

A Practical Clinical Suggestion for Strengthening the Alliance Based on a Supportive–Expressive Framework

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Supportive–expressive psychodynamic psychotherapy builds on the core conflictual relationship theme (CCRT) as a framework for case formulation and interpretations. Much has been written on how interpretive techniques should be implemented in the treatment sessions to bring about therapeutic change, but less is known about implementing supportive techniques for strengthening the alliance using this framework. The present article uses CCRT formulations to articulate clear and concrete supportive techniques that clinicians can use in clinical practice. To this end, we offered 4 main steps and used clinical case examples to illustrate them. We described how the CCRT formulation may be used to rise above relational enactments in a supportive way and how it can provide a corrective emotional experience to enhance the emotional bond between the patient and the therapist. Clinical cases from the pilot phase of a randomized clinical trial, together with theoretical conceptualizations and empirical findings, are intertwined to demonstrate the potential of the techniques presented.

Clinical Impact Statement

Question: The present article aims to help clinicians use supportive techniques based on a supportive–expressive framework, to strengthen the alliance. **Findings:** The article describes four techniques for doing so: (a) identifying the patient’s interpersonal wish, (b) paying attention to the therapist’s feelings toward the client, (c) enhancing empathy, and (d) choosing “acts of freedom.” **Meaning:** These techniques can help clinicians provide patients with a corrective emotional experience that enhances the alliance. **Next Steps:** Future studies should examine the effectiveness of these techniques for distinct patient populations.

Keywords: supportive expressive treatment, CCRT, actualizing the wish, alliance, active ingredient

Supportive–expressive (SE) therapy is one of the effective treatments for depression (Leichsenring & Leibing, 2007). SE is a psychodynamic therapy that combines an expressive, interpretive component with a supportive, alliance-strengthening one. The supportive element of alliance strengthening is perceived to be important in all treatments, but it is thought to play a special role in SE. In the pilot phase of a randomized controlled trial (RCT) we are conducting, we separated the SE from the purely supportive components of SE treatment, as distinct conditions. For this pur-

pose, we needed to specify before starting the RCT how to use supportive techniques and abstain from interpretations, by working indirectly on strengthening the alliance within the framework of SE. We found that understanding relational enactments and having a detailed roadmap for working with them in a supportive way were useful to our therapists in working on strengthening the alliance within the framework of SE. Therefore, in the present article, we introduce four steps of identification, countertransference, empathy, and freedom (ICEF), which help us understand, organize, and rise above relational enactments to enhance the therapeutic alliance. A brief introduction of the working alliance and of the core conflictual relationship theme (CCRT) framework will serve as an introduction to our suggestion.

Background

The Working Alliance

The working alliance is commonly defined as (a) the emotional bond established between therapist and patient, (b) their agreement

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concerning the goals of therapy (e.g., remission of symptoms and more satisfactory relationships), and (c) the degree of agreement between patient and therapist regarding the tasks pertinent to accomplishing these goals (e.g., speaking about daily interactions in close interpersonal relationships; Bordin, 1979; Hatcher & Barends, 2006). In some of his writings, Freud considered alliance to be necessary for treatment success, arguing that it should not be analyzed and that the curative aspect of therapy was contingent upon it (Freud, 1912). Others regard alliance as therapeutic in its own right (Zetzel, 1966) and essential for the process of change (Safran & Muran, 2000).

One of the most consistent findings in psychotherapy research is that the quality of therapeutic alliance is a predictor of outcome, so that stronger alliance is associated with better outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018). This finding is true even when accounting for the temporal relationship between alliance and symptoms (Falkenström, Granström, & Holmqvist, 2014; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014). Based on a review of recent alliance research, it has been argued that alliance is not merely a product of successful treatment or the context in which successful treatment is provided, but can also serve as an active ingredient in itself (Zilcha-Mano, 2016, 2017).

It is an open question, however, how therapists can benefit from the consistent significant association between alliance and outcome for the success of treatment, using it as an active ingredient in treatment (Zilcha-Mano & Barber, 2018). Two main approaches to benefiting from the alliance–outcome association have been suggested: the interpretive and the supportive. The interpretive approach suggests that the therapist interpret ruptures in the alliance in the “here and now” of the therapeutic relationship (Safran & Muran, 2000). The supportive approach suggests that the therapist strive to provide patients with a new corrective emotional experience of having a good bond, where their needs and wishes are attended to (Alexander & French, 1946; Castonguay & Hill, 2012). Our focus in this article is on the supportive approach of using alliance in treatment in accordance with the SE framework, which is based on the CCRT formulation.

The CCRT Formulation

SE treatment is based on a case formulation using the CCRT method (Book, 1998; Luborsky, 1984). CCRT proposes a psychodynamic understanding of psychological conflict, which includes three elements: a central wish from others (W), a perceived response from the other (RO), and a response of the self (RS). CCRT is based on the fundamental assumption of psychodynamic theory that people internalize patterns in their early relationships and repeat them in later ones, so that the purpose of psychodynamic therapy is to widen the repertoire of perceptions and responses. CCRT is generally used as a basis for interpretations, either of the here and now of therapy or of the patient’s relational episodes (Book, 1998). Less is known about how to use it as a basis for supportive interventions that aim to strengthen the therapeutic alliance.

