independence/ taking initiative Submission leading to pseudoalliance	Friendly and compliant Likely to stay in treatment
Obsessive-compulsive	Need for control Perfectionistic toward self and others Fear of criticism from therapist Restricted affect Stubbornness	Conscientious Use of intellectualization may be helpful at times Will try to be a "good patient"

quately capture the complexity of character pathology traits and symptoms. For instance, patients often meet criteria for at least two personality disorders, perhaps spanning different clusters, such as the co-occurrence of schizotypal personality disorder with borderline personality disorder or borderline personality disorder with avoidant personality disorder,[23] or a patient may not meet full criteria for any one disorder but could still have prominent features associated with one or several personality disorders.

Thus, in practical terms, a clinician considering salient elements of the therapeutic alliance should determine which aspects of a patient's personality pathology are dominant or in ascendance at intake and at various points over the course of treatment. That being said, it has been suggested that the nature of the alliance established early in the treatment is more powerfully predictive of outcome.[24] For example, a study of long-term psychotherapy with a group of borderline patients found that therapist ratings of the alliance at 6 weeks predicted subsequent dropouts.[25] As Horvath and Greenberg[21] noted: "It seems reasonable to think of alliance development in the first phase of therapy as a series of windows of opportunity, decreasing in size

with each session" (p. 3). Thus, Table 1 summarizes by personality disorder the tendencies that may serve to challenge early collaboration building as well as aspects that a clinician might use to engage the patient.

Cluster A

Cluster A—the so-called odd-eccentric cluster—is comprised of schizotypal, schizoid, and paranoid personality disorders. What is most relevant for alliance building is the profound impairment in interpersonal relationships associated with these disorders. Because there are often pronounced paranoid or alienated features, people with these characteristics often do not seek treatment unless dealing with acute Axis I problems such as substance abuse.

Schizotypal. Schizotypal phenomena are thought by some to exist on the schizophrenia spectrum, given the associated disordered cognitions and bizarre beliefs. Because it is almost always the case that such individuals have one or no significant others outside family members, it is often assumed that schizotypal individuals have no desire to become involved in relationships. However, in many cases, it is more a matter of being excruciatingly uncomfortable around people rather than a lack of interest in connection. This discomfort may not be readily apparent, so establishing an alliance with such patients may require being attentive to clues about what is not being said. The therapist may be a player in some elaborated fantasy that is making it difficult for the patient to find some minimum level of comfort. A recent study by Bender et al.[26] assessed various attributes of how patients with personality disorders think about their therapists. Interestingly, results showed that patients with schizotypal personality disorder had the highest level of mental involvement with therapy outside the session, missing their therapists and wishing for friendship while also feeling aggressive or negative. One man with schizotypal personality disorder (who had also become attached to the female research assistant) revealed the following view of his therapist:

> Very beautiful and attractive in a sense that I yearn to have a sexual relationship with her. She's very smart and educated. She knows what she wants out of life and I wish I were working for I could take her out to the movies and dinner. She turns me on and I desperately want to make love to her eternally. She's my life and knowing she doesn't feel the same, I live in dreams. (p. 231)

Schizoid. Benjamin[27] noted that schizoid personality is more consistently associated with a lack of desire for intimate human connection. She described how some people with schizoid character can be found living very conventional lives on the surface, having families, jobs, and so on. However, usually things are arranged so that people are kept at an emotional distance. There may also be a pronounced lack of conflict, with associated affective coldness or dullness, so that a truly schizoid person is unlikely to become anxious or depressed and thus is usually totally lacking any motivation to seek treatment. However, Akhtar[28] suggested that underlying all of this apparent detachment is an intense neediness for others and the capability of interpersonal responsiveness with a few carefully selected people. Patients who may have more access to these latter attributes have a greater likelihood of forming an alliance in therapy if they choose to seek treatment.

Paranoid. The "paranoid" label largely speaks for itself. Paranoid individuals are incessantly loaded for bear and see bears where others do not—that is, they are vigilantly on the lookout for perceived slights, finding offense in even the most benign of circumstances. Alliance-building challenges are obvious. However, it has also been noted that paranoid individuals are often acting in defense of an extremely fragile self-concept and may possibly be reached over time in treatment with an approach that includes unwavering affirmation and careful handling of the many possible ruptures.[27]

Cluster B

The "dramatic" cluster includes antisocial, borderline, histrionic, and narcissistic personality disorders. Each of these character styles is associated in some way with pushing the limits, and great care is needed by clinicians to avoid crossing inappropriate lines in a quest to build an alliance. Thus, many Cluster B patients present some of the most daunting treatment challenges.

Borderline. Kernberg[29] described the borderline personality as being riddled with aggressive impulses that constantly threaten to destroy positive internal images of the self and others. According to this model, the borderline person does not undergo the normal developmental process of psychological integration but rather, as a defensive attempt to deal with aggression, creates "splits" in his or her mind, protecting the good images from the bad. This leads to a fractured self-concept and the identity problems associated with this disorder.

