

# Therapeutic alliance, Transference and Countertransference in Psychopharmacology

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# Objectives

1

Understand the concepts of therapeutic alliance

2

Understand the role of therapeutic alliance and psychopharmacology treatment outcome

3

Understand attachment theory and apply attachment theory concepts to promote positive alliance

4

Understand and recognize transference and countertransference in prescribing medication

- Zetzel (1956, 1958), the therapeutic alliance referred to the patient's capacity to form a trusting relationship with the analyst. This capacity was the direct expression of the early maternal/child dyadic relationship.
- Greenson (1965), used the term "Working Alliance" to describe the importance of the relationship between therapist and patient. Emphasize the **"the real/authentic relationship"** between patient and therapist rather than the rigid and withholding technique from traditional psychoanalysis.

## Concept of therapeutic alliance

Auchincloss E. New Development of the Therapeutic Alliance (TA):  
Good News for Psychodynamic Psychiatry. *Psychodynamic Psychiatry*, 44(1) 105-116, 2016

# Concept of therapeutic alliance

- Ego psychology perspective; explore the specific ego capacities in the patient that are necessary for the maintenance of the therapeutic alliance.
  - An attitude of basic trust
  - The capacity for candor
  - The capacity to establish, tolerate, and reflect on an intense transference experience.

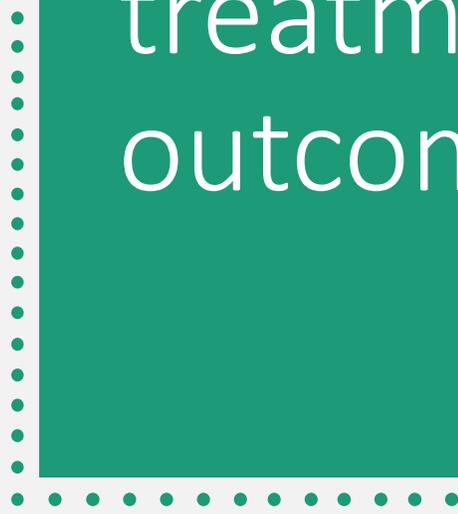
# Concept of therapeutic alliance

- Bordin (1979), describe the concept of the therapeutic alliance in the field of general psychiatry. Three components of the therapeutic alliance:
  - **Goal**: the patient and therapist/psychiatrist must agree about the goals that the patient wishes to achieve in the treatment.
  - **Task**: They also must agree about the therapeutic tasks each must perform in order to achieve these goals.
  - **Bond**: the bond that forms between patient and therapist/psychiatrist in the course of working on these goals and tasks includes a positive attachment that stimulates trust and confidence.

# Therapeutic alliance as common active ingredient

Therapeutic alliance has long been considered the most robust predictor of success in all kinds of psychotherapy, in many settings, and in many diagnoses ( Luborsky, 1976, 1994)Horvath & Symonds, 1991; Martin et al., 2000).

Krupnick et al., 1996). Published the first study showing that the TA was the best predictor of outcome not only in psychotherapy, but in the psychopharmacology treatment as well.



# Therapeutic alliance and treatment outcome

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The number of meeting with therapists, which may represent opportunities for therapeutic interaction, affects treatment outcome. It is also true for psychopharmacologic encounter (Falkenstorm et al, 2016).

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Meta-analyses suggested that in both placebo and anti-depressant medication group, the more visits with the treating physician resulted in significantly greater symptom reduction. (Rutherford et al.)

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A more recent meta-analysis further suggests that intensifying supportive care from 6 to 10 visits over 12 weeks resulted in a reduction of the average medication vs placebo difference from 12.2% to 0.4 % (Rutherford et al., 2014).

# Attachment Theory and Therapeutic Alliance



# Example of Patient's characteristics that can impact treatment outcome

- Autonomy (a sense of self-efficacy) VS Sociotropy (an orientation toward others for assistance, tends to please others).
  - High autonomy and low sociotropy showed a response of 74.1 % to anti-depressant, whereas high-sociotropic/low-autonomous patients responded at 38.5%.
- Patients with an internal locus of control also fare significantly better with anti-depressants than patients with an external locus of control.
- Attachment styles
  - Anxious-fearful attachment patterns, similar to sociotropy often worries about evoking a negative response from important others.
  - Avoidant attachment often shows particular difficulty with treatment adherence.



# Trait-like component of Therapeutic Alliance

- The trait-like component of alliance is a product of the patients' (and therapists') trait-like characteristics, such as ***attachment styles***, *their ability to create and the environment required to conduct any effective treatment*.
- This trait-like components can play a role as ***moderators*** of the psychopharmacologic response, patient's report of side effect, their adherence of treatment.
- The quality of therapeutic alliance serves as a ***mediator***, a mechanism of change in itself.