Below we demonstrate how therapists can use the CCRT formulation in a supportive way, based on the therapist’s understanding of the reenactment of the patient’s themes in the therapeutic relationship. The therapists then strive to extricate themselves from the enactment and give patients a new corrective emotional expe-

rience, aimed directly at strengthening the bond component of the therapeutic alliance. We use the cases of three patients in their 20s, all suffering from major depressive disorder and participating in the supportive condition of the pilot phase of our RCT. The therapists were psychologists who in the course of the RCT carried out both treatments and received individual and group supervision based on the videotaped recordings of the sessions. All cases and names included in this article were disguised, and all patients and therapists signed informed-consent forms agreeing that their information be published. Based on Book (1998), we used CCRT in a way that provides a new and different RO experience for the patient, seeking to actualize the patient’s wish in the here and now of the treatment. We did so by using only supportive techniques, without any expressive ones. In accordance with the focus of the article, all techniques demonstrated here are designed to strengthen the bond component of the alliance.

Breaking the Vicious Cycle of the CCRT: Seeking to Actualize the Patient’s Wish Using the ICEF Steps

To actualize the patient’s wish in the therapeutic relationship, it is important to formulate the patient’s CCRT in supportive treatments, similarly to the way it is done in SE. Formulating the CCRT helps the therapist continually enhance the therapeutic alliance, mapping the short-term therapy and defining its focus. When patients begin to feel that their wish is being heard, and especially when parts of their wish are actualized in therapy, self-esteem improves and hope arises that a new and different interpersonal experience is possible.

A corrective experience in the therapeutic relationship can help patients seek it in their other relationships as well. Many patients are blind to their interpersonal wishes, and feel as if they have nothing good to expect from other people. In therapy, they can start to believe that they can expect other reactions from people close to them, and want to look for these reactions outside the therapy room. The inner force of patients who want to find benevolent bonds helps most of them look for proof of possible corrective bonds, helping their therapists “pass the patients’ tests” (Silberschatz, 2012). In this way, the good alliance joins the “good object representations” of the patient and activates them, which helps overcome the hurtful or “bad object representations” that reactivate the traumatic relationships (Lieberman, Padrón, Van Horn, & Harris, 2005). As shown elsewhere, understanding the patients’ inner dynamics can be useful even when not intending to interpret them, as, for example, when working on homework in Cognitive behavioral therapy (CBT; Cronin, Lawrence, Taylor, Norton, & Kazantzis, 2015). Understanding how to work with the CCRT formulation in a supportive way can benefit the therapeutic work in many types of treatment, including psychodynamic interpretive ones.

It is often not easy to provide a new corrective experience of a good bond or of a wish being actualized. In many instances, the patient’s CCRT is enacted in the therapeutic relationship in combination with the therapist’s own countertransference. The therapist becomes somewhat critical, rejecting or otherwise enacting the patient’s expectations (RO), so that the wish is not likely to be fulfilled. This might result in a deterioration in the alliance, raising a challenge before the therapist trying to actualize the patient’s wish. When working in supervision with such cases during the

pilot phase of our RCT, we identified four main steps that can help the therapist in the process of untying the enactment. We refer to these four steps as identifying the progressive wish, countertransference reflection, empathy enhancement, and freedom from enactment (ICEF). The steps involve (a) *identifying* the most dominant progressive (positive) wish of the patient; (b) understanding the *countertransference* as containing the enactment of the patient's CCRT and as a contribution to it on the part of the therapist, and working through it; (c) enhancing *empathy* for the patient through deeper understanding of the roots of his or her CCRT; and (d) helping the therapist perform an "act of *freedom*" from the enacted pattern. We describe these four steps in detail below.

ICEF Step 1: Identifying the Patient's Progressive Wish

In SE therapy, a key task of the therapist is to enable patients to actualize their wish (Book, 1998). In recognizing the patient's wish in interpersonal relationships, it is important to differentiate between progressive and regressive wishes. Book (1998) noted that although the wish of some patients may appear at first to be of a regressive type, that is, to hurt someone or to be left alone, the therapist can help patients gain insight into their deeper, progressive wish. Thus, during supervision of supportive therapies, as well as in the course of SE therapies, when we formulate the patient's CCRT, we also assess the nature of the wish. The patient's wish is identified based on stories of episodes concerning relationships (REs; Book, 1998). If the patient's wish seems regressive, we try to look for the progressive wish underneath it and endeavor to become the figure that fulfills it (Book, 1998).

In the clinical example below, we demonstrate how we identify a particular central wish and its expression in the therapeutic relationship. Danny (Figure 1; Appendix), a 22-year-old single

man, has a loving and admiring mother. His family is highly traditional and religious. Danny is the youngest child. He was a bright student, very close to his mother. His father was remote and critical, abusive to the mother. When he was a teenager, Danny started watching porn movies and discovered that he had a gay sexual orientation. When he was 16, he started a relationship with an older man, and after finishing high school, Danny moved to a remote city to live with him, hiding the relationship from his family. Three years later, Danny broke up the relationship and moved into his own apartment. He started a new relationship with a man his age. At the time he started therapy, Danny was a student, about to finish his first academic year, but was behind on all his assignments and exams. He was working to make a living, spending hours every day watching porn, despairing and hopeless about his future.