Thus, one can expect the alliance-building work to be rather rocky because these patients frequently exhibit pronounced emotional upheaval, self-destructive acting out, and views of the therapist that alternate between idealization and denigration. Within relationships, such individuals are very needy and demanding, often straining the boundaries of the treatment relationship and exerting pressure on clinicians to behave in ways they normally would not. Research has demonstrated that such pressures can impair the clinician's ability to reflect on his or her mental states and those of the patient.[30] Furthermore, clinicians who work with such patients must be able to tolerate and productively discuss anger and aggression. However, because borderline patients are, in most cases, relationship-seeking, this is a positive indicator for engagement in treatment.

One treatment study of borderline patients[31] examined alliance development over time. Psychodynamic psychotherapy was employed using largely noninterpretive interventions in the initial alliance-building period (choice of intervention is discussed later in the article). The authors observed that a strong alliance and good treatment outcome were linked to two factors: 1) a solid commitment by the participating therapist to remain engaged in the treatment until significant gains had been made by the patients; and 2) special emphasis on facilitating the patients' expressions of aggression and rage without fear of retaliation. Horwitz et al.,[32] who studied the therapeutic alliance over the course of treatment of borderline patients, noted that "clinical observation of our cases revealed that the repair of moment-to-moment disruptions in the alliance often was the key factor in maintaining the viability of the psychotherapy" (p. 173).

Narcissistic. Narcissistic character traits have received considerable attention in the clinical literature. Kohut[33] described individuals in whom there is a fundamental deficit in the ability to regulate self-esteem without resorting to omnipotent strategies of overcompensation or overreliance on admiration by others. Some people who are narcissistically vulnerable have difficulty maintaining a cohesive sense of self because of ubiquitous shame, resulting from a sense that they fundamentally fall short of some internal ideal. They look for constant reinforcement from others to bolster their fragile self-images. This combination of traits has been referred to alternatively as *vulnerable*, *deflated*, or *covert narcissism*.

On the other side of the narcissistic "coin"—what the DSM narcissistic personality disorder diagnosis captures—are people who are intensely grandiose, seeking to maintain self-esteem through omnipotent fantasies and defeating others. They defend against needing others by maintaining fusions of ideal self, ideal other, and actual self-images. Thus, there is an illusion maintained whereby this type of narcissistic person has a sense that because he or she is perfect, love and admiration will be received from other "ideal people," and thus there is no need to associate with inferiors. In its most extreme form, this manifestation of character pathology has been referred to as *malignant narcissism*.[34]

It is obvious that such personality traits pose significant challenges in alliance-building. It is often the case that the patient will need to keep the therapist out of the room, so to speak, for quite a long time by not allowing him or her to voice anything that represents an alternative view to that of the patient's. For such patients, other people, including the therapist, do not exist as separate individuals but merely as objects for gratifying needs. The clinician must tolerate this state of affairs, sometimes for a lengthy period of time. Meissner[9] observed, "Establishing any degree of trust with such patients may be extremely difficult, but not impossible, for a consistent respect for their vulnerability and a recognition of their need not to trust may in time undercut their defensive need" (p. 228).

Histrionic. A patient with histrionic personality needs to be the center of attention and may behave in seductive ways in an attempt to keep the clinician entertained and engaged. At the same time, emotional expressions are often shallow and greatly exaggerated, and the histrionic patient assumes a deep connection and dependence very quickly. Details are presented in vague and overgeneralized ways. There is very little tolerance for frustration, resulting in demands for immediate gratification. As opposed to the more well integrated, higher functioning, neurotic "hysterical personality" often written about in the psychoanalytic literature, the histrionic personality disorder organization more closely resembles the borderline. Particular borderline aspects include a tendency to utilize splitting defenses rather than repression, and a marked degree of identity diffusion.[28] The attention-seeking attribute can be helpful in establishing a preliminary alliance. However, as with patients with borderline pathology, the clinician must be prepared to manage escalating demands and dramatic acting out.

Antisocial. Antisocial personality is associated with ongoing violation of society's norms, manifested in such

behaviors as theft, intimidation, violence, or making a living in an illegal fashion such as by fraud or selling drugs. Also narcissistic by definition, people with antisocial personality disorder have little or no regard for the welfare of others. Clearly, this personality disorder is found extensively among inmates within the prison system. Stone[35] suggested that there are gradations of the antisocial style, with the milder forms being more amenable to treatment. However, within the broader label of *antisocial* is a subset of individuals who are considered to be psychopathic. Psychopaths are sadistic and manipulative pathological liars; show no empathy, compassion, or remorse for hurting others; and take no responsibility for their actions. The most dramatic form is manifest by individuals who torture or murder their victims. Those who perpetrate such violence reside on the extreme end of the spectrum of antisocial behavior and would be the most difficult to treat.

In keeping with notion that there is a spectrum of antisocial psychopathology, empirical evidence shows that some antisocial patients are capable of forming a treatment alliance resulting in positive outcome.[36] Consequently, it has been recommended by some that a trial treatment of several sessions be applied with antisocial patients who may typically be assumed to be untreatable. However, there is always the risk that such patients, particularly within an institutional context (e.g., a hospital or prison) may exhibit a pseudoalliance to gain certain advantages.[37] For example, there could be a disingenuous profession of enhanced self-understanding and movement toward reform as an attempt to manipulate the therapist into recommending inappropriate privileges.