Zicha-Mano S, Roose SP, Brown PJ and Rutherford BR (2019). Not just Nonspecific Factors: The roles of Alliance and Expectancy in Treatment, and Their Neurobiological Underpinnings. *Front. Behav. Neurosci*, 12:293.

# Case example

- 17-year-old young woman who presents with chronic anxiety and depression, seeking medication for anxiety and depression. She has experienced intolerable diarrhea with every medication she tried.
- Review of her history uncovered a pattern of concerns about control and autonomy, including an intrusive, controlling relationship with her mother.
- The patient and her psychiatrist agreed to meet regularly, make medication changes slowly, and attend carefully to patient's reactions. Having formed an alliance that attended to patient's needs for control over her bodily functions, she was able to find and tolerate medications that addressed her psychiatric symptoms.

Clinical  
Implications-  
Work with  
Adolescents  
and Young  
Adults

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Psychiatrist serves as a secure base or  
transference reflective receptacle

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Psychiatrist has to be aware of his/her  
attachment styles and internal working  
models

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Interventions with high-risk parent-child  
dyads should be intensive and consistent to  
ensure higher rates of attachment security

# Clinical Implications-Work with Adolescents and Young Adults

Importance of eliciting information about early life experiences to understand readiness to attach/engage in treatment.

Moving from insecure to secure attachment styles requires being consistently emotionally responsive.

Relinquishing control and supporting collaborative decision-making rather than a paternalistic stance.

# Therapeutic alliance with parents

A decorative graphic at the bottom of the slide consists of a long, horizontal teal bar on the left, which transitions into a 3D-style rectangular block on the right. The block has a white shadow on its bottom and right sides, giving it a sense of depth. The entire graphic is set against a dark teal background.

# Parental Emotion Regulation

- “Why do otherwise calm, regulated individuals lose it with their children? What is so dysregulating about being a parent? One of the byproducts of the deep attachments that we form with our children may be that they are able to stir emotions and block our thinking more than just about anyone else in our lives. We fall deeply in love with our children; the difficulty is that love sometimes makes it hard to think.”

-Meehan & Zick, *Parental Humility* (2016)

# Therapeutic communication with parents/caregiver

- Emphatic listening, with attitude of trying to understand
  - An emphatic attitude towards caregivers with the aim of helping caregivers develop emphatic and mentalizing attitude toward their child.
- A warm collaborative attitude, gentle clarification with nonjudgmental stance.
- Pay attention to the internal working model of attachment relationship between parents and child.
- Recognize common parental anxieties as well as their protective strategies
  - Sense of shame, humiliation, anxiety and uncertainty or hopelessness
  - Sense of denial, blame on others

# Case example

- A 17-year-old perfectionist, depressed high school student was deeply attached to her mother. She was offered SSRI for her depression. She asked her mother's advice. Her mother replied, "I don't want my daughter to become suicidal or drug addicted". The patient refused pharmacology treatment.

# Transference and Countertransference

- “In those days, I didn’t understand anything. I ought to have judged by deeds and not by words. She cast her fragrance and her radiance over me. I ought never to have run away from her . . . I ought to have guessed all the affection that lay behind her poor little stratagems. Flowers are so inconsistent! But I was too young to know how to love her . . .”
- “Of course, I love you,’ the flower said to him. ‘If you were not aware of it, it was my fault.”

*Antoine de Saint-Exupéry, The Little Prince*



# Clinical tips to recognize transference and countertransference

1

Listen what we hear

2

Observe non-verbal  
message and  
behaviors

3

Reflect how we feel

# Transference

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Medication management doctor-patient relationship interactions on activate parental transferences.

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Patients may regress as doctors become paternalistic.

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Placebo and Nocebo responses can have transference element.  
(Guthei, 1982).