In the first therapy session, Leah, the therapist, felt that Danny had various interpersonal wishes, but what he needed from her was concrete help in stopping his porn addiction. The following is a typical quote from Danny's account during the second session:

I couldn't do almost anything this week. I came home from work or from the university and had to rest a bit, and just couldn't stop watching porn. Eventually it got really late and I had to eat something and go to sleep.

Leah felt pressured to quickly help Danny with his porn addiction, so he could spend more time studying for exams and try to salvage his university studies. Everything was about to collapse in his world, and it seemed to Leah that all that mattered was to somehow stop the porn addiction. Yet in supervision, Leah understood that "saving Danny" by focusing only on his dysfunctional part would result in neglecting to attend to his other, creative, smart, and

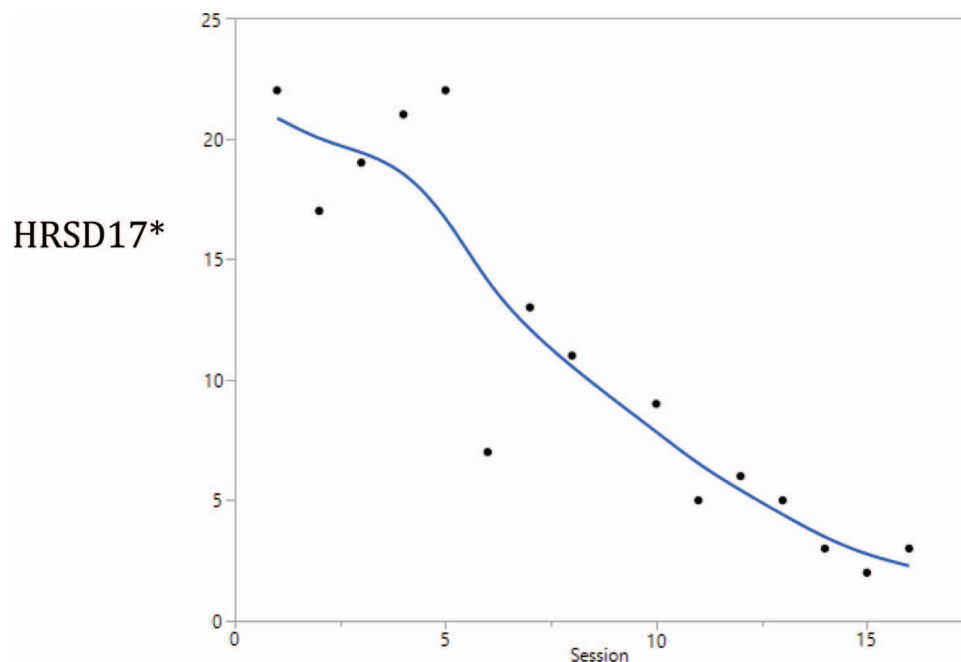


Figure 1. Hamilton values of Patient 1 along the therapy. HRSD17* = Hamilton Rating Scale for Depression (Hamilton, 1967). See the online article for the color version of this figure.

compassionate sides. She thought that such an emphasis would somehow reenact Danny's relationship with his parents, who knew him only in a narrow sense. As she was pondering in supervision what could his more progressive, deeper wish be, and watched the videos from the sessions, Leah noticed that whenever Danny told her about some aspect of his unusual life, and she was amazed or impressed, he seemed extremely pleased and relaxed. In supervision, Leah said that she truly admired Danny for being so brave, struggling to lead a life that was authentic and worth living. Danny was depressed because he felt that he had no hope in succeeding to live this life. These reflections helped Leah understand that what Danny might need from her (and desperately needed from other people in his life) was to see his different and contradictory aspects and be able to admire the mixture they produce.

The new conceptualization of Danny's CCRT was that he wished to be seen as a whole and complicated person, with his particular choices, desires, strengths, and weaknesses (W). But because he came from a traditional background, he could not show members of his family his different sides, and therefore could not have his wish fulfilled. Rather, he felt that people saw him only in a distorted and partial way (RO). This made him feel helpless and hopeless, trying to avoid these feelings by watching porn (RS), creating an illusion of connectedness with others. After this wish became clear to Leah, she could easily fulfill it, as demonstrated in the following dialogue from Session 6:

Danny: *Dad was always more nervous, I was more withdrawn with him. It's hard to know how he will respond. Withdrawn . . .*

Leah: *You told me before you never kissed him?*

Danny: *I do not think so . . . I do not remember . . . I was not physically in touch with him . . . distant. With mom I did.*

Leah: *Did you?*

Danny: *Sure, she is always hugging and kissing me . . .*

Leah: *It's simpler with mother.*

Danny: *When I come home, I try to respect her, talk to her, and share with her. It's not easy because she doesn't know almost anything about me . . . Not what bothers me, not about my boyfriend . . .*

