The Working Alliance in Psychotherapy: Risk, Criticism and Perspectives in the Italian Context

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This paper investigates which factors inherent to the various forms of psychotherapy are conducive to success and which are not. Particular emphasis is placed on the role of communication between the therapist and the patient, with specific regard to the outcome of treatment. The habitual practices and main problems facing healthcare professionals with regard to information and consent to psychotherapy are analysed in the context of the results of some recent studies of outcomes and processes which support the notion that the factors most frequently associated with successful psychotherapy are cooperation, proper information and a shared commitment to achieving the objectives of treatment.

Key words: confidentiality; consent; ethics; malpractice risks; psychotherapist responsibilities; psychotherapy; working alliance.

1. Areas of Risk in the Therapeutic Relationship

The issue of the risks connected with the practice of psychotherapy and their possible legal consequences is a thorny one which has not yet been fully explored. In general, in regard to the issue of the psychotherapist's legal responsibility, claims for damages account in Italy for only a small portion of lawsuits in the medical and healthcare setting.¹ Nevertheless, there are specific issues in the psychiatric field which have come under the courts' scrutiny. One example concerns unauthorized practice of the profession and the difficulty of establishing unequivocal and agreed-upon boundaries between therapy and activities of support, accompaniment and counselling, not least in view of the multiplicity of training courses currently available and the variety of those authorized to treat mental disorders.² Other

examples concern potential mental conditioning and interference in the interests and affairs of the patient by the therapist. Indeed, accusations of exploitation and manipulation of incapacitated persons and fraud are not rare.³

A great deal of attention has also been focused on questions of abuse of trust owing to the failure of therapists to respect the reciprocal roles and the setting involved, particularly in cases of affective relationships with a sexual content. The Italian jurisprudence on this issue has consistently upheld specific hypotheses of unlawful behaviour, in light of the nature of the therapeutic relationship (trust, fragility, passivity of the patient and power of the therapist), which is comparable to the relationship between a guardian and an incapable person.

In the sphere of psychotherapy, moreover, the debate is still open whenever such

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situations arise after the professional relationship has been terminated. Indeed, does the patient remain the patient forever, or does the termination of treatment free the therapist from previous constraints? In addition, there is a general consensus regarding the importance of the procedures of supervision as useful tools for preventing and managing such eventualities, too (Pope, Keith-Spiegel, & Tabachnick, 2006).

Other amply-investigated issues pertain to professional confidentiality, the boundaries of which are particularly delicate and uncertain, not only because of the confidential nature of the patient's revelations but also because the clinician may have access to personal, intimate and profound information of which the patient might not yet be fully aware (Calvi & Gulotta, 2012; Jourdan & Fornari, 2006). Moreover, specific problems arise with regard to the difficult balance between the patient's right to confidentiality and the protective role that is conferred by law upon those who work within the sphere of mental health, particularly with reference to the possibility of preventing/containing behaviours that are harmful to the patient or to others.⁴

The general principle is that the therapist can make use of information received from the patient exclusively for the benefit of the patient himself or herself, and without communicating such information to third parties. Clearly, however, public-interest considerations may conflict with the therapist's duty to remain silent. In this regard, several questions arise: to what extent can the therapist really foresee behaviours that are harmful to the self or others? What means does the therapist have to prevent such behaviours? When in doubt, should the therapist intervene at all costs – and, if so, in what ways (Catanesi & Carabellese, 2011; Vallini, 2013)? All of these questions imply the need to listen carefully and consistently to the patient and to develop genuine understanding. They also underline the profound solitude of the therapist when faced with the patient's revelations

and the choice of what action to take (Fiori & Buzzi, 2008; Pellegrini, 2010).⁵

In recent times, attention has turned to the need for psychotherapy, just like any other professional intervention that involves significant interference in the private and family life of persons who suffer, to fulfil the requirements of legitimacy, validity, efficacy, formal and methodological rigour, respect for the patient, proper training, adequate skills, and adherence to shared ethical principles and values (Migone, 2011; Ruggeri & Tansella, 2011).

