Classics in Psycho-analytic Technique

Robert Langs, Editor

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THERAPEUTIC MISALLIANCES

ROBERT LANGS

EDITOR'S NOTE

This paper offers the most extensive and detailed consideration of disturbances in the therapeutic alliance available. It adopts a distinctly interactional approach to the subject and carefully explores the contributions of both patient and analyst to these very subtle and therefore often unrecognized problems. There is a similarly detailed consideration of the conscious and unconscious efforts by both participants to identify and resolve their collusion in these disturbances. The maladaptive symptom relief often achieved by such collusion is termed *misalliance cure,* a concept that provides considerable insight into the general subject of noninsightful "cure."

In addition to detailing the basis and manifestations of this particular type of disturbance in the therapeutic alliance, the misalliance concept leads to a further clarification of the analytic interaction itself. It provides considerable impetus for the definition of interactional mechanisms, and of the actualities of the analyst and the unconscious implications of his interventions. As such, it serves as an important basis for my subsequent studies of the unconscious communicative interaction (Langs 1976a,b, 1978a,b).

This paper will study aspects of the psychopathology of the patient-analyst and patient-therapist relationships[1] and the therapeutic alliance, and in particular the efforts by either the patient or the analyst—or both—to effect a *therapeutic misalliance.* If we briefly define the therapeutic alliance as the conscious and unconscious agreement—and subsequent actual work—on the part of both patient and analyst to join forces in effecting symptom alleviation and characterological changes through insight and inner structural change within the patient, then therapeutic misalliances constitute interactions that are designed either to undermine such goals or to achieve symptom modification, however temporary, on some other basis. I believe that there are inherent needs in both patient and analyst to both create and resolve therapeutic misalliances in every analytic and psychotherapeutic situation, and that the recognition, analysis, and modification of these propensities and actualities is a first-order therapeutic task. In this paper I want to define therapeutic misalliances, to discuss their development, recognition, and resolution in analysis and psychotherapy, and to explore the main technical considerations which evolve from these observations.

While there had been occasional passing references to deviant alliances in the literature (see Corwin 1972 and Greenacre 1959 for examples), I believe that the first extensive and explicit use of the term *therapeutic misalliance* (alternately, *antitherapeutic alliance* to delineate its dimensions as a deviant search for "cure" that is opposed to insight) appeared in my two-volume work, *The Technique of Psychoanalytic*

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Psychotherapy (Langs 1973b, 1974). In general, this area has been studied under the rubrics of transference and countertransference gratification, resistance, mutual acting out, and acting in—topics which still merit further study in themselves. As I shall demonstrate, the concept of therapeutic misalliances overlaps with each of these but goes beyond them as well, enabling us to develop aspects of these and other problems in technique that have otherwise been relatively neglected. In particular, this concept is especially relevant to the adaptive and interactional aspects of the patient-analyst dyad, including the mutual influence of patient and analyst upon each other, and the realistic and intrapsychic consequences of the relationship for both participants. While not all disturbances in the therapeutic alliance take the form of misalliances (there may be primarily uniliteral impairments in the alliance, so that the mutuality inherent in the concept of misalliance is missing), it seems advisable to make a special study of these particular interactions, since they are basic to many disturbances in the analytic situation and are probably the single most common dimension to stalemated or failed analyses. The concept also highlights the analyst's contributions, however large or small, to such impasses or temporary difficulties in the treatment situation.

Actually, the concept of therapeutic misalliance has been implicit in many of the more extensive studies of the patient-analyst relationship, including those which focused on the therapeutic (or working) alliance dimension of it. (Freud 1915, Fenichel 1941, Greenacre 1959, 1971, Tarachow, 1962, Greenson 1965, 1957, 1971, 1972, Greenson and Wexler 1969, Friedman 1969, Myerson 1973, and Langs 1973a,b, 1974, 1975a), and it is reflected in Freud's case histories as well (1905, 1909, 1918; see Langs, in press, for a discussion of this topic). As background for the present study, I shall confine myself to succinctly defining the concept of the therapeutic alliance and to describing some of the main indirect allusions to therapeutic misalliances in the literature (for a fuller résumé of the subject of the therapeutic alliance see Zetzel 1956, 1958, 1966–1969, Stone 1961, 1967, Greenson 1965, 1967, Dickes 1967, Friedman 1969, Binstock 1973, and Langs 1973b, 1974).

To be brief, we may view the patient-analyst (and patient-therapist) relationship as an interaction based on the respective intrapsychic needs and sets, evocations and reactions—and adaptive responses—of each party. It has primarily realistic (nontransference—see Greenson and Wexler 1969, Greenson 1971, 1972, and Langs 1973a,b, 1974, 1975a) and primarily unrealistic or fantasied (transference) dimensions that readily intermix—intrapsychically and interactionally—for both participants. These two polarities are weighted differently for each, however; the latter are disproportionately greater in the patient (Racker 1968). It is out of this matrix that we isolate for study those facets, conscious and unconscious, that constitute the therapeutic alliance—the pact between that part of the patient that is motivated to cooperate with the analyst and is seeking adaptive and appropriate symptom relief, and that part of the analyst which is competent to offer it to him through his professional empathy with the patient and his relatively neutral interventions that are geared toward interpretations. Founded on both a basic mother-child relatedness (Zetzel 1958, Greenacre 1959, Stone 1961, 1967) and more mature relationships (Stone 1961, Greenson 1965), the therapeutic alliance is an agreement between the mature ego sectors of both parties (Sterba 1943) to work in consort toward the goals of treatment. However, there are also more primitive ego and id contributions to this pact (Friedman 1969) which must be well neutralized and sublimated to contribute positively to the alliance.

The therapeutic alliance has conscious and unconscious, explicit and implicit components (Myerson 1973, Langs 1973b, 1974), and is shaped by the needs and ego functions of both patient and analyst, especially by the latter's ground rules, personality, stance, work style, and interventions. It is these that guide the unfolding of this alliance in the direction of work toward inner structural change for the patient, based on a variety of communications from the analyst that are soon understood on some level by the patient.

Efforts toward therapeutic misalliances arise primarily out of unresolved intrapsychic conflicts—inappropriate instinctual drive needs, and superego and ego disturbances—and prior disturbed object relations and interactions experienced by either patient or analyst, which prompt either to seek gratifications and defensive reinforcements in their relationship that are not in keeping with the search for insight and inner change. The factors which lead to such efforts are on a continuum with those that contribute to a viable therapeutic alliance, and they intermingle; we are therefore faced with a delicate and sensitive issue. It is one that may be described in still another way: transference and countertransference inevitably contribute to and may interfere with alliance; when they do so, they must be detected, analyzed, and resolved (Zetzel 1958, Greenson 1965, Friedman 1969, Myerson 1973, Langs 1973b, 1974). It is in this realm that transference and

countertransference fantasies influence reality and contribute to the ongoing adaptive efforts of each party to the therapeutic relationship. It is here that fantasy and memory are translated into actualities, gross or subtle—e.g., maladaptive conflict "resolutions" and pathological unconscious identifications—that are experienced as resistances and the search for alternative solutions to the patient's neuorsis. If the resolution of such efforts is not given precedence in the analysis, little else will be accomplished; failure to detect and modify actual misalliances undermines the work toward more lasting adaptive solutions to the patient's conflicts—structural and characterological change based on insight and constructive identifications (Fenichel 1941, Langs 1974).