Leah: *I'm sure that if your mom could know more about you she'd have been very proud of you . . .*

Danny: *It's too late to change them. I need to accept what they can give me . . .*

Leah: *And they can give you, especially your mother, despite the differences.*

This intervention is an admiring form of mirroring (Kohut, 1984), aimed explicitly at fulfilling the wish of being seen in full. This wish has been hurtfully frustrated by Danny's family. Danny responded dramatically to these supportive interventions, stopped suddenly his recourse to porn, and invested great efforts into completing his university assignments. He was grateful, and shared the following fantasy toward the end of therapy: "I sometimes imagine that you are a professor at the university and we sit

here, on the university campus, and talk about me and all the other issues . . ." This fantasy may be seen as the expression of a wish. It was partially fulfilled by the supportive and accepting relationship, which also had an "open" intellectual aspect, between Danny and the therapist. In this example, actualization of the progressive wish occurred after it was conceptualized. Leah worked on fulfilling Danny's wish of being looked at as a whole person, admired for his efforts and for the process he underwent.

Often the therapist hears only regressive wishes, as in the example of Avi (Figure 2; Appendix), a 30-year-old avoidant and emotionally restricted single man, shunning close relationships, specifically romantic ones. He grew up as the youngest child of older parents who were both married before and had older, teenage children. Avi's family emigrated from Russia when he was a young child, going through extremely difficult times. Avi was the one who learned the new language first and became a spokesman for his parents. Avi was shy and emotionally remote from his older parents. He was a good student in school, studied computer networking, and was working full time as well as taking a course in the evenings. When Michelle, his therapist, met him, he was lonely and pessimistic about the future. Consider the following of exchange between Michelle and Avi:

Avi: *She [his team leader] was not happy with the answer I gave her. She asked me again to try to figure out a different solution.*

Michelle: *How did it feel?*

Avi: *It was annoying.*

Michelle: *So how did you respond?*

Avi: *I didn't. I hoped she'd just forget about it.*

In this example, it appears that Avi's wish is to be left alone. It is a regressive wish, because it shuns connection with others. Michelle felt that this was also his wish from her and that her questions and suggestions annoyed him. It was quite clear that Avi expected criticism and disapproval from other people (RO) and reacted by avoiding close contact and defending himself aggressively (RS). Because he seemed to want nothing from other people, his (progressive) interpersonal wish was unclear and deeply concealed.

As mentioned in Danny's example, another way of finding the patient's progressive wish (in addition to the RE inquiry) is to use the therapist's countertransference. In this example, Michelle had a difficult time during the sessions, feeling tired and critical toward Avi. She felt that the sessions dragged on forever and that she had to be extremely careful not to sound critical. She perceived the patient to be functioning at a very low level, both emotionally and in his interpersonal relationships, and despaired of finding a way to help him in a short-term therapy. Consider the next dialogue, from Session 3, demonstrating the way in which the CCRT is reenacted in therapy, with Michelle becoming judgmental and moving away from Avi.

Michelle: *It sounds like you do not really like going to work.*

Avi: *Yes, it became like that at some point, when the relationship with the team leader started to*

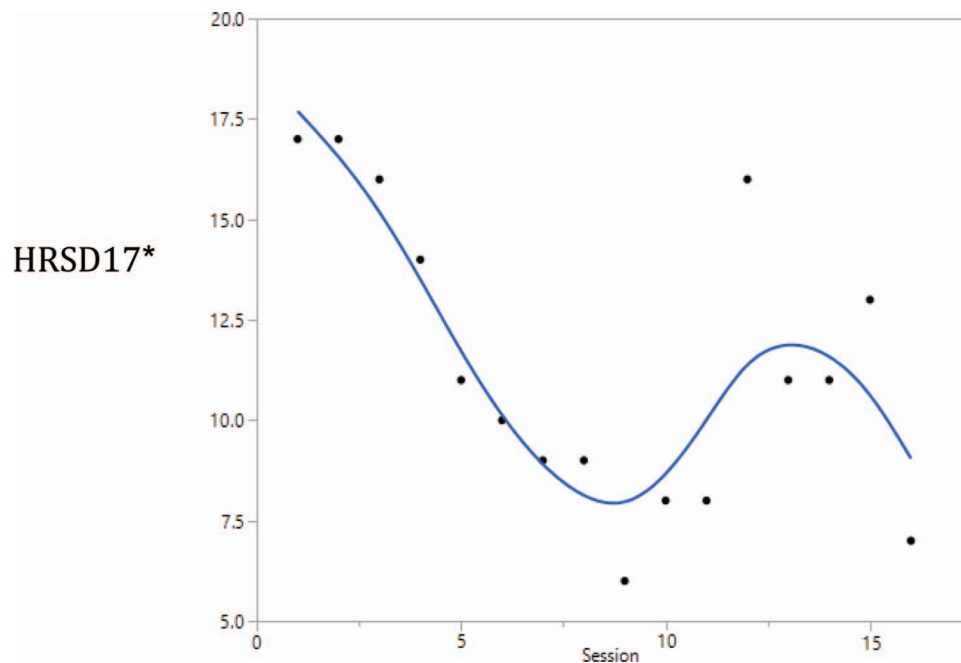


Figure 2. Hamilton values of Patient 2 along the therapy. HRSD17* = Hamilton Rating Scale for Depression (Hamilton, 1967). See the online article for the color version of this figure.

deteriorate. It was not as bad as it is today. But slowly . . .