Certain questions therefore arise: does psychotherapy have intrinsic risks? How great an influence may the psychotherapist have in maintaining or activating pathological dynamics during the treatment process? What factors are associated with a good outcome of treatment, and what are the prejudicial factors? How far does adequate information impact on the success of the treatment? These are complex questions – or rather, dimensions – each of which has its own specificity. Moreover, each should be tackled scientifically, within the sphere of research but with constant reference to clinical practice.

In reality, scientific bases and methodological protocols have already taken on an important role, both on account of the progress that therapies of this kind have made and because such therapies have been recognized in a context in which the individual's right to seek health care has to come to terms with dwindling healthcare resources.

Recent data from studies of outcome (the final results of treatment) and process (concerning all phases of the therapeutic pathway and the changes that occur in each phase) have been made available by the American Psychological Association (APA). The consensus that emerges from these data is that collaboration, proper information and a shared commitment to achieving the objectives of the treatment are the factors most frequently associated with the success of the

intervention itself (Brownawell & Kelley, 2011).

2. The Risks Connected with Information and the Issue of Consent in Psychotherapy

For a long time, psychotherapy seemed to be exempt from the requirement of so-called ‘informed consent’ on the grounds that this type of treatment was presumed to be non-invasive. This conviction stemmed from a failure to recognize the transformational power of words, as opposed to the incisiveness of surgical instruments and pharmacological medications. It is a cultural prejudice which has now been overcome, at least in part, as a result of studies dealing with the influence of psychotherapy to reorganize an individual’s neurological structures (Beauregard, 2009; Potenza, Sofuoglu, Carroll, & Rounsaville, 2011).

Informed consent is a prerequisite of diagnostic-therapeutic intervention in all areas of healthcare. As such, it is specifically regulated in the Deontological Code of Physicians and Psychologists (as well as the primary sources of law). Critics of informed consent, however, point out that it has a ‘defensive’ connotation. Indeed, while it is intended to be both a means of promoting an active role in the patient and a preliminary condition that legitimizes therapeutic intervention, it may taint the sense of a relationship that is developed progressively once work is underway – a relationship based on ‘coming together’, empathy, understanding and welcoming. In other words, introducing norms (with all their corollaries) into patient–therapist relations could divert the sense of a relationship towards bureaucracy and abstract formalism.

In the case of psychotherapy, a range of information must be provided, including: the reasons, objectives and modalities of the treatment; the characteristics of professional confidentiality and its limits; the methodology, or the chosen therapeutic approach; the

features of the treatment in terms of the cost–benefit ratio; any other psychotherapeutic techniques available or alternative therapeutic measures; the probabilities of success, failure, and complications; the appropriateness of integrating pharmacological and rehabilitative therapies that have complementary purposes; and prognosis. Moreover, in the psychotherapy setting, the provision of information is particularly delicate given the potential vulnerability of the patient and the risk of triggering mechanisms of suggestion. Nevertheless, the patient cannot be denied the right to know what the treatment consists of and why it should be undertaken.

Clearly, the duty to provide ‘the most suitable information’ constitutes a critical node that is essential to the elaboration of the patient’s free choice. Indeed, today doctors can no longer avail themselves of the so-called ‘therapeutic privilege’ enshrined in the Medical Deontological Code (MDC) of 1995 – now reformulated (MDC of 2014) – whereby information to the patient may be limited to those elements which the patient’s culture and psychological condition are able to accept (Molinelli et al., 2009; Battistuzzi et al., 2012).