Elsewhere (Langs 1973b, 1974, 1975a), I have discussed in detail the manner in which misalliances arise, especially from efforts by the patient to act out primarily transference-based fantasies and from unneeded deviations in analytic or therapeutic technique and technical errors on the part of the analyst that serve as expressions of his countertransference problems (Langs 1975b). Far more subtle means of generating and maintaining misalliances also exist, though not all misalliances stem from transference and countertransference problems. They may arise primarily through extraneous sources, such as third parties to treatment (insurance companies, supervisors, etc.), manipulative nontransference motives for therapy (e.g., court remands), and personal noncountertransference needs in the analyst (e.g., a candidate's needs with a patient whom he is analyzing to fulfil his requirements at an analytic institute). Such situations may impose limiting realities on the analytic outcome and may effect unmodifiable sectors of misalliance—aspects I will discuss in a later paper (Langs 1975b).

Sectors of misalliance offer, in the realities of the therapist's involvement, an image of him that interferes critically with the three basic and interrelated avenues of sound symptom resolution: positive identifications with the therapist based on his behavior within his therapeutic role; curative interactions in which the therapist's interpretations and maintenance of the boundaries replace living out and misalliance (Racker 1968); and the development of cognitive insights based on the interpretations of the therapist. This latter is itself based on a maximal opportunity for the patient to project his intrapsychic fantasies onto the therapist and on the patient's experience of the therapist as a sound figure whose interpretations have a constructive impact on him.

These introductory considerations were first developed empirically from clinical observations of analytic psychotherapy (Langs 1973, 1974a) and psychoanalysis. It was reassuring to find in studying the literature that many others had made similar observations, though they were conceptualized in somewhat different terms. Freud, for instance, was well aware of such occurrences and the dangers they entail. This is most apparent in his paper on transference love (1915), where he warns analysts against accepting transference love as a conquest of the patient; he developed the rule of abstinence in this context. Should there be compliance by the analyst, "the Patient would achieve *her* aim, but he would never achieve *his*" p. 165). Nor, Freud goes on, must the analyst actively repulse this transference love; he should "treat it as something unreal" (p. 166; see also Tarachow 1962) and analyze it. Then Freud refers to those women with whom attempts to analyze the erotic transference will not succeed. "These are women of elemental passionateness who tolerate no surrogates. They are the children of nature who refuse to accept the psychical in place of the material, who, in the poet's words, are accessible only to the logic of soup with dumplings for arguments" (pp. 166-167). In the terms being presented here, their sole wish is for misalliance with their analyst. Throughout his writings, Freud emphasized that gratifications of this kind preclude successful analytic work.

Nunberg (1926, 1955) observed that patients have narcissistic and magical concepts of "cure" through fulfillment of their infantile wishes and through a different kind of work than that expected by their analysts. His presentations provide considerable clinical material related to inevitable efforts by patients to create misalliances. Fenichel (1941) put this concept succinctly: "In what is called 'handling of the transference,' 'not joining the game' is the principal task. Only thus is it possible subsequently to make interpretations" (p. 73)—in essence, avoiding a misalliance is fundamental for interpretive work. Throughout her writings on technique, Greenacre (1971) shows a sensitivity to the problem. In one notable allusion, she refers to the importance of the preservation of the patient's autonomy by the analyst. She therefore counsels against the use of active support or manipulation which impair the analytic result and weaken the patient's ego. "The therapeutic alliance is thus insidiously diluted with ingredients of a narcissistic alliance" (Greenacre 1959, p. 487). Corwin (1972) also studied narcissistic alliances.

Tarachow (1962) writes: "*The task of setting aside the other as a real object I regard as the central problem* in the theory of the treatment process" (p. 377). This

problem arises out of the mutual object need of the patient and the analyst; rather than gratify these needs, the latter imposes a therapeutic barrier by interpreting and not participating in reality. This promotes expressions of unconscious fantasies in the patient's free associations and the development of the transference neurosis. The analyst must be capable of renunciation, especially of his wishes for fusion with the patient. The slightest alteration in the analyst's behavior calls for self-scrutiny; collusion (i.e., misalliance) with the patient has usually been involved.

Greenson's discussion of the working alliance (1965, 1967) alludes to aberrations in this alliance which clearly reflect therapeutic misalliances; he emphasizes that analytic efforts in this area must take precedence over all other aspects, including work related to the transference neurosis. Inherent in the modifications of the misalliances described by Greenson was the recogntition of the analyst's participation in the aberrant interaction with the patient, and the need for the analyst to modify his contributing behavior as well as to analyze the sources for the difficulty with the patient. In describing one such misalliance, Greenson noted: "The analysis of this transference resistance, however, was ineffectual, partly because the first analyst worked in such a way as to justify the patient's infantile neurotic behavior and so furthered the invasion of the working alliance by the transference neurosis" (1965, pp. 166–167).

Friedman (1969) studied a paradox within the patient-analyst relationship: transference is the major motivating factor in analysis and yet the prime weapon—resistance—that the patient uses to combat these efforts, and to try to gain actual fulfillment of his neurotic needs. Similarly, the emphasis on the therapeutic alliance as a compact between the mature and relatively autonomous parts of the egos of both patient and analyst presents the paradox that such an alliance, to be effective, must also rely on contributions from instinctual needs and entail some degree of gratification of these needs. In traversing the fine line between offering the patient too little and too much gratification, the danger of participating in misalliance is ever present.

In another vein, Myerson's studies of the analytic modus vivendi (1969, 1973) describe ways in which certain patients attempt to work in analysis with either too little or too much involvement with the analyst, thereby limiting analytic progress. He states that the prime task with such patients is the disruption of these deviant modi vivendi (i.e., efforts toward misalliance) through various types of interventions, some of which are noninterpretive.

Kanzer (1975) calls into question the common tendency in analysts who deal technically with aberrations in the therapeutic alliance to suggest noninterpretive interventions. His contention that such measures are antitherapeutic suggests that these techniques actually foster new sectors of misalliance, rather than constructively modifying the original problem in the alliance. My own observations support those of Kanzer (see Langs 1973b, 1974, 1975b; and see below).

There are, of course, many descriptions of misalliances in the literature on countertransference problems (for a partial bibliography, see Langs 1974). Space will not permit a survey of this aspect here except to note that Searles (1965) and Racker (1968) have been especially sensitive to this kind of problem; the latter's profound studies most clearly foreshadowed the findings to be presented here. In particular, Racker's paper (1968 [1957]) on the meanings and uses of countertransference (for him, defined as all of the analyst's reactions to his analysand) documented the occurrence of "vicious circles" in which the analyst enters the patient's neurosis and thereby cannot interpret it. Racker emphasized the role of the analyst's self-observations in preventing misalliances and demonstrated repeatedly how reactions in the analyst that complement the patient's neurotic needs preclude a proper understanding of the patient. In one pertinent statement among many, he wrote (1968, p. 152):

> The transference, insofar as it is determined by the infantile situations and archaic objects of the patient, provokes in the unconscious of the analyst infantile situations and an intensified vibration of archaic objects of his own. . . . the analyst, if not conscious of such countertransference responses, may make the patient feel exposed once again to an archaic object (the vicious circle), and . . . in spite of his having some understanding of what is happening in the patient, the analyst is prevented from giving an adequate interpretation.