Michelle: *How does it look like?*

Avi: *For example, the other day she wrote everyone a mail that now there's a new procedure with the customer service department . . .*

Michelle: *Did she explain the rationale for it, or she just decided?*

Avi: *She told me she had reached an agreement on it with Tom from the customer service department.*

Michelle: *She didn't discuss it with you.*

Avi: *No . . . I told her it's a really bad decision. And at the team meeting I said it again. And she got all upset. Maybe she understood that her decision was wrong. But she wouldn't admit it. It's like, I made a decision and that's the way it is.*

Michelle: *But by stating it again you challenged her authority.*

Avi: [silent]

Michelle: *You go on arguing . . . Arguing is judgmental . . . You do it to the team leader because you're sure you're right, that her decision isn't right for the team . . .*

In supervision we came to understand that Avi's regressive wish, both in his REs and in the therapy, was a reaction to what he felt as criticism from the other. When Michelle was asked in

supervision to reflect carefully on the session, she found certain moments in the session when Avi was calmer and engaged, usually in response to times when Michelle was interested, not critical, and positive toward him. Based on these moments, we suggested in the supervision meeting that although Avi could not articulate it, deep inside he wanted and needed people to be proud of him and take true interest in him, without becoming critical.

ICEF Step 2: Countertransference Reflection

In Avi's case, it is clear that the therapeutic relationship produced a critical and emotionally remote countertransference reaction, which also characterized the patient's other relationships, as manifested in his CCRT. Working through the therapist's countertransference included the uneasy feelings this relationship elicited in her. Michelle felt critical of the patient, and at the beginning of the therapy, at times behaved accordingly, wishing he made faster progress. We conceptualized Michelle's behavior as participating in the enactment of the patient's patterns. Avi's RO was that people were critical and that they could not understand him or be truly interested in him. We found the therapist's feelings to be somewhat similar to those of the patient's parents, wishing he were more than what he can be, and function better.

What was the therapist's contribution to this enactment? Because the therapy was part of a research project, every session was videotaped and many measures were obtained. Therefore, the therapist felt pressured to show results and was angry with the patient for being slow to do so. Naturally, the slow response could also reflect the early feelings of the patient's parents toward the patient. In the first supervision ses-

sions, we worked on accepting the fact that the relationship cannot yet be authentic and close and that it was disappointing for the therapist.

ICEF Step 3: Empathy Enhancement

Understanding the countertransference can open space in therapy to deepen the therapist's understanding of the patient. In some cases, such as Avi's, great effort is needed to show more empathy toward the patient. A better understanding of the patient's history enhances empathy and makes possible a deeper understanding of the patient's CCRT. It also helps answer the question: How did he get to be this way?

During the middle phase of the therapy, Michelle tried to understand more about Avi's history. This was not easy because Avi was preoccupied with his current problems and had difficulty allowing space for what seemed to be "psychological" nagging, which was not of true interest and he did not want to talk about it. Nevertheless, Michelle assembled a few threads and understood that Avi grew up practically as an only child (his older brother and sister being much older than he), was extremely lonely, and did not seem to develop adequate interpersonal skills. The computer became his company, and his main means of getting positive attention were his good grades. Michelle understood that Avi did not know how to talk about his feelings or needs or to negotiate them with his team leader. At the same time, she became increasingly impressed with his strengths and abilities to work very hard, go every day to a nonrewarding job, and even study in the evenings.

ICEF Step 4: Freedom From Enactment

In many therapies, both patient and therapist begin by enacting the patient's old and well-known relationship pattern, as formulated in the CCRT. At times, we found that the three steps described earlier were not enough, and a fourth, more active measure was needed to change the repeated RO. We borrow Symington's (1983) concept of "act of freedom" to describe this stage. Symington wrote about the therapist actively extricating himself from the lasso of the relationship with the patient. In CCRT terms, the release can be described as opting out of the repeated RO in a deliberate act, at times perceived by the therapist as unnatural or dangerous. In this case, we wanted to free Michelle from the stress of delivering results, change Avi, and make him act differently. When she was able to sit more comfortably in her chair, listen more calmly, and accept the fact that Avi was different from what she wished him to be, she could be less critical and more accepting, indeed, even admiring. Consider the following example from Session 6, demonstrating a small but substantial act of freedom:

Michelle: *How are you?*

Avi: *Ahhh, OK.*

Michelle: *What?*

Avi: *Kind of tough, but OK.*

Michelle: *What is tough and what is OK?*

Avi: *All this work thing. It's not easy . . . OK . . . After a few days I talked to my team leader about*

everything that happened with the vacation days. What I told you last week.