By contrast, the Deontological Code of Psychologists (art. 25) identifies the parameter of the *psychological safeguard* of patients as the essential reference point that guides therapists in modulating the communication of the results of their diagnostic interventions and assessments in order to favour the positive mobilization of the patient’s resources (PDC, 2009). In this regard, it has been pointed out that communicating all the investigative elements connected with the therapeutic pathway could, in itself, compromise not only the unfolding of the relationship but also the very initiation of the therapeutic project (Borgna, 2012). Indeed, there is no doubt that providing the patient with detailed information on his or her psychological disorder can, in some cases at least, have deleterious effects. Doing so may elicit excessive emotive reactions, put off the patient from

engaging in any form of therapy, condition the patient negatively, or even instil in his or her mind a picture of illness (with all its therapeutic and prognostic corollaries); in the final analysis, it may create therapeutic distortions that could even constitute iatrogenic damage. (PDC, 2009).

From the above considerations, it emerges that the patient's participation in the treatment plan is essential. This participation, which must necessarily – especially in psychotherapy – be gradual and diachronic takes place within a process of the progressive acquisition of 'skill', the capacity for self-determination and awareness. In this regard, Mordini (1997) claims that consent to psychotherapy is truly informed not when the patient shares all the information in the therapist's possession but when the patient is properly informed (and in a manner that is comprehensible to him or her) of the reference psychological model in the specific case.

An even more critical aspect is the possible dissent of the patient wherein refusal might be interpreted not as a fully conscious choice but as resistance to the therapy. In such situations, the so-called *Ulysses Contract* may be invoked. In the sphere of those psychiatric illnesses that are characterized by phases of remission and relapse, in which moments of derangement alternate with periods of greater equilibrium, this instrument can be used to predetermine the patient's will to undergo treatment during those phases in which their decisional competence is absent.

This possibility – the juridical validity of which is debated and, at the same time, supported by the measure of legal guardianship as a tool to support the personal autonomy – clearly has a certain efficacy. Indeed, it enables the parties involved to negotiate (and in principle to agree upon in advance) treatment modalities and even forced and incisive interventions; in this way, it can reduce the subsequent onset of perceptions of persecution, intrusion or betrayal, which are extremely dangerous to the maintenance of the therapeutic alliance.

3. Risk Factors and Efficacy in Psychotherapy: The Working Alliance

Recent research based on meta-analyses of the outcomes of psychotherapy has confirmed that the most important factor in determining the success of psychotherapy is the relationship of respect, trust and collaboration which may (or may not) be built up between the patient and the therapist, regardless of the therapist's theoretical orientation (Norcross, 2011). Specifically, it appears that certain factors (the techniques adopted) account for only 15% of the total influence on the outcome of treatment, while non-specific factors (those variables present in all forms of treatment which do not depend directly on the theories and techniques utilized) account for 40% of the outcome (Norcross & Lambert, 2011).

Among these non-specific factors, the working alliance is regarded as fundamental; while it is not, in itself, curative, it seems to be essential to conditioning the outcome of therapy. This is not to say that clinicians should not focus on learning and improving specific techniques; rather, it means that, in doing so, they must remember that developing and maintaining a good relationship (and a good alliance) with the patient is essential to creating the context in which such techniques can be applied efficaciously (Horvath, Del Re, Flückiger, & Symonds 2011; Norcross & Lambert, 2011; Norcross & Wampold, 2011).

Moreover, research has shown that efficacious psychotherapy yields better and longer-lasting results than pharmacological treatment alone. In particular, psychotherapy appears to be able to reduce the number of relapses, especially in the treatment of anxiety and mild or moderate depression, to a greater degree than drugs alone. Indeed, the Norwegian health authorities have issued new guidelines (and others are being prepared by the American Psychological Association) for the treatment of these disorders, recommending that psychological support should take priority over pharmacological treatment (Brownawell & Kelley, 2011).

External factors include the patient's own self-healing capacity, the presence of a positive social-support network and the concomitant occurrence of improvements in the patient's life conditions. By contrast, therapeutic techniques contribute to the positive evolution of the treatment pathway to a far lesser degree (15%), their contribution being comparable to that of factors of a suggestive nature (15%) (Norcross & Lambert, 2011).