There is some indication that depression serves as a moderator in the treatment of antisocial patients. One study demonstrated that depressed antisocial patients are more likely to benefit from treatment compared with nondepressed antisocial patients.[38] Thus, the presence of depression may serve as motivation for these patients to seek and comply with treatment.

Sadomasochistic Character

Cases in which difficult patients take a prominent role in orchestrating situations to sabotage a potentially helpful treatment are ubiquitous in the clinical literature. This type of dynamic points to an additional element commonly overlooked in treatments in general but of particular relevance when trying to establish and maintain an alliance with patients with character pathology: sadomasochism. Most dramatically overt in patients with borderline, narcissistic, and/or antisocial issues, relational tendencies that are anywhere from tinged to saturated by sadomasochistic trends span the spectrum of personality disorder pathology. The presence of sadomasochistic patterns does not mean that overt sexual perversions will be present, although they may be, but that the patient has characteristic ways of engaging others in a struggle in which one party is suffering at the hands of the other. Patients with a sadomasochistic approach to relationships make it very difficult for the clinician working in any modality to be a helpful agent of change. Furthermore, it is sometimes the case with such patients that at the foundation of the alliance is a very subtle, or not so subtle, sadomasochistic enactment.

For example, a patient may, on the surface, be agreeing with the therapist's observations but is actually experiencing them as verbal assaults while masochistically suffering in silence and showing no improvement in treatment. There is the patient who is highly provocative, attempting to bait the therapist into saying and doing things that may prove to be counterattacks. There are also patients who act out in apparently punishing ways, such as attempting suicide using a newly prescribed medication when it seemed as though the treatment was progressing.

Bach[39] described a sadomasochistic way of relating as arising as "a defense against and an attempt to repair some traumatic loss that has not been adequately mourned," (p. 4). This trauma could have come in the form of an actual loss of a parent, loss of love as a result of abuse or neglect, or some experience of loss of the self due to such things as childhood illness or circumstances leading to overwhelming anxiety. From this perspective, the cruel behavior of the sadist may, for instance, be an attempt to punish the object for threatened abandonment. The masochistic stance involves a way of loving someone who gives ill-treatment—the only way of maintaining a connection is through suffering.[40] Early in development, this way of loving is self-preservative—the sadism of the love object is turned upon the self as a way of maintaining a needed relationship.[41] However, in an adult, this masochistic solution, with its always attendant aggressive-sadistic elements, serves to cause significant interpersonal dysfunction.

A single woman in her forties, Ms. P, was referred for psychotherapy after she had gone to see four or five other therapists, staying for only several sessions maximum because she found them all to be incompetent in some way. An avid reader of self-help literature, she

dependent patients are loath to see the value in asserting some independence. Furthermore, there is a deeply ingrained assumption by these patients that they are actually incapable of functioning more independently and that being more assertive will be experienced by others as alienating aggressiveness. Thus, a therapist must be very alert to the withdrawal types of strains and ruptures, such as withholding information, as well as to the challenge to the alliance that may occur when the therapist attempts to encourage more independence.

Avoidant. The avoidant individual is extremely interpersonally sensitive, afraid of being criticized, and constantly concerned about saying or doing something foolish or humiliating. In spite of an intense desire to connect with others, an avoidant person does not let anyone get close unless absolutely sure the person likes him or her. Because of this acute sensitivity, there is some evidence that some avoidant patients are somewhat difficult to retain in treatment. One study showed that a group of avoidant patients was significantly more likely to drop out of a short-term supportive-expressive treatment compared with patients with obsessive-compulsive personality disorder.[42] Clinicians who work with avoidant patients need to be constantly mindful of the potentially shaming effects of certain comments but can also work with the patient's underlying hunger for attachment to enlist them in building an alliance.

Furthermore, there is preliminary evidence supporting the notion that at least some of the patients diagnosed with avoidant personality disorder are actually better characterized as vulnerable narcissists. These patients covertly crave admiration to bolster their fragile self-esteem and secretly or unconsciously feel entitled to it rather than simply being afraid of not being liked or accepted.[43] Gabbard[37] also referred to this style as *hypervigilant narcissism*, emphasizing extreme interpersonal sensitivity, other-directedness, and shame proneness aspects. An underlying unrecognized narcissism in avoidant personality disorder has significant treatment implications, changing the nature of the forces affecting the alliance as well as shaping the types of treatment interventions that are indicated.

Obsessive-compulsive. The obsessive-compulsive character is associated with more stable interpersonal relationships than some other styles, but typical defenses are centered on repression, with patterns of highly regulated gratification and ongoing denial of interpersonal and intrapsychic conflicts.[44] Self-willed and obstinate, with a constant eye toward rules and regulations, people with obsessive-compulsive attributes guard against any meaningful consideration of their impulses toward others. Maintaining control over internal experience and the external world is a top priority, so rigidity is often a hallmark of this character type. Except in its most severe manifestations, obsessive-compulsive character pathology is less impairing than some of the others and more readily ameliorated by treatment. Although stubborn and controlling and averse to considering emotional content, obsessive-compulsive individuals also generally try to be "good patients" and so can be engaged in a constructive alliance that is less rocky compared with other types of personality disorder patients.