Michelle: *Yes.*

Avi: *It was annoying from the beginning that she doesn't trust me. It feels bad when your boss doesn't trust you. She wanted to discuss it and so did I, but each time I was busy and postponed it, so when we finally set down she said she talked with the manager. It annoyed me a little that she didn't talk to me first. Unpleasant tone . . .*

Michelle: *What do you mean? Angry?*

Avi: *Yes, a lot of anger. I explained my take to her.*

Michelle: *What did the manager say?*

Avi: *From what I understood, I'm not sure I interpreted it correctly, I first of all told her she should have talked to me first. It's not nice of her, he must be thinking now that I'm using the system . . . She got mad and said I do not know what she told him. I told her this is a principle . . . It ended on negative tone and she said I have a negative attitude. When we got back, I felt she was upset. I felt bad . . .*

Michelle: *Felt bad?*

Avi: *She took it very bad.*

Michelle: *You felt sorry for her . . .*

Avi: *No, I wanted to know she was OK. I was worried . . .*

Michelle: *Did you tell her?*

Avi: *I saw her walking out of the office upset. When this happens, I usually talk to her best friend to make sure she's OK. But she was not around, so I asked someone else.*

Michelle: *Does she know you care like this?*

Avi: *I do not know.*

Michelle: *It sounds like you really care. You're very sensitive.*

Avi: [smiles quietly] *I saw that she didn't take the vacation days off in the end . . .*

The two dialogues have a lot in common. In the second dialogue, Michelle was again, as usual, feeling critical of Avi's behavior and wanted to help him notice the mistakes he made. Yet she postponed her criticism, waiting until she felt something else, and chose to comment on what she felt was commendable, although it was only a small part of the interaction that Avi described. This act of Michelle actively fulfilled his wish. Being noncritical and even proud of him was meaningful and nourishing for Avi, as he rarely receives this type of responses from people.

In subsequent sessions, Michelle was more careful to hold back her criticism and tried instead to gently raise questions and to be

supportive and admiring when she felt it was possible. It was clear that the experience of being an object of interest and even approval rather than of criticism was a new and powerful one for Avi. The alliance became strong enough to enable him to slowly and carefully share his fears of intimacy, including specific physical facts he was extremely shy about. His self-esteem was enhanced and for the first time in his life he felt secure enough to form a romantic relationship.

Actualizing the Wish and the Desired Change in the RO and the RS

All patients participating in the pilot phase of this RCT arrived to treatment with a diagnosis of major depressive disorder. By having their wish actualized, patients gained opportunities to expand the repertoire of their RO and RS. Working on strengthening the alliance provides a platform for practicing new ROs and RSs. In most therapies, actualizing the wish may result in a change in the patient's expectation of the therapist's reaction (RO; [Leichsenring & Leibing, 2007](#)), granting an opportunity for the patient to experience new types of expectations from the therapist. The patient may have received positive responses before, in addition to the negative ones formulated in his or her RO. But repeated and dominant positive reactions on the part of the therapist can make patients notice the change and penetrate beyond their transference distortions to change their CCRT.

When patient and therapist go through a phase of enactment, and when the therapist notices it and steers them both away from it without explicitly talking about it with the patient, the patient faces the new corrective experience of a fulfilled wish and, consequently, new expectations of responses from others (RO). In the following example we show how after a short phase of enactment

of the old pattern, the therapist changed his reactions to the patient. This made possible the actualization of the patient's wish, as the patient experienced a change in her expectations from the therapist, as well as from others (change in RO). This corrective experience formed a strong alliance in the relationship with the therapist.

Amy ([Figure 3; Appendix](#)), a 28-year-old single woman, started her Bachelor of Arts degree but did not like what she studied and did not enjoy it. She was working part-time as a saleswoman and hated her job. At the time of her intake appointment, she reported experiencing anhedonia, constant anxiety, and worries about the future. She never had a meaningful romantic relationship, felt hurt and abused in her dating experiences, and worried about not marrying and about loneliness. Amy reported that her parents were good and caring, but also gave an example of recently coming home to get help and support with one of her articles, and her mother dismissing her as nagging. Amy described an abusive relationship with her older brother, who acted aggressively and insultingly toward her since they were children. Her parents dismissed her complaints.

Amy's wish (W) was to be treated respectfully and warmly. Her usual expectation of others (RO) was to be abused and insulted, and her response (RS) was either to avoid others or to react in a way that may have perpetuated this type of abuse. How she did this in practice was unclear at the beginning of treatment. Amy seemed smart, pleasant, easygoing, and charming.