Lastly, in quite a different vein, Glover's early paper (1931) on the therapeutic effects of inexact interpretations may be viewed as one of the first psychoanalytic studies of therapeutic misalliances. Briefly, Glover defined an inexact interpretation as one in which the specific fantasy system on which a symptom is based is not uncovered; a related fantasy system is instead interpreted to the patient. He described the manner in which the patient may seize upon the inexact interpretation and convert it into a

displacement-substitute that is sufficiently remote from the real sources of the patient's anxiety as to afford him considerable symptom relief. He also noted that such improvement occurs at the cost of refractoriness to deeper analysis. In addition, Glover described a variety of defenses, suggestions, offers of sanction, and other efforts toward providing the patient the kind of displacement systems commonly offered by nonanalysts. In the terms defined within this paper, Glover was, indeed, exploring a variety of therapeutic misalliances and their effects.

Overall, the literature reflects the inevitability of efforts toward misalliance, major or minor, the infinitely varied forms that such endeavors may take, and the prime importance of their detection, analysis, and modification. It is, however, relatively lacking in specific discussions of the means of detecting misalliances, the techniques related to their resolution, the special efforts of the patient toward modifying them, and the mutual influence of patient and analyst upon each other in creating, maintaining, and altering misalliances. Some clinical data will enable us to clarify these and other aspects of this problem.

Clinical Material

Every patient who seeks psychoanalysis or psychotherapy will attempt on some level to effect a therapeutic misalliance with his analyst or therapist. The direction of these efforts is the product of his past history, character makeup, unresolved intrapsychic conflicts and symptoms, current life situation, and responses to the analyst and the analytic situation.

It is characteristic of such efforts that they tend to re-create pathogenic and unresolved infantile relationships and traumas, and unmastered conflicts—along with efforts at adaptive and maladaptive mastery. They represent attempts to gratify infantile and unfulfilled pathological fantasies directly with the analyst. Simultaneously, they defend the patient against anxiety and guilt, intrapsychic conflicts, unresolved unconscious fantasies, and the threats posed by the relationship with the analyst. Patients try to involve the analyst in living out complex, pathological, unconscious fantasies and relationships, usually as an alternative to their verbal communication in derivative form.

It is one of the analyst's tasks in the opening phase of psychoanalysis to detect expressions of the patient's—and his own—wishes for a misalliance with him (Nunberg 1926). Throughout the subsequent therapy or analysis, the therapist remains alert for such a development at any juncture, especially at times of difficulty and at termination—the latter being a very common period for needs of this kind to occur in both participants. In general, the patient's efforts may appear in derivative or direct form in his associations, or may be attempted through some behavior and actual effort to engage the analyst in this type of involvement. These efforts need not be grossly acted out, but are often reflected in the manner and content of the patient's free associations and in his general analytic modus vivendi (Myerson 1969, 1973). While these intentions and fantasies, which are initially strongly related to the patient's unconscious motives for seeking analysis and to what has been termed *the pre-formed transference* (Langs 1974), contain the potential for misalliance, they also prove to be a rich source of analyzable material if the analyst does not consciously or unconsciously join in the misalliance. The analyst or therapist may have unresolved needs for a misalliance with his patients in general, or with a specific patient, that are mobilized upon his beginning a new therapeutic venture. The underlying motives are similar to those already described for the patient, with some specific additional aspects related to his role as analyst, and they reflect a variety of countertransferences and counterresistances to his patient.

The intermingling of the sources of misalliances is such that an unconscious circular interaction is characteristic. Both patient and analyst are attempting to adapt to their own inner needs and to the stimuli emanating from the other person. One of them may initiate a move toward misalliance or may respond to some cue from, or reaction by, the other; in turn, the second one will unconsciously participate or resist, or may communicate his own need for a different type of neurotic relationship, to which the first will then react. Unconscious evocation of, reaction to, acceptance of, resistance against, attempts to intensify, and attempts to rectify the area of misalliance occur in quick succession on both sides.

As previously noted (Langs 1974), misalliances may be classified as mutually narcissistic, sadomasochistic, exhibitionistic-voyeuristic, seductive, and infantilizing. However, such terms tend to offer a classification that fails to reflect the specific nuances and richness of these interactions; a deep, dynamic clinical description and formulation promises to offer a more precise picture.

In this spirit, then, let us move directly to a vignette drawn from the opening phase of a

psychotherapy; as we will see, the principles and concepts to be derived from it are fully applicable to the psychoanalytic situation as well.[2]

Dr. Z. presented a patient, Mr. A., to me in supervision. Mr. A. was a man in his fifties who sought therapy for recurrent moderate depressions and failures to advance in his work despite apparent strong abilities. He served as a consultant to an electronics firm and was concerned that his contract would not be renewed. His wife was depressed and currently in therapy. Of note regarding his past history is the fact that his parents had both died in an automobile accident when the patient was in his late teens; he had dissipated his inheritance in the years that followed and was currently worried about finances. Diagnostically, he was assessed as an obsessive character disorder with depression.

In his first sessions, Mr. A. spoke repeatedly of his financial worries and of his failure to provide his wife with security, closeness or an adequate sexual relationship. He envied the younger men who always appeared to replace him in his work. He tended to withdraw whenever he was under stress. When others failed, he always felt better.

Mr. A. detailed his current realistic problems in this manner over several hours, and the therapist asked occasional questions about them. When the patient then revealed that he was currently having joint sessions with his wife's therapist, Dr. Z. asked him how he felt about it, but otherwise did not explore or deal with it. In his associations, Mr. A. spoke of not wanting to hear about his wife's problems and of how he lacked family ties. His brother hated Mr. A.'s wife and never spoke to either of them; Mr. A. allowed his guilt to plague and inhibit him. He alluded to a previous psychotherapy in which the therapist unnecessarily reduced his fee and which got nowhere. That therapist had also seen his wife and had been overtly seductive; Mrs. A. had stopped seeing him when she caught him in an error—a contradiction—and he asked her to leave. When the therapist asked further about this past therapy, Mr. A. spoke of his anger over his wife's seductiveness with other men; he did not trust her. He would end up having to fix things himself.

In the next few hours, allusions to the sessions with his wife's therapist, which are soon discontinued at that therapist's request, were intermingled with recollections of his parents' deaths, in which his own hostility toward them was hinted at. He then recalled primal observations from his childhood, his attachment to male friends, and vaguely wondered if he was homosexually attracted to a cousin who had understood and helped him as a teenager. Later, he spoke of a cousin who had had a nervous breakdown and of how two therapists were too much to handle. His guilt immobilized him and he preferred to be left alone; maybe hypnosis would help him. He never committed himself.