Mr. S, a 25-year-old philosophy graduate student, began a twice-weekly psychotherapy. His presenting complaint was difficulty with completing work effectively, particularly writing tasks, due to excessive anxiety and obsessionality (he met criteria for obsessive-compulsive personality disorder and generalized anxiety disorder). When he came for treatment, he was struggling to make progress on his masters thesis. Although Mr. S socialized quite a bit, he reported that intimate relationships often felt "wooden." He was usually overcommitted with an endless list of "shoulds" that he would constantly mentally review and remind himself how much he was failing to satisfy his obligations. A central theme throughout treatment was his tendency to be self-denigrating, loathing himself as a person deserving of punishment in some way yet being extremely provocative (sadomasochistic trends). He also held very strong political beliefs, sure that his way of viewing things was superior to others'.

Establishing a productive alliance with Mr. S was not easily accomplished at first. In the early phase of treatment, he was extremely controlling and challenging in sessions, talking constantly and tangentially, often losing the core point of his statements because of a need to present excessive details. Any statement the therapist made was experienced as an intrusion or interruption. For example, if the therapist attempted to be empathic using a word Mr. S had not used, such as saying, "That sounds difficult," he would respond, "Difficult? I don't know if I'd choose the word difficult. Challenging, maybe, or daunting, but not difficult." Thus, for a number of months in the initial phase of the treatment, the therapist chose her words carefully, which eventually paved the way for increased dialogue about Mr. S's problems. Mr. S also began to tolerate a

discussion of his emotional life, a topic that previously had been very threatening to him.

Passive-aggressive. Some of the aspects of this case example may be described as passive-aggressive, particularly the patient's tendency to procrastinate excessively in doing his work. Passive-aggressive traits include argumentativeness, scorning authority, resistance to carrying out social and occupational responsibilities, angry pessimism, alternating between defiance and contrition, envy, and exaggerated complaints about personal misfortune. These attributes pose challenges to the formation of an effective therapeutic alliance because these patients are likely to expect that the treatment holds no promise of helping, and they behave in ways that contribute to that outcome. The passive-aggressive (negativistic) personality disorder diagnosis was included in Cluster C in DSM-III-R,[45] but was subsequently shifted to the appendix of disorders needing further study in DSM-IV.[46] Some experts on phenomenology argue that this diagnosis is clinically very useful and should be restored to the DSM list of personality disorders (e.g., Wetzler and Morey[47]).

ALLIANCE CONSIDERATIONS WITHIN DIFFERENT TREATMENT PARADIGMS

Clearly, no matter what treatment paradigm one adopts for working with patients with personality disorders, attention to the alliance is of utmost importance. Thoughts and feelings on the part of the therapist must be monitored closely, because interactions with difficult patients may often be provocative, inducing reactions that must be carefully managed. (For a discussion of some of the most serious consequences of treatments gone awry, readers are referred to the article by Gutheil[48] on boundary violations in this issue [p. 88].) Although this topic is usually discussed as countertransference in the psychoanalytic/psychodynamic tradition, it is also quite applicable across all treatments.[49]

Treatment approach and technique must be flexible, so that interventions can be made appropriate to the individual patient's style. Otherwise, the alliance may be jeopardized and the patient will not benefit or may leave treatment altogether. Furthermore, it is likely that noticeable improvements in symptoms and functioning in such patients will likely require a significantly longer period of treatment than for patients with no character pathology. The following section reviews some considerations relevant to alliance in different treatment contexts. Readers are also referred to the 2005 *American Psychiatric Publishing Textbook of Personality Disorders*[6] for more detailed discussions of issues related to specific treatment approaches.

Psychodynamic Psychotherapy/Psychoanalysis

One longstanding issue within the psychodynamic psychotherapy tradition is the application of particular techniques. Interpretation of the transference was long considered the heart of the psychoanalytic approach. However, as the application of this treatment evolved and clinicians gained more experience with more disturbed patients—most notably those with borderline and narcissistic trends—it became apparent that, in many cases, transference interpretations with such patients were often counterproductive. Refraining from making deep, interpretive interventions early on is consistent with notions of writers such as Winnicott[50] and Kohut,[51] who asserted that certain more disturbed patients cannot tolerate such interpretations in the initial phase of treatment.

Gabbard[37] stressed the importance of understanding that there is usually a mixture of supportive and expressive (interpretive) elements in every analysis or psychodynamic psychotherapy. That is, the expressive, insight-oriented mode of assisting patients in uncovering unconscious conflicts, thoughts, or affects through interpretation or confrontation may be appropriate at times, whereas a more supportive approach of bolstering the patient's defenses and coping abilities is preferable in other circumstances.