Amy's therapy, which was part of the pilot phase of this RCT, started with her being highly cooperative and talkative. The rhythm of the sessions was very fast, with ping-pong-like interactions. David found himself giving Amy advices on how to behave differently in interpersonal relationships. Because he was in a

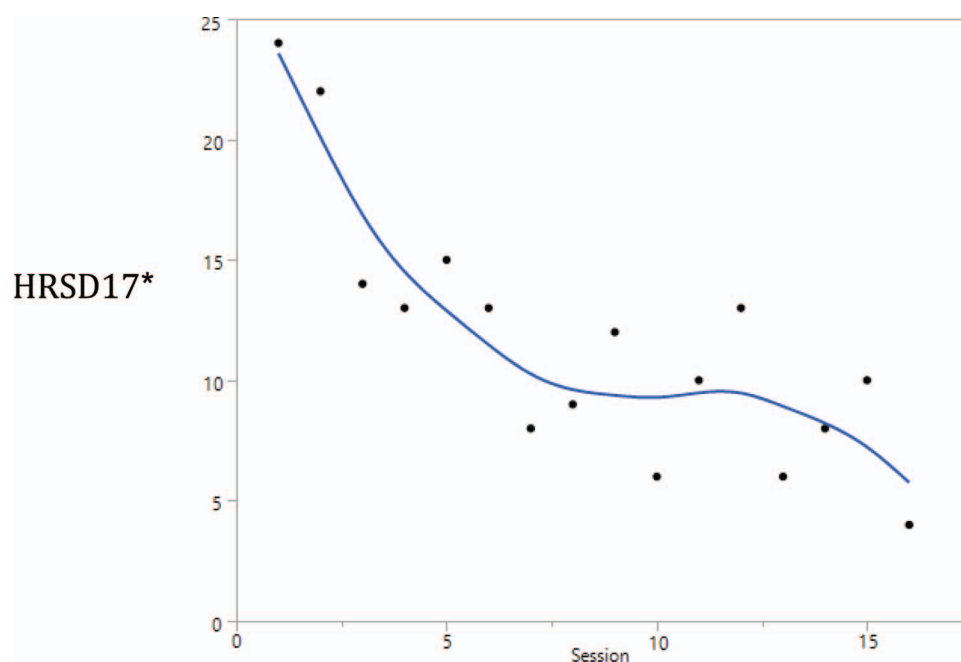


Figure 3. Hamilton values of Patient 3 along the therapy. HRSD17* = Hamilton Rating Scale for Depression ([Hamilton, 1967](#)). See the online article for the color version of this figure.

supportive condition, he had to work hard to avoid interpreting Amy's behavior. He thought that he was encouraging Amy's expression while staying neutral, but when we watched the video, in supervision, it all looked different:

Amy: *I never date anymore. It turns out horrible every time I try. And it never lasts anyway . . .*

David: *Can you tell me about some date you went on?*

Amy: *Yeah . . . OK . . . Last time I went on a real date it was probably a year ago. I wrote to him on Facebook, and then we talked a little on the phone. We said we should meet, but he was really busy, so I said I would come meet him in the city . . .*

David: *Sounds like it might be a risky offer . . .*

Amy: *Yeah, I went by train, and then I waited in the train station for almost two hours until he came to pick me up, he was busy at his office. I knew he didn't like me when he saw me . . . he just wanted to get it over with . . .*

David: *Ouch!*

Amy: *It was funny, it was like in a movie . . . I offered to get back to the train station on my own. It took me an hour to get a cab. It was scary. One a.m.*

David: *Oh my god, that sounds scary! And you didn't insist on him taking you . . .*

Amy: *Yeah . . . that's the way I am . . . Always not wanting to be a burden . . .*

David: *Not wanting to be a burden . . .*

Amy: *Yeah . . . Funny, isn't it?*

David was surprised and upset as he watched himself on the videotaped session during supervision. He found it difficult to show empathy for what he perceived to be foolish behavior and felt critical about it. In response, Amy was joking with him, flirting, or firing little comments, followed by more critical attitude on David's part. David noticed this pattern in supervision and recognized that some of it may be part of Amy's CCRT: her wishing to be respected, trying to act sweet, but also expecting criticism, even trying to put herself down in the face of potentially cynical, aggressive remarks. This RS was not clear in the beginning of therapy and in Amy's original REs. Unknowingly, David was reenacting some of Amy's abusive relationship patterns. His countertransference, and having to hold back his reactions and interpretations, also contributed to making him frustrated and angry with Amy. When David noticed how similar he was to Amy's older brother and abusive dating partners, he was shocked. He felt more empathic toward Amy for having to deal with such responses since she was a child. David made a deliberate effort to stop his criticism and instead recognize her efforts and minor changes. Consider the following dialogue from the end of Session 6:

(Amy tells a very long story about her brother-in-law accusing her mother for turning his kids (her mother's grandchildren) against him,

and breaking the family apart by not allowing his wife (Amy's sister) and kids to be in touch with the rest of his family.)