I shall pause here to describe the relevant supervisory discussions and formulations. In brief, Mr. A. consciously sought help for his depression, guilt, and need to fail. Unconsciously, he initially indicated that a misalliance in which the therapist would fail would temporarily reassure ("cure") him. His associations suggested that he would also accept a situation of mutual withdrawal in which his hostile and sexual impulses were covered over (and somewhat gratified) as another sector of misalliance. This became especially clear when his associations revealed that the other therapist was protecting Mr. A. from experiencing, and therefore facing, his unconscious homosexual fantasies toward his present therapist.

Despite supervisory discussions, the therapist chose to ignore the emerging derivatives of Mr. A.'s unconscious fantasies and did not deal with the evident resistances embedded in the deviation in technique—the sessions with the second therapist (Langs 1975b). Unconsciously, he communicated to the patient his own wishes to avoid both closeness with Mr. A. and meaningful material and interaction, and his preference for focusing on realistic problems in which intrapsychic conflicts and disturbing affects and fantasies were relatively ignored.

Mr. A. and Dr. Z., each prompting and responding to the other, rather quickly and unconsciously had arranged a ruminative intellectualizing, reality-focused, fantasy-avoiding misalliance of major proportions. Despite supervisory comments, the therapist did virtually nothing to modify his position. Soon Mr. A., who had unconsciously perpetuated the misalliance, also initiated unconscious efforts to modify it. Such curative endeavors by patients toward their analysts and therapists have been described previously by Little (1951), Searles (1965), and myself (1973a, 1975a). More recently, Searles (1975) in an extensive study of the curative work of his schizophrenic and neurotic patients toward himself as their analyst, has suggested that they reflect a basic human need that arises in the infant in his earliest relationship and symbiotic experiences with his mother.

Empirically I have found that patients are exquisitely sensitive to and unconsciously perceptive of

their therapist's errors, and that they respond by efforts to correct and assist the therapist at such moments. Their unconscious communications at such junctures bear the hallmark of sound confrontations and interpretations; they express ideas and formulations remarkably parallel to my own thinking and direct interventions with their therapists in supervision. Upon reflection, the underlying principle is a sound one: if the therapist is blocked or unhelpful in his therapeutic work, his cure must take precedence so that he can ultimately help the patient.

In a well-run treatment, such efforts are relatively infrequent and generally minor, though nonetheless quite important (Searles 1975). The patient's reactions at such moments are, as always, based on a mixture of valid unconscious perceptions and bona fide therapeutic efforts on the one hand, and their own intrapsychic fantasies, conflicts, and needs—including transference distortions—on the other. In emphasizing the need to recognize and implicitly make use of the patient's helpful endeavors, we must not overlook the ultimate shift of the focus of treatment to the therapy of the patient. However, the therapist who treats these efforts entirely as distortions and ignores their realistic aspects (Searles 1975) will make hurtful and insensitive interventions. Here, I shall merely attempt a preliminary sketch of patients' efforts at cure, pending more conclusive investigations.

As we have seen, Mr. A., quite early in the therapy, and well after the first sectors of misalliance had been established, spoke of withdrawing under stress and of his own failures to provide his family with a growth-promoting relationship. In part this material reflects his unconscious perception of the therapist's failings—indeed, of his need to fail—and of the misalliance; it reflects too his subsequent incorporative identification with these aspects of the therapist. While this may well appear somewhat speculative, in part because I have condensed the initial material to an extreme degree, let us follow the subsequent developments.

Mr. A. had soon revealed that he had a second therapist. In addition to reflecting his own fears of closeness and his homosexual anxieties, this is an indication of the patient's unconscious awareness of Dr. Z.'s supervisor (such communications are common among clinic patients). Perhaps Mr. A. was also suggesting that supervision might be a factor in Dr. Z.'s fears of the therapeutic relationship; this indeed was an impression that I had in the supervision. More important, however, it represented an effort to alert the therapist to the presence of a third (and fourth—his wife) party to the treatment, and its implicit defensive and neurotically gratifying dimensions. When Dr. Z. failed to explore the situation, thereby accepting and participating in it, we can observe a variety of unconscious reactions in Mr. A.—incorporative identification, what I term *unconscious intepretations,* and further extensive efforts to "cure" the therapist.

Thus, Mr. A. alluded to the way he allows guilt to plague and inhibit him, a view—again confirmed by my supervisory observations—of an aspect of the therapist's countertransference problems. He also suggested through displaced derivatives that the therapist had an underlying hatred for him (and therefore permitted a detrimental situation to continue, while protecting himself from his anger by having an observer present); he also spoke of his own refusal to listen to his wife (the therapist who will not hear). He referred to the therapist who inappropriately reduced his fee, failed to help, was seductive, made a blunder, and sent his wife away. When these indirect allusions to the present therapist went unheeded, we hear of the patient's growing mistrust and his despairing conclusion that he will have to cure himself.

Further derivatives connect the two-therapist situation to Mr. A.'s rage at his deserting parents (the therapist) and to primal scene experiences (threesomes). There is then a strikingly condensed association that contains another unconscious interpretation, one that was exquisitely intended to bring to the therapist's awareness the underlying, interfering homosexual conflicts that prompted him to accept a third party to his relationship with Mr. A. As his supervisor, I could not have expressed such insights into Dr. Z.'s countertransference difficulties and motives for misalliance more clearly. It is evident, of course, that these associations also reflect Mr. A.'s own latent homosexual conflicts. Such condensations and multiple functions of communications from the patient are the rule.

Finally, Mr. A. went on to express his fears for his own mental integrity if the blind spot and misalliance prevailed. Simultaneously he offered a confrontation and interpretation of the therapist's anxieties: that they were based on guilt, primal scene and homosexual conflicts, and fears of being overwhelmed. Lastly, there was another reference to the therapist's striking failure to intervene—commit himself—and to another search for self-cure through hypnosis. In actuality, many of these derivatives convey unconsciously from Mr. A. direct comments that had been made in supervision to Dr. Z.

To continue more briefly with this vignette, the

patient was soon told that his business contract would not be renewed. He spent many sessions ruminating about this problem and how to deal with it, and from time to time the therapist questioned him about it or pointed out an obvious aspect of Mr. A.'s concern. Soon the patient conveyed feelings that he was getting nowhere in his therapy and the therapist reported to me that he felt bored and was annoyed with his patient. In supervision, I too experienced the sessions as uninteresting and hollow. Since the therapist made no effort to deal with the resistances and misalliance that he and the patient had effected, I more strongly recommended confrontations with the patient's failure to communicate expressions of his inner conflicts (derivatives of his unconscious fantasies) and a modification of the therapist's stance: he should no longer participate in the reality focus and should confine himself to confronting and analyzing the patient's defenses and to exploring any expressions of intrapsychic conflicts that emerged. I also used Mr. A.'s unconscious interpretations to Dr. Z. to alert the latter to the underlying basis for his block.