For instance, it may be difficult to focus on more insight-oriented interventions with a patient with borderline impairments until that patient is assisted in achieving a safe, more stable alliance. Similarly, the severely narcissistically impaired patient may not be able to accept the analyst's interpretations of his or her unconscious motivations for quite a long time, so that supportive, empathic communications may be more effective interventions in building an alliance by helping the patient feel heard and understood. Conversely, some obsessional patients may benefit earlier in treatment by interpretations of the repressed conflicts that may underlie the symptoms.

The results of the Psychotherapy Research Project of The Menninger Foundation, which included patients with personality disorders, led Wallerstein[52] to conclude that both expressive and supportive interventions can lead to character change. At the same time, there is empirical evidence supporting the notion that a fairly solid alliance must be present to effectively utilize

transference interpretations per se. Bond et al.[53] demonstrated with a group of personality disorder patients in long-term treatment that for those patients whose alliance was weak, transference interpretations caused further impairment to the alliance. Conversely, the alliance was strengthened by transference interpretations when already solidly established. At the same time, supportive interventions and discussions of defensive operations resulted in moving the therapeutic work forward with both the weak and strong alliance groups of patients.

These findings are consistent with a study conducted by Horwitz et al.[32] exploring the effect of supportive and interpretive interventions on the therapeutic alliance with a group of patients with borderline personality disorder. The authors concluded that, although many times therapists are eager to pursue transference interpretations, such interventions are "high-risk, high-gain" and need to be employed carefully. They may damage the alliance with patients who are vulnerable and prone to feelings of shame and humiliation. Therefore, there must be flexibility in adjusting technique according to the dynamics of a particular patient at a particular time given the patient's capacities and vulnerabilities, appropriately balancing both supportive and expressive interventions.

Ms. A sought treatment when she was in her early 30s. She was referred for psychotherapy from her graduate school's counseling center. Ms. A presented in a major depressive episode and met eight out of a possible nine DSM-IV-TR criteria for borderline personality disorder. The initial phase of the twice-weekly psychodynamic treatment was focused on her depression and helping her to stabilize sometimes devastating affective instability. She also reported intermittent, but not life-threatening, instances of cutting herself, particularly after some unsatisfactory encounter with a friend or colleague.

The patient's lack of object constancy, her affective instability, and a fragmented sense of self contributed to great variations in the nature of Ms. A's presence in sessions. At times she would be overwhelmed by fatigue, whereas other times she would be engaging, funny, and analytical. She would often defend against undesirable thoughts or emotions by spending the session recounting events of her day-to-day life in great detail. The disjunctions in self-states made it difficult at times to maintain continuity in the process, because Ms. A did not remember what happened from session to session.

A Kernbergian formulation[29] of this patient was theoretically informative in describing some of her dynamics (defensive splitting had been one prominent theme in the treatment). However, the technical implications of this particular approach, with its direct confrontation of aggression in the transference early in the treatment[54] would have endangered the sometimes fragile working alliance being forged. In fact, a few times when transference interpretations were attempted in the first phase of treatment, Ms. A became confused and distressed, quickly changing the subject away from a discussion of her relationship with the therapist, talking about ending treatment, or becoming very sleepy and shut down for several sessions. On one occasion early on when an attempt was made by the therapist to address something in their relationship, Ms. A became very angry and said, "Why is any of this about here? These are my problems and I don't see what any of this has to do with you!" Clearly, in the beginning phase of treatment with some patients, one needs a different way of entering the patient's psychic world.[55] On the other hand, Ms. A was responsive to gentle interpretations of her defenses, such as the therapist pointing out to her that her self-harm behaviors were a way of "being mean" to herself instead of channeling anger toward those who had upset her.

Thus, for most of the first 3–4 years of this treatment, the primary tasks were to develop a working alliance and establish a "holding environment"[50] within which Ms. A could begin to feel safe to explore her history, her feelings, and her own mind. This approach paid off, because it eventually became possible to uncover, in ways that were meaningful and transformative to Ms. A, some of the split off rage and despair underlying the identity instability and distorted cognitive functioning. Deeper experience and exploration of these findings paved the way for further integration and less disjunctive experiences in her life and from session to session, and working with the transference increasingly became both possible and very productive. Ms. A has not been depressed for years and no longer meets any borderline criteria.

Cognitive-Behavioral Therapies

In recent years, work has been done to apply to personality disorders cognitive and cognitive-behavioral treatments that have typically been used to treat Axis I symptoms. However, Tyrer and Davidson[56] observed that the approaches generally taken in these therapies for Axis I "mental state disorders" cannot be simply transferred to treating personality disorders without certain adjustments. Most cognitive and cognitive-

behavioral therapies are based prominently on a therapist-patient collaboration that is assumed to be present from very early in the treatment. Such a collaboration, which revolves around the patient undertaking specific activities and assignments, depends on the establishment of a solid working alliance; however, it is sometimes very difficult to engage certain personality disorder patients in the therapeutic tasks. To facilitate this alliance when working with patients with personality disorders—in addition to requiring lengthier periods to complete these treatments—work needs to directly address patient-therapist collaboration with clearly set boundaries and to focus on the therapeutic relationship itself when appropriate.[56]

For example, in using the initial sessions of dialectical behavior therapy (DBT)[57] to begin establishing a working relationship, Linehan[58] observed: "These sessions offer an opportunity for both patient and therapist to explore problems that may arise in establishing and maintaining a therapeutic alliance" (p. 446). Even though DBT is a manualized treatment with clearly elaborated therapeutic tasks, it is quickly evident, particularly in working with borderline patients, that a great deal of flexibility must be maintained within this paradigm to achieve an alliance. More specifically, there may be frequent occurrences of therapy-interfering behaviors ranging from ambivalence causing missed sessions to multiple suicide attempts that prevent the treatment from progressing as the method outlines.