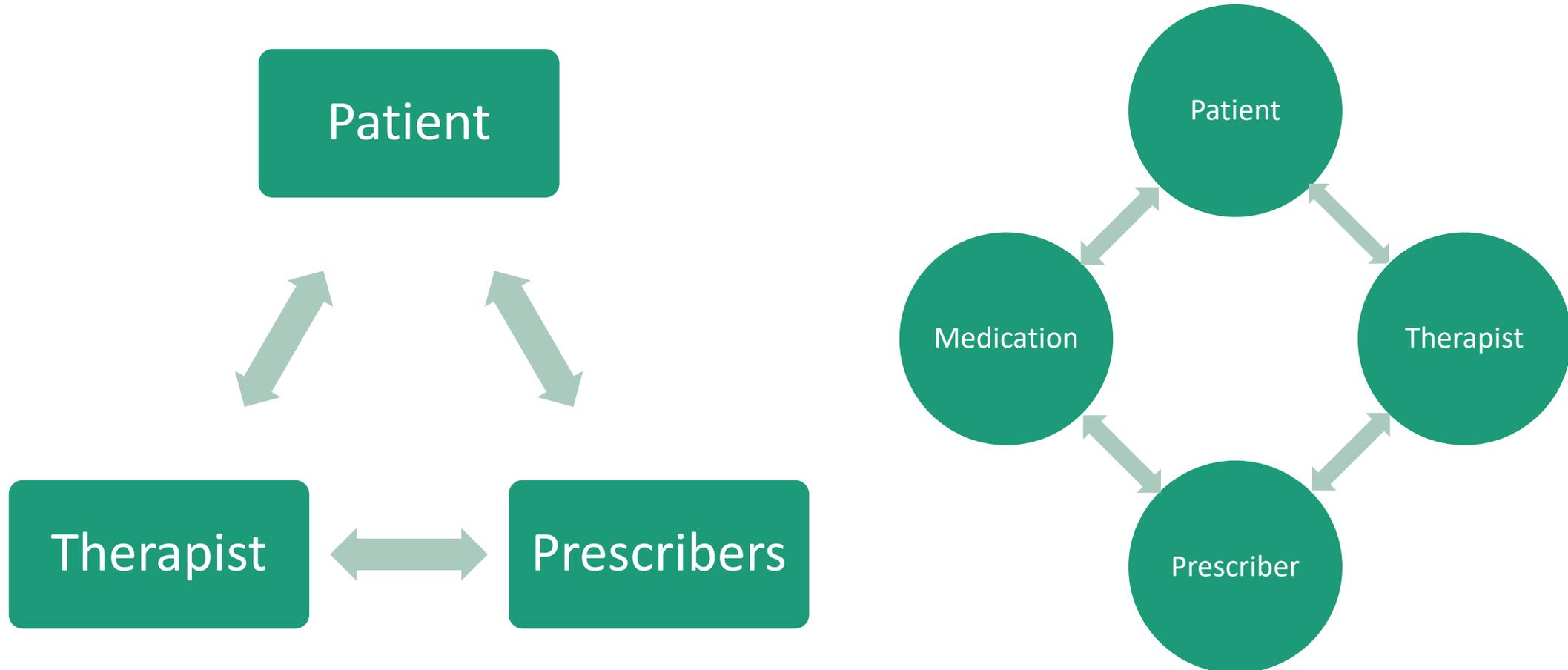
# Transference

- Gabbard (2005) points out that patients often have subjective experience of feeling dismissed when medication is recommended to alleviate their distress.
- ***If the clinician does not make an effort to validate the patient's feelings, medication may be experienced as an anesthetic rather than as an effective tool to alleviate distress.***

# Transference

- Prescribing may be seen as enactments-past relational experience being repeated in current relationship; or acting out-intense relational experience that is acted out rather than put in words.
- Tutter (2006), Medication may represent a third person within the therapeutic relationship who takes on unacceptable transference feelings. A patient's attitude or feelings toward medication may offer insights into unspoken aspects of the patient's psychodynamics.
- Positive transference can be a therapeutic tool, not a treatment interfering behaviors

# Changes in relationship as medications are added



*adapted from Beitman B.D., Riba M.B., Balon R. (2003),  
The challenges of Split Treatment. Integrating psychotherapy and pharmacology*

# Emotional reaction to medications



Resist/refuse and insist/cling.



These emotional reactions must be understood and interpreted if patients are to make rational decisions about medication use.



We can learn much about the therapeutic alliance and the patient's reactions to the doctor from the emotional reaction to medication



These emotional reaction can inform about aspects of ego functions of the patients.

# Transference to medication

- The emotional reactions will help inform and predict the personality reactions to doctor, to treatment, to important people in the patients' lives, present and past.
- The emotional reaction will involve a projection onto the medication of fears and wishes, organized as object relations compromises (Tutter, 2006)
- Dynamic contents of emotional reactions triggered by medications
  - Fears of dependency and its rages and shames
  - Fears of control and submission, its paranoid anxieties of poison and of damage

# Medication transference and ego function

- The medication transference can tell us something about ego organization of personality of the patient.
  - How the ego handles these transference projections?
    - Do patients experience these transference as purely emotional or also as reality?
    - Are patients able to view such reactions dispassionately or experience them as truly veridical and valid?
  - These information can demonstrate the level of projection and hence the level of ego organization from neurotic, to near psychotic, to psychotic (Marcus, 2003).