As the therapist very tentatively began to modify his stance, Mr. A.'s associations—which had been undecipherable in connection with any type of unconscious fantasy other than those related to the misalliance—came alive again. He spoke of how he should give his son more responsibilities, and of the lack of dialogue between himself and his wife. When confronted with the lack of reference to his inner stirrings he, for the first time, told the story of the man who gets a flat and needs to borrow a jack to fix it. On walking to a house to ask for help, he is so convinced that he will be refused, and builds the scene so much in his mind, that he rings the bell and attacks the man who answers it. Mr. A. also anticipates a royal shafting wherever he goes; he becomes the good guy, and then no one feels bad.

In other sessions, he spoke of his anger when his wife stirred him up, adding, however, that he wanted to take on responsibilities with her. His friend had been in therapy and had not changed; he just accepted it. His son did nothing—it was Mr. A.'s own fault for being permissive and not meddling in his problems; he was afraid he might crush his son. His own father never intervened with him, though his mother did.

As the therapist continued to explore Mr. A.'s fears of revealing himself, the patient spoke of how he pressured his inactive son to do things and to communicate. He played psychiatrist with his son but not with himself. He disliked having the same conversation with his wife over and over; his first therapist never got behind the same old reality issues. If he exposed himself to the therapist, the latter would be just like his wife and give him advice.

We see, then, that the therapist's constructive efforts to modify the misalliance were unconsciously perceived by the patient, who also appears to have positively identified with the correctly and unconsciously perceived newfound strengths of the therapist. Derivatives of Mr. A.'s own intrapsychic conflicts become available for cognitive-emotional insight through interpretation by the therapist. Thus were opened up crucial routes for the modification of misalliances and for new, constructive avenues of conflict resolution and change for the patient.

I have presented this vignette in some detail because it demonstrates in its two misalliances—the accepted third party to the therapy and the shared obsessive-avoidance defenses—many typical characteristics of these misalliances: their mutuality, and the clues whereby they can be recognized and resolved.

Subjectively, therapeutic misalliances should be considered when the therapist senses a lack of progress or depth in the therapy, or in the unfolding of the material from the patient. Beyond such cognitive awareness, the therapist may experience a range of thoughts, feelings, and fantasies: things are not right; he dislikes the patient, or has other unusual attitudes or feelings toward him; he feels used or manipulated, or that he is ineffectual as a therapist; he is aware of notably seductive or aggressive felings toward the patient that he is unable to resolve; he cannot understand a stalemate or a regression in the patient. Subjectively experienced disturbances in his therapeutic attitudes, or any unusual manner of intervening or behaving, are clues to the presence of countertransference problems, and direct the therapist to search for their expression in the actual interaction with the patient.

Subjective clues lead the therapist to listening especially carefully to the patient's associations with the suspected misalliance in mind. A correct and sensitive subjective appraisal that leads to the identification of a misalliance should be confirmed in the patient's associations. At times, when the therapist is especially blocked, these will stimulate him to focus on his own inner feelings and fantasies. Themes of noncommunication, of manipulation, of poor parental functioning, of poor therapy of any kind, of collusion, and other misalliance-related content should alert him. The valid understanding of these associations as they relate to a misalliance or any aspect of the patient-therapist relationship should always, in turn, be confirmed by the therapist's subjective experiences and realizations (see Langs 1975a).

In this vignette, the therapist's sense of boredom and anger could have alerted him to the obsessive misalliance (not simply Mr. A.'s resistances). A review of his interventions (e.g., repeated realistic inquiries and avoidance of instinctual-drive derivatives) would have been helpful, as would other, inevitable feelings that he did not report to me. In my supervision, I detected many clues to the misalliance. Mr. A.'s multiple communications were also available.

Therapeutic misalliances foster symptom relief through pathological, shared defenses and inappropriate gratifications. They repeat and confirm the patient's neurotic fantasies, needs, and past pathogenic interactions, and the participating therapist cannot interpret and modify such pathology; he is, for the moment, an integral part of it.

Modification of misalliances entails the following steps:

1. Recognition by the therapist.
2. Modification of the therapist's participation through self-analysis, without burdening the patient, though full use should be made of the patient's unconscious perceptions and interpretations. The therapist's failure to resolve his inner conflicts will promote new versions of the misalliance.
3. Full analysis, without blame, of the patient's own needs for the misalliance, and his role in effecting it.

When a major technical error, deviation in technique, or erroneous stance by the therapist has contributed to the misalliance, the therapist in proper context may *implicitly* acknowledge his contribution—a practice that is largely misused by patient and therapist, and therefore best confined to indirect means. Basically, even if the therapist's participation was inadvertent, he should never deny his role, should tacitly accept the actuality of his contribution, and not treat the patient's perceptions of it as fantasy-based. However, this does not preclude a full exploration of the patient's involvement in the misalliance, his extensions of reality into conscious and unconscious fantasies, and his frequent attempts to misuse the misalliance to sanction his own pathology. A full analysis of the unconscious motives for seeking and maintaining a misalliance not only clears the way to a viable therapeutic alliance, but is the vehicle for vital therapeutic work.

In fact, the analytic resolution of misalliances is a moving experience for both patient and therapist, providing both an intense kind of experience that is appropriately gratifying in a way that is unique even in the therapeutic relationship. The final mutual triumph over pathological inner needs and defenses is especially satisfying.

The interaction between the patient and the therapist has alternating thrusts toward misalliance and rectification of the misalliance—restoring the therapeutic alliance. In focusing on the efforts of one or the other toward maladaptive equilibrium, we must not overlook their respective efforts toward healthier adaptations. While we tend to focus on the therapist's conscious efforts toward resolution of the misalliance, this vignette clearly indicates consistent efforts by the patient to alert the therapist to the misalliance and to help him modify it.

Having established some basic concepts and technical principles, let us now attempt to apply and expand upon them with a second vignette.

Mrs. B. was a young teacher who had sought therapy for marital difficulties. She had been in psychotherapy for several months with a woman therapist who was, at the time of the sessions to be described, in her sixth month of a pregnancy. The patient appeared to have some phobic systems, primarily a fear of driving and an anxiety that she would be physically damaged in an accident caused by another car; these symptoms had been reported in recent sessions.

The patient had missed a session because of a legal holiday and for her following hour knocked on the therapist's door fifteen minutes early; in the session itself, she spoke of feeling isolated and lonely in her marriage, and complained about her husband's incessant nagging. She recalled having had some facial moles removed when she was thirteen years of age, a procedure that included cosmetic plastic surgery as well. While her appearance had improved, the changes had intensified her anxieties and especially exacerbated a choking sensation in her throat and difficulty in swallowing. The therapist responded with a lengthy intervention, in which she related the patient's feelings of loneliness to the missed session and connected this to her coming early; in addition, she suggested that this also related to the anticipated separation that would occur at the time of her delivery. The patient responded with some general agreement.

Mrs. B. was late to her next session; she stated that she no longer felt lonely and that she was not attached to her therapist, who she felt was somehow implying that she had had feelings during her mother's pregnancy in her childhood (a sister had been born when she was five and a brother when she was eight); she rather elaborately denied any such

reaction. She also complained that the sessions were exhausting her and that the therapist was too silent.