Ms. D, a young woman with dependent personality disorder, was referred for behavioral treatment of a phobia of all forms of transportation (her other issues were already being addressed in an ongoing psychotherapy). The therapist spent several sessions with Ms. D outlining the exposure techniques recommended for treating her phobia, but the patient was resistant to beginning any of the activities described. At the same, while trying to pursue a classically behavioral approach, the therapist realized that it was very important for Ms. D to spend some of the time talking about her life and the impact the phobia symptoms had for her. This approach helped Ms. D feel a connection to the therapist. The therapist made this relationship-building aspect explicit with Ms. D by agreeing to take a part of each session to talk about her situation, but the therapist also made it clear that it was necessary to reserve enough time for the exposure activities. This approach fostered an alliance sufficiently to begin the behavioral tasks. By being flexible, while setting clear tasks and boundaries, the therapist was able to engage Ms. D in the treatment, and she began taking short rides with the therapist on the bus, eventually overcoming these fears completely.

Psychopharmacology Sessions

One large-scale depression study[59] comparing several different psychotherapies with medication and placebo showed that the quality of the alliance was significantly related to outcome for all of the study groups. This finding demonstrates the importance of considering the alliance not only in psychotherapies but in medication sessions as well. Gutheil[60] suggested that there is a particular aspect of the therapeutic alliance—what he calls the *pharmacotherapeutic alliance*—that is relevant to the prescription of medications. In this formulation of the alliance, it is recommended that the physician adopt the stance of *participant prescribing*—that is, rather than adopting an authoritarian role, the clinician should make every effort to involve the patient as a collaborator who engages actively in goal-setting and observing and evaluating the experience of using specific medications. Such collaboration, like other therapeutic processes, may be affected by the patient's transference distortions of the clinician.

This latter notion can be more broadly applied in transtheoretical terms to personality disorders, where it is appropriate to consider how the patient's characteristic style may influence his or her attitudes and behaviors toward taking psychiatric medications. Some patients may become upset if medication is not prescribed, feeling slighted because they think their problems are not being taken seriously. Others with paranoid tendencies may think the physician is trying to put something over on them, or worse. Some patients who are prone to somaticizing, such as those with borderline or histrionic tendencies, might be hypersensitive to any possible side effects (real or imagined) and argue with the prescriber about his or her competence. The following is another example from Benjamin[27] illustrating the importance of being mindful of the how personality disorder patients might react around issues of medication:

A patient [with avoidant personality disorder] overdosed one evening on the medicine her doctor had prescribed for her persistent depression. She liked and respected him a lot. She was discovered comatose by a neighbor who wondered why her cat would not stop meowing. The neighbor was the patient's only friend. It turned out that that morning her doctor had wondered aloud whether she had a personality disorder. The

patient was deeply humiliated by that idea but secretly agreed with it. She felt extremely embarrassed and was convinced that her doctor now knew she was a completely foolish person.... Rather than endure the humiliation of facing him again, she decided to end it all. (p. 411)

Psychiatric Hospital Settings

Across the spectrum of personality disorders, psychiatric hospitalizations—both inpatient and day treatment programs—are most common for those with borderline personality disorder.[61] The central consideration regarding the alliance in this treatment context is that there is always a team of individuals responsible for the patient. With patients with borderline issues, splitting tendencies are frequently quite pronounced. That is, as a way of trying to cope with inner turmoil, the patient's mental world is often organized in black/white, good/bad polarities, and through complicated interaction patterns with various staff members, this internal world becomes replayed externally, dividing staff member against staff member (see Gabbard[62] for an explanation of projective identification).

Gabbard[63] has observed that this dynamic is often set up because the patient will present one self-representation to one or several team members and a very different representation to another. One of these staff factions may be viewed as the "good" one by the patient and the other as the "bad" one—although these designations can flip precipitously in the patient's mind—and this split becomes enacted among team members as they begin to work at cross purposes. It can be seen rather readily that trying to develop a constructive alliance with such a patient can be extremely precarious, particularly given the ever-decreasing length of hospital stays under managed care. That means that communication and close collaboration among the members of the team are vital during every phase of the hospital treatment.