David: *I'm preoccupied by the price you are paying. I hear you are paying a very big price having done nothing wrong . . . It's not fair what he's doing to you.*

Amy: *I'm sure, I'm positive I'm the solution to this problem. I care about him and about my sister and about my mother, I can really solve this if he would only talk to me . . . I understand that he got really hurt by my mother . . . He lost his own mother when he was a boy and looked up to my mother . . . But this is a bad solution . . .*

David: *It's really moving to hear you speak, willing to go on and forgive. Making space for him after all he had done . . .*

In this example we can "hear" that David was both impressed and critical of Amy, but he chose to give strong expression to his admiration. This was unusual for Amy, who at the beginning of the same session mentioned how her father ignored her. By acting in this manner whenever possible, David was able to fulfill Amy's wish to be respected and not treated abusively. Consequently, her expectation to elicit this type of respectful attitude from men appeared to solidify, facilitating change. When her wish became a reality, she was able to start believing that she could inspire a respectful attitude in other men as well. She was encouraged to go back to dating and quickly formed, for the first time in her life, a meaningful and respectful relationship with a romantic partner.

This example illustrates how using the four ICEF steps enabled the therapist to actualize the patient's wish, and in return, the patient changed her RO expectations as well as her RS. First, in supervision, David formulated Amy's CCRT (identification of the progressive wish). Second, after watching the video, David became aware of the enactment, understood it, and assumed responsibility for his countertransference feelings and actions (countertransference reflections); third, he enhanced his empathy toward the patient, understanding her past behavior as intended to be helpful (empathy enhancement); finally, the therapist changed his behavior and stopped the enactment, working to strengthen the alliance and actualize the patient's wish (freedom from enactment). Having her wish actualized enabled Amy to change her expectations of the therapist as well as of others, to change her usual resentful attitude toward herself, and to try new behaviors.

Research found that patients who show changes in their depression tend to also show changes in their responses of the self (RS; Leichsenring & Leibing, 2007). Most depressed patients in the pilot phase of our RCT became less avoidant and more willing to try new behaviors with others. Having their wish actualized helped patients be less critical and punishing toward themselves, more accepting of their faults, and more compassionate toward themselves. Their usual defense mechanisms (most often avoidance or aggression), which were used to defend against what they expected to be rejection or otherwise hostile responses from others (RO), also changed when they felt they could let go and try other behaviors. The consistent striving to actualize the wish and thereby enhance the alliance enabled a new repertoire of ROs and RSs.

Discussion

In this article, we described how identifying and subsequently working to actualize the patient's interpersonal progressive wish in therapy can be helpful in understanding relational enactments in treatment and eventually rising above them to provide a meaningful corrective experience for the patient. Based on SE treatment conceptualizations, specifically within the CCRT framework, we speculated that when it is not easy for the therapist to actualize the patient's wish, the reason may be, in part, a relational enactment that involves the patient's old interpersonal patterns and the therapist's countertransference. Rising above and freeing themselves from these enactments, therapists can strengthen the bond aspect of the therapeutic alliance and actualize the patients' wishes.

To use the CCRT framework supportively, we proposed four steps—identifying, countertransference, empathy, and freedom (ICEF)—and used three detailed clinical examples to illustrate how to use these steps operatively. Based on our experience, and as reflected in the clinical cases demonstrated here, investing effort early in therapy in conceptualizing the CCRT formulation, especially the patient's progressive wish, and reflecting on the countertransference feelings of the therapist to enhance empathy toward the patient, can help overcome relational enactments. A deliberate move on the part of therapists to make slight adjustments in their behavior during therapy sessions can at times make the difference between participating in an enactment and facilitating a new corrective experience.

The importance of actualizing the patient's wish in treatment and forming a corrective experience is supported by empirical studies suggesting the beneficial role of corrective experiences during the course of treatment across therapeutic orientations (Castonguay & Hill, 2012) and by research on the working alliance (Flückiger et al., 2018). Recent studies on the working alliance demonstrate that gains in alliance over the course of treatment result in subsequent reductions in symptoms, especially in treatments focusing on here-and-now enactments between patients and their therapists (Zilcha-Mano et al., 2014). Actualizing the patient's wish using the ICEF model and creating a corrective experience may enhance in-session alliance, which in turn can bring about symptom reduction as well as gains in self-esteem and well-being. These directions should be tested in future research.

We suggest that the CCRT conceptualization, especially identifying the nonregressive wish, can be beneficial even if this wish ends up not being discussed or interpreted in the therapy sessions. Fulfilling the wish and giving a new corrective emotional experience to the patient can pave the way for patients to change their expectations from others and their choice of actions, that is, to search for similar opportunities outside the therapy room. This wish actualization element of therapy should be further examined empirically as an active ingredient that can be used differently in different treatments to contribute to successful outcomes.

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Appendix

Patient Outcome Measures Across the Active Phase of Treatment

Session number	HRSD17 ^a		
	P1	P2	P3
1	22	17	24
2	17	17	22
3	19	16	14
4	21	14	13
5	22	11	15
6	7	10	13
7	13	9	8
8	11	9	9
9	N/A	6	12
10	9	8	6
11	5	8	10
12	6	16	13
13	5	11	6
14	3	11	8
15	2	13	10
16	3	7	4
Clinical sample, <i>M (SD)</i>		16.97 (5.17) ^b	
Nonclinical sample, <i>M (SD)</i>		3.39 (3.23) ^b	

Note. HRSD = Hamilton Rating Scale for Depression; P1–P3 = Patients 1–3.

^a Hamilton (1967). ^b Rehm and O'Hara (1985).

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