In the next hour, the patient was five minutes late but eager to talk. She had quarreled with her husband and had been angry over his attachment to his mother, stating that he did not seem to understand that she and he were a couple and that they should function as a couple. They had argued and the patient had slept alone, but then became frightened. That night she slept at her sister's house and when the therapist asked why the patient was behaving in this way now, Mrs. B. related it to being in treatment, feeling stronger, and not seeing any change in her husband. The therapist asked her to relate it more clearly to treatment and the patient reiterated what she had said. She then spoke of her difficulties in opening up in treatment and suggested that she had to work on that. The therapist made another lengthy intervention in which she attempted to link the patient's becoming more freely verbal in her sessions to her wish to leave her husband, adding that it also seemed to reflect feelings of hurt in response to the therapist's recent comments and to the missed session. The patient said that she was thinking of reducing her sessions from two to one weekly, and the therapist commented that this represented an effort to deny any need for her.

Mrs. B. said that she had felt hurt and criticized by the therapist and had thought of not coming for her session, adding that she overreacts in an unproductive way. Doing things when she was hurt would not change the problem and her husband simply would not change. The therapist seemed not to realize how frightened she was of leaving him; she added that she had her faults too, and had to accept the marriage since she could not expect anything better. The therapist made another long intervention about the manner in which the patient was feeling criticized and therefore angry with her, relating it to her conflict with her husband. The patient responded by ruminating about her exaggerated sensitivity to hurts, relating it to her father's hitting her as a child, and contrasting it to her parents' efforts to be supportive at other times.

I shall pause here to formulate the interaction between this patient and her therapist. The material begins essentially with a missed hour and with derivatives related to what is quite evidently the primary adaptive task intrapsychically for Mrs. B., her therapist's pregnancy. The associations indicate that this patient is experiencing the pregnancy as a development through which she will suffer a great loss and a rupture of the close twosome that she had been experiencing with the therapist. In addition, there is evidence of an unconscious incorporative identification with the pregnant therapist, with related bodily anxieties—the fear of being smashed by a car and being damaged bodily, and the reparative references to the plastic surgery. On the basis of the therapist's subsequent interventions, we might speculate that the allusions to the nagging husband relate to an unconscious perception of the manner in which this therapist intervenes.

In the following hour, Mrs. B.'s denial of any reaction to the therapist's pregnancy offers a genetic clue to its unconscious meaning and is apparently designed, however defensively, to alert the therapist to the fact that it is a crucial source of anxiety and conflict—the main adaptive and therapeutic context for the moment. When the therapist failed to recognize these implications, the patient complained about treatment.

In the next hour, the patient, through displaced derivatives, expressed her anger regarding the anticipated rupture of the therapeutic couple, acting out the denial of her need for her therapist in her relationship with her husband. When the therapist failed to recognize the central source of this behavior and of the underlying conflicts (her own pregnancy), the patient soon undertook unconscious efforts to alert her to this blind spot—talking about her own problems in opening up in the sessions and in being in touch, and her thoughts of canceling her hours. When the therapist responded with lengthy, apparently anxious and inaccurate interventions, the patient spoke of the manner in which she herself overreacted unproductively—a formulation that was anticipated in supervision.

Mrs. B. goes on to again express her conflicts over leaving treatment, once more displacing these reactions onto her husband. Her own devalued self-image and an incorporative identification with the impaired (pregnant and insensitive) therapist lead her to allusions to her own faults. Another generally incorrect intervention follows, and Mrs. B. speculates on her own sensitivity to hurts, an unconscious interpretation to the therapist, perhaps an unconscious perception of the therapist's excessive sensitivity, with a related genetic intervention—that the therapist's sensitivity is related to a disturbed interaction with her parents.

The sectors of misalliance between Mrs. B. and her therapist primarily involved the establishment of a somewhat sadomasochistic and intellectualized defensive interaction designed to avoid and deny the main areas of intrapsychic conflict evoked—probably for both of them—by the pregnancy.

I would view the patient's momentary feeling that

she was stronger as a *misalliance cure* (for the earlier roots of this concept see Langs 1974 and Barchilon 1958) in which the patient found support and reassurance through the therapist's difficulties and mobilized her own resources because of the latter's failure. The mutual avoidance of the patient's central anxieties and conflicts afforded her momentary relief through the shared defenses. In general, then, it is important to accurately identify the underlying basis of symptom relief and to recognize the indicators of a momentarily successful "cure" through therapeutic misalliance.

The patient began the next hour by reporting that she felt better and had worked things out with her husband; it was not completely satisfactory, but she had made an effort. She went on to describe a movie that she had seen in which several people were crippled and paralyzed; she had fled the theater. She now remembered a dream from that night, one in which she was working with crippled children. On the night prior to the present session, she had dreamt of sitting in a luncheonette and hearing some children criticize her singing.

In the session, she stated that if she were crippled or handicapped like the men in the movie, she would kill herself, even though they seemed to make the adjustment. She felt that the dream meant that she could not imagine herself being damaged and that the second dream alluded to her difficulty in taking criticism as a child, something that she could handle better now. She related this to treatment and stated that it bothered her that she ruminated in her sessions; she felt guilty with her husband because she did not do the things that she should do for him—she did not give enough to him.

These communications condensed a variety of unconscious perceptions and fantasies. The dream and associations to them reflect the patient's unconscious identification with the pregnant therapist in a manner that indicates that pregnancy is seen by Mrs. B. as a potentially crippling experience that is evoking considerable anxiety in her. This material also reflects unconscious perceptions of the therapist, who did not intervene or understand these communications—that is, failed to do the things that she should have done in the sessions. Further, the associations represent another effort on the part of Mrs. B. to direct the therapist to the source of their respective conflicts and anxieties. Mrs. B. sensed, apparently correctly, that her therapist was anxious about her pregnancy and avoiding it in the treatment situation. On this basis, she offered a series of unconscious interpretations which are amalgams of her fantasies with efforts to direct the therapist to the possible sources of her anxieties. These efforts are best illustrated in the reference to the handicapped and crippled men. In this context, the flight from the theater dramatizes the therapist's own massive avoidance.

Mrs. B. began her next hour by describing minor surgery that her husband would be having; she would have to drive him home because he would be groggy (another allusion to the necessity for this patient to take responsibility for her therapy). She had had a pleasant visit with her in-laws but had been demeaned by her husband when she had reacted to his tormenting of a waitress. There was a period of silence; when the therapist inquired into it, Mrs. B. said she had been thinking of menstruation. Her periods had been irregular for the past couple of months and her gynecologist had said it was her nerves. It made her feel that there was something wrong with her and that she would not be able to have babies; she somehow connected this to her fears of accidents and damage. When she was thirteen, she had had similar anxieties.

The therapist intervened, reiterating the various themes to which the patient had alluded, and pointed out that the patient's increased anxiety undoubtedly reflected concerns about her pregnancy and delivery, and worries that she—the therapist—would be damaged. Mrs. B. responded with a broad smile; she said that she envied her therapist's Ph.D.—she actually had an M.D.—and added that she was worried that she herself would be unable to have children when she wanted them. She suddenly recalled that she had had a dream where she had delivered a baby who was fine but was taken away. She guessed that she was, after all, concerned about her therapist's pregnancy and delivery.