Matters are further complicated at times by the need to find a productive way for hospital staff to collaborate with clinicians providing ongoing outpatient psychotherapy and/or psychopharmacology treatments. Although the hospitalization may represent a significant rupture in the outpatient treatment alliance, this rupture does not necessarily indicate that the outpatient treatment was ineffective and must be terminated but that work will be needed to reestablish the continuity of the treatment relationship. However, it is not uncommon for the hospital staff, seeing the patient's current condition, to conclude that the outpatient clinicians were somehow not doing a competent job (this conclusion may, of course, be fueled by further splitting on the part of the patient). Moreover, at times it may be obvious that the outpatient treatment was inadequate or inappropriate. In any event, it becomes rather dicey for all parties concerned to sort out the proper role of hospital staff versus outpatient staff over the course of the inpatient or day treatment program.

Ms. B, a young woman with borderline personality disorder, was admitted to a psychiatric inpatient unit after coming to the emergency department reporting acute suicidal ideation. This patient had been hospitalized several times previously, was in a mental health field, and "knew the ropes" quite well. She had been assigned a psychiatrist who was responsible for overall case management and a psychologist who was to provide short-term psychotherapy on the unit.

The initial psychotherapy session was extremely difficult, with Ms. B refusing to speak very much and regarding the therapist with rageful contempt. However, after several more encounters, there was some softening by Ms. B, and she began to discuss the upsetting circumstances that led to her hospitalization. It appeared there might be the beginnings of a working alliance. Indeed, as she opened up more about her life, she reported feeling slightly more hopeful and less fragmented.

However, at the same time, she had created quite a bit of trouble with the rest of the staff by being very demanding and uncooperative and attempting to initiate discharge procedures even while refusing to deny that she would kill herself. Having reached a point of needing to take some action in the courts to keep Ms. B hospitalized, the psychiatrist hastily called a meeting including himself, the psychologist, and the patient. Having had no opportunity to confer with other team members on the matter, the psychiatrist proceeded to tell Ms. B that he was initiating legal proceedings to keep her in the hospital. Mindful of the splitting tendencies of such patients, the psychiatrist was careful to make it clear that he represented the viewpoint of the entire team, including the psychologist. However, he unwittingly created another split. Ms. B, feeling betrayed, stared hatefully at the psychologist, the fragile working alliance was shattered, and she subsequently refused to participate in psychotherapy or any other therapeutic activities for the rest of the hospitalization. It is possible this rupture could have been ameliorated had there been adequate consultation among treatment team members so that a less alienating approach could be formulated.

FUTURE RESEARCH DIRECTIONS

There is a need for further research concerning the nature of therapeutic alliance in the treatment of character pathology, especially over the course of long-term treatments. A detailed discussion of research in this area is beyond the scope of this article, but readers are referred to a meta-analysis by Martin et al. and the chapter from which this article is adapted for a discussion of instruments that have been developed for measuring therapeutic alliance.[8,64]

CONCLUSION

Establishing an alliance in any treatment paradigm requires a great deal of empathy and attunement to a patient's way of seeing the world. Attention to alliance building is even more important when working with patients with personality disorders, because these individuals often present with disturbed patterns of interpersonal relationships. Research has shown not only the importance of building an alliance but also that this alliance is vital in the earliest phase of treatment. One cannot rigidly pursue the dictates of one's treatment paradigm without being prepared to make frequent adjustments to address the various ruptures that may occur. Gleaning clues from the patient's accounts of his or her relationships can serve to guide the clinician's general interpersonal stance. Further, monitoring the therapeutic alliance in response to clinical interventions is a useful way to assess the effectiveness of one's approach and is informative in determining appropriate adjustments in the style and content of the therapist's interactions with the patient.

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The Therapeutic Alliance in the Treatment of Personality Disorders

DONNA S. BENDER, PhD

Because personality disorders are associated with significant impairment in interpersonal relationships, special issues and problems arise in the formation of a therapeutic alliance in the treatment of patients with these disorders. In particular, patients with narcissistic, borderline, and paranoid personality traits are likely to have troubled interpersonal attitudes and behaviors that will complicate the patient's engagement with the therapist. While a strong positive therapeutic alliance is predictive of more successful treatment outcomes, strains and ruptures in the alliance may lead to premature termination of treatment. Therefore, clinicians need to consider the patient's characteristic way of relating in order to select appropriate interventions to effectively retain and involve the patient in treatment. Research has shown not only the importance of building an alliance but also that this alliance is vital in the earliest phase of treatment. The author first reviews several definitions of the therapeutic alliance with reference to how they apply to the treatment of patients with personality disorders. Issues relevant to forming a therapeutic alliance with patients with personality disorders are then discussed in terms of the three DSM-IV-TR personality disorder clusters. However, the author notes that these categories do not adequately capture the complexity of character pathology and that clinicians also need to consider which aspects of a patient's personality pathology are dominant at the moment in considering salient elements of the therapeutic alliance. In dealing with Cluster A personality disorders (schizotypal, schizoid, and paranoid personality disorders), what is most relevant for alliance building is the profound impairment in interpersonal relationships. The Cluster B "dramatic" personality disorders (antisocial, borderline, histrionic, and narcissistic) are all associated with pushing the limits. Consequently, clinicians need to exercise great care to avoid crossing inappropriate lines in a quest to build an alliance with patients with one of these disorders. Patients with Cluster C "anxious/fearful" personality disorders (avoidant, dependent, and obsessive-compulsive personality disorders) are emotionally inhibited and averse to interpersonal conflict. These patients frequently feel guilty and internalize blame for situations even when there is none, a tendency that may facilitate alliance building because the patients are willing to take some responsibility for their dilemma and may engage somewhat more readily with the therapist to sort it out, compared with patients with more severe Cluster A or B diagnoses. The author then reviews considerations relevant to treatment alliance that arise in the different treatment approaches that may be used with patients with personality disorders, including psychodynamic psychotherapy/psychoanalysis, cognitive-behavioral therapies, and psychopharmacology. The author also discusses issues, especially splitting, that arise in the alliance when patients with personality disorders are treated in inpatient psychiatric hospital settings. (*Journal of Psychiatric Practice* 2005;11:73–87)