Finally, it emerges that therapeutic success depends to the greatest degree (30%) on factors connected with the nature of the interpersonal relationship and the working alliance forged between therapist and patient, which requires empathy, acceptance, careful listening to the patient's experiences, collaboration and flexibility. Appropriately, research distinguishes the objective-centred working alliance – which contributes to the success of therapy – from factors that negatively impact on therapy outcomes such as an unchallenged endorsement of the patient's experiences, collusion between therapist and patient, and underestimating or trivializing the patient's problems (Norcross & Lambert, 2011).

The working alliance is a process of ongoing, dynamic inter-subject negotiation that involves both break-ups and reconciliations. Its introduction into clinical practice seems to have considerable repercussions (Auchincloss, 2016). Indeed, it could be claimed that the process which leads to tackling and solving problems within the alliance (whether they concern treatment aims, the means of achieving those aims, or the patient-therapist relationship) is not so much a requisite for change as the very essence of the therapeutic process. In this regard, recent research has demonstrated that the dialectic of the processes of break-up and reconciliation and the ability to overcome seemingly insurmountable obstacles are important factors in any model of clinical intervention that may be adopted (Lingiardi, Colli, Gentile, & Tanzilli, 2011).

Treatment pathways characterized by periodic break-ups and reconciliations seem to be those which yield better outcomes (Stiles,

Osatuke, Click, & MacKay, 2004). This finding runs counter – and perhaps not by chance – to the 'fluid' scenario of life that is typical of contemporary society, and which through the liquefaction and blurring of behaviours, roles, bonds and *connections*, feeds boundary disorders, uncertainty, a sense of emptiness and existential anguish. Thus, it is only the 'human relationship' which, through that heroic act described by Bauman in his text on 'fluid' love, can restore the ability to symbolize, to be sorry and to repair (Bauman, 2006). As in society, so in clinical practice.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Notes

1. Cf. Andamento e Costo del Contenzioso a Livello Nazionale, Medmal Claims Analysis, (4th edition) in: http://www.sanita.ilsole24ore.com/pdf2010/Sanita2/_Oggetti_Correlati/Documenti/Regioni-e-Aziende/MEDMAL%20CLAIMS%20ANALYSIS%20DATI%20OK.pdf
2. See, for example, Penal Supreme Court Sect. VI, Decision, (hearing 23-03-2011) 11-04-2011, n. 14408, which recognizes psychoanalysis as a veritable psychotherapeutic activity that, as such, requires regular enrolment on the Register of Psychotherapists. This decision has been criticized both on the grounds that it does not distinguish between psychoanalysis (as a theory) and analytical psychotherapy and because of its somewhat debatable assertion that the conversational method is a 'veritable form of therapy and a typical act of the medical profession'; indeed, this would make the professional practice of such an activity problematic even for the psychotherapist-psychologist. Cf. also Penal Supreme Court Sect. VI, 15 May 2013, n. 23843.
3. For a discussion of this issue, see Giacomo Pestelli, Diritto penale e manipolazione mentale: tra vecchi problemi e prospettive de jure condendo, in Riv. it. dir. e proc. pen. 2009, 03, 1274; Cassazione penale, sez. II, 7 gennaio 2011, n. 4183.
4. On this issue, see Cass. Pen., sez. IV, 12 February 2013, n. 16975; V. sez. 4, sentenza n. 48292 del 27.11.2008, Rv. 242390. Cf. also:

- Giandomenico Dodaro, La posizione di garanzia degli operatori psichiatrici. Giurisprudenza e clinica a confronto, Franco Angeli, 2011.
5. In Italy, this issue (regulated both by the Deontological Code of Psychologists and by that of Physicians) pertains to public law, in that the Penal Code (art. 622) classifies as unlawful the violation of professional confidentiality, thereby reaffirming the social relevance of the citizen's right to confidentiality in all that concerns the intimate sphere of the person. However, its citation of 'just cause' of revelation also leaves room for interpretation.
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