# Psychotherapeutic understanding to medication transference

- Neurotic transference
  - May be associated to their emotional experience to their caretakers and/or authority figures of the past.
  - The transference to the psychiatrist will usually have the same content because the displacement is from unconscious neurotic experience.
- Near psychotic transference
  - They often use projective identification
  - The near psychotic transference of fears to medication may contaminate the patients' conscious experience of the psychiatrist and of the therapeutic alliance.

# Address problem in negative transference

- The negative transference are often not articulated and may not even be conscious, may be expressed as ***poor adherence, treatment nonresponse, or nocebo effects***.
- The maintenance of an alliance requires the prescriber to develop comfort with hearing the patient's criticism and negative feelings and the ability to address those feelings nondefensively.
- It is helpful to remember that in any enduring relationship, injuries, however small, will always occur.

Two  
commons of  
transferences  
to  
medication  
as we are  
prescribers.

- The medication cures everything and every therapy stalemate is an indication for medications, rather than an exploration of the transference and countertransference stalemate.
- The medication is a cure for nothing, and everything is interpretable, and nothing is an indication for medications.

# Countertransference

Objective (Homogenous)  
Countertransference reaction is considered to reflect how most therapists in a similar situation would react (Winnicott, 1949).

Subjective (idiosyncratic)  
countertransference reaction is considered to stem from the therapist's own unresolved intrapsychic conflicts (Marshall, 1979; Ritvo 2002)

We can learn about the object relations of our patients' defensive ego functioning when we are aware about transference and countertransference.

# Countertransference clustered in 8 domains

- Overwhelmed/disorganized
- Helpless/inadequate
- Positive
- Special/overinvolved
- Sexualized
- Disengaged
- Parental/protective
- Criticized/mistreated

## Countertransference in child and adolescent patients

- Both the parents and the child are recipients of different countertransference emotions.
- Countertransference can occur directedly at the imagined parental figure. Example: Hostile feelings towards the absent parents who have “abandoned” their child.
- Child psychiatrist often view a child as a defenseless product of his/her environment, often lead to common countertransference emotions such as protective feelings towards the child and negative feelings toward the parents. Underrecognized this countertransference may lead to a failure to recognize the parents’ own underlying feelings of guilt and shame.

# Countertransference in child and adolescent patients

- Working with adolescents commonly arouses the psychiatrist's own adolescent conflicts.
- Adolescents often vocalize their dissatisfaction with treatment which can activate feelings of inadequacy in the psychiatrist.
- Suicidal adolescents can trigger powerful fears within psychiatrist, leading to a variety of behaviors and feelings including feelings of inadequacy, anger toward patient for not improving, avoidance of the topic of suicide, and feelings of hopelessness (Brandell, 1992).

# Countertransference in prescribing medications

Patient's dysphoria is infectious, provoking intense feelings of anger, hopelessness, helplessness, or even despair in the doctor, prescriptions may unconsciously be aimed at decreasing those feelings.

Patient's transferences to badly needed medication tend to elicit physician countertransference that are either complimentary or concordant with the patient.

Medication prescribing provides the prescriber with a sense of authority and status.

# Countertransference in prescribing medications

When we are prescribing medications, we have to acknowledge that we are enacting the authoritarian object relations fear that the patient projects.

Use the simple term patient acceptance or not, of medications? It would imply the true fact that patients have the right and responsibility to decide their treatment. We have little power other than insight.

## Common Countertransference reaction in prescribing medications

- Aggressive overprescribing can be a manifestation of devaluing psychotherapy (more common in split/fragmented treatments).
- Under-medicating may be an unconscious manifestation of doctors' need to see themselves as separate from the patient. By maintaining a safe distance from our patients, we can isolate affect and defend against our reciprocal distress (S. W Perry, 1984).

## Case example

- 16-year-old female who presents with significant depressive symptoms after her parents divorced 2 years ago. Her father inconsistently visits or contacts her. Her father recently remarried. A male child psychiatry fellow evaluated this case and prescribed anti-depressant. Patient missed the first follow up appointment. A child psychiatrist had to reach out and reschedule the appointment, but the patient came to the second appointment late and told the fellow that she often forgot taking the medication. She was not cooperative and replied questions only yes or no. What is possible transference and countertransference? How can we improve treatment adherence in this case?

Summary:  
Clinical  
implication for  
developing  
therapeutic  
alliance

- Understand patient's characteristics such as personality, defense mechanism, attachment style
- Understand parents' caregiving style.
- Promote parent's capacity for reflection and accurately interpreting child's needs
- Create safety environment, non-judgmental stance
- Focus on therapeutic communication
- Increase the dose of doctor visit can improve securely therapeutic alliance
- Recognize transference and countertransference in prescribing medication

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