KEY WORDS: therapeutic alliance, personality disorders, ruptures in alliance, schizotypal personality disorder, schizoid personality disorder, paranoid personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, sadomasochism, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, psychodynamic psychotherapy, cognitive-behavioral therapy, psychopharmacology

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Any patient beginning treatment enters a relationship, whether it is for a short time during a hospital stay or over many years in long-term psychotherapy. This relationship with the clinician has the potential for improving the patient's quality of life, perhaps through the alleviation of symptoms or more profoundly through shifts in character structure. It is sometimes difficult to determine a priori who will benefit from what treatment with whom, but one factor has stood out in the research lexicon as the most robust predictor of outcome—therapeutic alliance.[1–3]

Because establishing a productive alliance arises within the matrix of a relationship between patient and therapist, when considering personality disorders, one must note that most such disorders are associated in some way with significant impairment in interpersonal relations. Speaking about the nature of relationships of individuals characterized by a certain types of personality pathology, Masterson[4] has stated the following:

> Each type of pathology produces its own confusion and its own distorted version of loving and giving. The borderline patient defines love as a relationship with a partner who will offer approval and support for regressive behavior.... The narcissist defines love as the ability of someone else to admire and adore him, and to provide perfect mirroring.... Psychopaths seek partners who respond to their manipulations and provide them with gratification. The schizoid... finds love in an internal, autistic fantasy. (pp. 110–111)

In fact, several studies have shown that, rather than categorical diagnosis, it is the preexisting quality of the patient's relationships that most significantly affects the quality of the therapeutic alliance.[5–7] Consequently, the clinician must consider an individual's characteristic way of relating so that appropriate interventions can be employed to effectively retain and involve the patient in the treatment, regardless of modality. Forming an alliance is often difficult, however, particularly in work with patients with severely narcissistic, borderline, or paranoid proclivities, because troubled interpersonal attitudes and behaviors will also infuse the patient's engagement with the therapist. For example, narcissistic patients may not be able to allow the therapist to be a separate, thinking person for quite a long time, whereas someone with borderline issues may exhibit wildly fluctuating emotions, attitudes, and behaviors, thwarting the potential helpfulness of the clinician.

This article is adapted from a chapter in the 2005 *American Psychiatric Publishing Textbook of Personality Disorders*.[8] Readers are referred to that publication for discussions of other issues related to the assessment and treatment of personality disorders.

DEFINITION OF THERAPEUTIC ALLIANCE

The concept of the therapeutic alliance is often traced back to Freud, who observed very early in his work the need to convey interest and sympathy to the patient to engage her or him in a collaborative treatment endeavor.[9,10] Freud[11] also delineated an aspect of the transference—the unobjectionable positive transference—which is an attachment that should not be analyzed because it serves as the motivation for the patient to collaborate: "The conscious and unobjectionable component of [positive transference] remains, and brings about the successful result in psychoanalysis as in all other remedial methods" (p. 319). This statement is an early precursor to the modern empirical evidence showing that alliance is related to treatment outcome across modalities.

There are several contemporary definitions of alliance that we might consider to further our discussion of treating patients with personality disorders. One conceptualization, using psychoanalytic language, was posited by Gutheil and Havens.[12] The patient's ability to form a rational alliance arises from "the therapeutic split in the ego which allows the analyst to work with the healthier elements in the patient against resistance and pathology" (p. 479). This definition is useful vis-à-vis personality disorders in two regards: 1) the recognition that there will be pathological parts of the patient's personality functioning that may serve to thwart the attempted helpfulness of the clinician; and 2) the need for the clinician to be creative in enlisting whatever adaptive aspects of the patient's character may avail themselves for the work of the treatment.

Another definition that was developed in an attempt to transcend theoretical traditions is Bordin's[13] identification of three interdependent components of the alliance: bond, tasks, and goals. The *bond* is the quality of the relationship formed in the treatment dyad that then mediates whether the patient will take up the *tasks* inherent in working toward the *goals* of a particular treatment approach. At the same time, the clinician's ability to negotiate the tasks and goals with the patient will also affect the nature of the therapeutic bond. This multifaceted view of the alliance underscores the complexity of the factors involved.[10]

Arguably, if the goal of treatment is fundamental character change, the Bordin definition of alliance spec-