In this session, relatively undisguised derivatives of Mrs. B.'s unconscious fantasies, conflicts, and anxieties as they are related to the therapist's pregnancy unfold. The onset of the patient's irregular periods coincided with the recognition of the therapist's pregnancy and affords further evidence of the patient's identification with her therapist. In addition, it hints at unconscious wishes to destroy the fetus and at rage in the rivalry with the therapist, a thesis that is supported by her own fear that she would not be able to have a child, the allusion to accidents and damage, and the element of the final dream in which the baby disappears. The therapist failed to recognize these derivatives as related to specific aggressive fantasies—a failure that could form the nucleus of another misalliance, and demonstrates how a therapist's failure to resolve his

contributing intrapsychic conflicts can lead to new versions of the search for unconscious collusion.

Perhaps because the patient's unconscious interventions were of some help to this therapist, she was finally able to identify some of the important meanings of these less and less disguised associations and to interpret aspects of them. Her relatively correct intervention evoked a strongly confirmatory response in the patient in the form of the recall of a previously repressed dream (Langs 1974a). The dream also suggests an unconscious incorporative identification with a more positive image of the therapist, in that it portrays the patient as being capable of delivering a baby, although this is marred by the disappearance of the child—an element which undoubtedly refers to the patient's own hostile wishes, but may also be a further unconscious attempt to suggest to the therapist that the latter's need to avoid the subject of her pregnancy was related to her own unresolved hostility toward her fetus. A further acknowledgment of the therapist's capacities is contained in the reference to her degree, although the patient again showed her hostility by mentioning a Ph.D., which, her later associations revealed, she considered lower than the M.D. the therapist had actually attained.

As with the first vignette, the material presented here strongly indicates that this patient's apparent resistances against dealing with the conflicts, fantasies, and anxieties evoked by her therapist's pregnancy were not solely evoked by intrapsychic defenses. It is clear that the therapist's own unconscious defensive avoidance of the pregnancy significantly contributed to and reinforced the patient's defensiveness. It follows, then, that the first step toward resolving this resistance was a modification of the therapist's defenses so that she could consciously acknowledge and deal with the derivatives from the patient related to her pregnancy, and would no longer unconsciously communicate to the patient her own wishes to avoid the subject.

This material also demonstrates the manner in which a patient who is faced with a seriously defensive therapist, and who also has mounting inner anxieties and distrusting fantasies, will actively attempt to cure the therapist of her difficulty in order to obtain much-needed help in return. The therapist's correct though limited intervention was subsequently confirmed by associations that included both the further modification of repressive barriers and indications of a momentary positive incorporative identification.

In retrospect, it appears that if the therapist had properly understood the communications regarding the patient's marital problems as a means of expressing Mrs. B.'s unconscious perception of her misalliance with the therapist, and if she had more sensitively monitored the patient's associations for unconscious perceptions of her own role in the stalemate that she herself had sensed, she would have been directed much sooner to her own difficulties. Discussions with the therapist suggested that her anxieties regarding her pending delivery, and her own conscious and unconscious fantasies of bodily damage, were so intense that she did indeed unconsciously share many of these disturbing fantasies with the patient and therefore utilized comparable defenses.

We see also that the therapist's difficulties in dealing with this area created pressures within the patient toward greater self-confidence and more effective communications, and therefore afforded her a momentary misalliance cure. The symptom relief obtained by the patient through these shared defenses, and through the gratification of being more in tune with her anxieties than the therapist was with hers, was short-lived, and the patient's anxieties soon returned. The subsequent material clearly reflects the fact that the patient had in no way understood her intrapsychic conflicts and anxieties as related to the pregnancy, but that she had found temporary relief through bypassing them. As her anxiety intensified, it became necessary for her to return to the specific unconscious fantasies that were disturbing her and to seek the assistance of the therapist in resolving them. In a small way, these observations provide clues regarding the vicissitudes of the identificatory processes in the therapeutic relationship as they fluctuate with the therapist's actual capacities and thereby strengthen or weaken the patient's self-image and general ego capacities. The interpretation of derivatives of unconscious transference fantasies, by contrast, offers specific cognitive insights that enable the patient to master areas of conflict.

In concluding my discussion of this vignette, I would note that the material supports the thesis that the development of a firm therapeutic alliance depends on both the nonparticipation of the therapist in a misalliance and correctly timed, pertinent interpretations. Attempts to be reassuring, to offer so-called reparative deviations in technique, and any other kind of noninterpretive intervention could only foster additional sectors of misalliance and further convey the therapist's difficulties in understanding the patient's intrapsychic conflicts. In addition, any effort to reassure the patient regarding the therapist's good intentions (Zetzel 1966–1969) or to discuss the patient's realistic concerns (Greenson and

Wexler 1969) would not only reflect an insensitivity to the main source of the patient's conflicts and difficulties, but would also entail at times the conscious denial of the patient's valid, unconscious perceptions of the therapist. Such a noninterpretive stance reflects the therapist's failure to appreciate both the transference and realistic elements in the patient's communications, and their unconscious elaborations.

I am well aware of the danger of reading too much into the patient's associations. I want to emphasize that it was the striking correspondence between my own conscious assessment as a supervisor, and the unconscious perceptions and communications of the patient that led me to recognize the remarkable extent to which patients are in touch with their therapist's failings, and the extent of their endeavors to assist the therapist with them. Similarly, when in this case I formulated that the therapist had made a sound and helpful intervention, the patient's unconscious communications reflected a perception and incorporation of these positive attributes. Once this exquisite sensitivity on the part of the patient is fully appreciated, it enables the therapist to understand and predict the unfolding of many previously confusing sessions—a powerful means of understanding the patient-therapist and patient-analyst interactions.

Discussion and Conclusions

Therapeutic misalliances, as sectors of the patient-analyst relationship, are related to the intermixtures of transference and countertransference, as well as to other aspects of the patient's and the analyst's mutual attempts to adapt. They may be present in patients or analysts who appear to be working well and seem overtly to be cooperating and not acting out or acting in. They offer, however, momentary maladaptive resolutions to the patient's and/or analyst's conflicts, and foster maladaptive identifications of each with the other, undermining the therapist's effectiveness. They must, therefore, be analyzed and resolved to permit other aspects of the analytic work to unfold effectively. Yet, as inevitable expressions of the patient's pathology and of the residuals of the pathology in the analyst, these efforts at misalliance are, paradoxically, a major opportunity for effective and necessary analytic work and for growth within both participants.

Although misalliances are always embedded in the specific conflicts, character structure, and genetic history of the patient and the analyst, we may identify certain general motives for the creation of misalliances. On the patient's part, the search for misalliance stems from the hope for maladaptive relief from the anxiety and guilt related to his intrapsychic conflicts. A misalliance can serve as a major defense against closeness with the analyst and all that such intimacy represents to the patient. It may also provide him inappropriate gratification of his neurotic needs and be a means by which he repeats past interactions that fostered his neurosis and justifies its continuation. Through a misalliance, the patient also bypasses the painful process of renunciation and inner change. A misalliance can reinforce inappropriate superego sanctions and punishments, and offer a wide range of pathological defenses to the patient—as well as to the analyst. For any given moment, it may provide the patient temporary and usually unstable symptomatic relief so that he does not attempt to seek out other, more adaptive but arduous solutions to his conflicts. To the extent that misalliances gratify wishes to circumvent reasonable boundaries and to deny separateness, they also provide the patient illusions of symbiotic ties, and a false sense of omnipotence and of a right to special gratification, which can momentarily reassure him to the extent that he is not plagued by his intrapsychic conflicts. The inherent depreciation and destruction of the analyst who becomes involved in a misalliance provides the patient neurotic feelings of power and pathologically gained self-esteem.

Through a misalliance, the analyst no longer represents insight, delay, optimal adaptation, renunciation, and the process of analytic scrutiny; the patient thereby is able to unconsciously justify his abandonment of meaningful analytic work toward inner change. More broadly, the analyst is for the moment no longer a "good object" with which the patient can constructively identify, but has become instead a "bad object" who is incorporated to the detriment of the patient's self-representation and functioning. In all, the inevitable wish to maladaptively and momentarily lessen conflict, anxiety, and guilt at any cost, the universal human search for unlimited closeness and immediate discharge, and the need to repeat and master past traumatic relationships prompt these efforts toward misalliances in patients.

Despite these gains, the inherently maladaptive, destructive and inappropriately gratifying aspects of an effected misalliance will prompt the patient to make efforts to modify and renounce the collusion with the help of the analyst. Unconsciously aware of the ultimately self-defeating dimensions of a misalliance, the patient communicates his perceptions to the analyst in his efforts to find a new and healthier

adaptation. In addition, he unconsciously attempts to resolve the misalliance through curing the therapist as well as himself.

In general, despite the momentary symptomatic relief that misalliances afford, they are often followed by serious regressive and acting out episodes if they are not detected and modified. Further, if the patient's efforts to modify the misalliance go unheeded and if the analyst has unresolved unconscious needs to maintain it, the patient will either abruptly terminate the therapy or will continue in the stalemated therapeutic situation in which he can maintain the inappropriate relationship and gratifications so obtained.

The analyst's inevitable residuals of unmastered anxiety and guilt, neurotic and maladaptive defensive needs, his longings for personal or magical closeness and for inappropriate gratifications, his struggles against the severe limits imposed by the analytic relationship, and his own search to repeat and master past pathological interactions prompt him to search for misalliances with his patients. Specific unresolved intrapsychic conflicts stirred up by a particular patient may prompt him to seek out a misalliance rather than to assist the patient in resolving his difficulties analytically. It should be noted, however, that the analyst's or therapist's responsibilities in this area differ from those of the patient. He must recognize and master a developing misalliance as quickly as possible, to prevent it from permanently impairing the therapeutic relationship and derailing the analytic work. While the patient, for his analysis to be successful, must be willing at some point to explore, analyze, and resolve his quest for misalliance with the analyst, the analyst, the analyst carries the responsibility to resolve his inner difficulties along these lines largely on his own, tacitly accepting whatever assistance the patient consciously or unconsciously offers. He should not feel unduly guilty over a misalliance that he has evoked, but should utilize his disturbed interaction as a means of understanding the patient and his own neurotic needs.

I will conclude by briefly listing the main heuristic and technical implications of the concept of the therapeutic misalliance.

1. The misalliance concept leads directly to a study of the patient-analyst interaction and its intrapsychic consequences when impairments arise in the therapeutic alliance and in the treatment situation. This is a viable alternative to the more common focus at such moments on the patient's damaged capacities, such as an inability for mature object relationships and trust (Zetzel 1958, 1966–1969). While recognizing the importance of such factors, the misalliance concept points to the frequency with which difficulties arise from shared unconscious interactions and communications.

2. The concept of therapeutic misalliance fosters use of the adaptational-interactional viewpoint, in which the intrapsychic repercussions of the actualities of the therapeutic relationship and the behaviors of the analyst are considered, along with manifestations of the effects of transference and countertransference fantasies.

The therapist's ongoing relationship with the patient, his therapeutic stance and "hold," and his projections and communications to the patient as an actual person ("object"—Loewald 1960) contribute to important incorporative identifications into the patient's self-representations and psychic structures, and create the basic background for effective interpretive work. They are as important as the capacity of the therapist to offer meaningful insights through interpretation.

3. The misalliance concept leads to a full appreciation of the importance of the patient's unconscious perceptions of the therapist, and the kernels of reality in his relationship with the therapist. It establishes them as a constituent to be added to unconscious fantasies and memories (transference) as the main determinants of the patient's reactions to the therapist or analyst, and the main basis for neurotic symptom formation.

4. The concept also leads us to recognize the vital importance of who the analyst is, and how he behaves and structures the relationship with the patient—in addition to how and what he interprets. The therapist's need and identity are conveyed in the way he uses the ground rules of therapy, in his maintenance of the boundaries of the relationship, and in his capacity to interpret rather than participate in a pathogenic interaction. These now become important focuses of therapy, rather than peripheral factors.

5. This concept leads to a recognition that the patient's intrapsychic resistances and pathogenic needs often find unconscious reinforcement in the responses of the therapist, and to a more careful study of the manner in which intrapsychic conflicts and defenses are, in general, supported by interactions with others.

6. This concept focuses on a facet of the treatment situation that must be analyzed first before other effective work can be done, and on an aspect of the therapist's interaction with the patient that must be modified, along with the intrapsychic basis on which it has developed; for true resolution to occur, words are not enough.

7. The concept helps to create a better perspective on the therapeutic relationship and the contributions of transference and countertransference (distortions) on the one hand, and nontransference and non-countertransference (reality) on the other. It leads, also, to a fuller appreciation of the pathological needs of both participants, and especially to the curative needs and capacities of both. It shows us, too, that in pathological interactions lie the seeds of growth and constructive change.

My emphasis on the patient's curative efforts toward his therapist is not intended to suggest that this dimension of their relationship should be prominent or central to therapy. The therapeutic situation is designed for the patient's needs and should center upon them; however, we should not neglect the potential for adaptive change available to the therapist at those moments (hopefully relatively infrequent) of need. I am aware that I have dealt briefly with many pertinent issues, but hope primarily that I have stimulated fresh considerations of the patient-analyst interaction and its role in impediments and progress in therapy. The spirit of this report is reflected in a quote from Freud (1937, p. 221): "Instead of an enquiry into how a cure by analysis comes about (a matter which I think has been sufficiently elucidated) the question should be asked, what are the obstacles that stand in the way of such a cure."

Notes

1. I shall use the terms *therapist* and *analyst* interchangeably here because the segment of the therapeutic relationship that I am investigating is largely (though not entirely) comparable. The clinical data that I can specifically report in this paper are drawn from analytic psychotherapy, though I have made countless comparable observations in the psychoanalytic situation as well.

2. For a variety of reasons, I have made the decision to not use material from my own clinical practice, past and present, in any of my writings. In part, this decision has derived from the observation that such use of one's therapeutic or analytic work entails serious risk of misalliance with the patient (see also Langs 1975b).

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