The flip side of collaborative alliance: a single-case study

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ABSTRACT

The present single case study explored whether a positive collaboration may conceal some of the patient's dysfunctional interpersonal schemas, hence reflecting a *non-authentic* collaboration. In particular, we reasoned that conceiving collaborations only as adaptive relations may prevent a comprehensive insight of the therapeutic relationship itself. To explore this possibility, we used an intersubjective approach that emphasizes the integration of specific and non-specific factors in an interdependent way. In particular, we assessed different constructs (*i.e.* therapeutic alliance, technical interventions, defense mechanism, therapeutic relationship) of the therapeutic process and combined them through statistical methods able to investigate the micro- and macro-analytic processes that define each interaction. Results of a single case study (Sara) showed that the collaborative functioning may hold back many critical aspects, that hardly conciliate with the classic positive definition of collaboration. These findings, therefore, indicate that Sara's collaborative alliance works mainly as a *pseudo-alliance*.

Key words: Therapeutic alliance; Psychodynamic therapy; Psychotherapy relationship; Psychotherapy process; Defense mechanism.

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See online Appendix for additional Tables.

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Introduction

Subsequently the *Dodo Bird Verdict*, therapeutic alliance became the nonspecific factor most investigated in psychotherapy research, also because it was identified as the nonspecific factor able to explain most of the variance of treatment outcomes (Horvath & Luborsky, 1993). In this phase, many researchers investigated the relationship between therapeutic alliance and therapy outcome and confirmed this association (Horvath & Symonds, 1991) in terms of clinical, relational and functional change (Castonguay, Constantino, & Holtforth 2006; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). These studies took into consideration several variables (*i.e.*, perspective of evaluation, the time of evaluation and therapy orientation) and demonstrated that therapeutic alliance is the only variable that remains a stable predictor of the treatment outcome across treatment methods. These results showed the importance of focusing on the effects of personal and interpersonal interaction variables on outcome (Horvath & Bedi, 2002).

This empirical suggestion matched the exponential trend toward a relational reconsideration of psychoanalysis, the Relational Turn (Greenberg & Mitchell, 1983), an integrative movement in which different perspectives, ranged from psychoanalytic theory to infant research (Benjamin, 1990; Beebe & Lachmann, 2002; Sander, 1977; Stern, 1985; Stern et al., 1998). This perspective has drastically influenced the definition of therapeutic process now intended as a specific psychological field created by the interplay between the patient and therapist's subjectivities (Stolorow, Brandchaft & Atwood, 2014).

Consistently, compelling literature focused on the study of the interpersonal perspective (Henry & Strupp, 1994), as a more complete approach able to define the broad construct of therapeutic alliance. On these grounds, therapeutic alliance has been defined as an interactive process between patient and clinician, based on their ability to create a respectful and cooperative bond (Bordin, 1994). This formulation harks back to the modern pantheoretical reconceptualization of the therapeutic alliance (Bordin, 1980; Hatcher, Barends, Hansel, & Gutfreund, 1995; Luborsky, 1976). Indeed, in contrast to classic formulations that emphasized either therapist's contributions to the relationship (Rogers & Wood, 1974) or the unconscious distortions of the relation between the therapist and the client (Freud, 1958), the new alliance construct emphasizes the conscious aspects of the relationship and the attainment of concerted *work together* aspects of the relationship (Horvath et al., 2011). This recent definition, thus, identifies therapeutic alliance as a relationship, with an active cooperation between clinician and patient, who would both work on tasks that are strictly interconnected with a shared goal.

Such approach reflects more generally the vigorous development of relational perspective in psychoanalytic theory (Aron, 1996; Benjamin, 1990; Mitchell, 1993). In line with this, Safran and Muran (2003) refined the concept of alliance by drifting from the construct of *agreement* to *negotiation*. More specifically, they proposed that alliance is a negotiation between therapist and patient: under this view, alliance is not a static variable necessary to establish an effective intervention, but rather a constantly shifting, emergent property of the therapeutic relationship (Safran & Muran, 2003, 2006). In other words, therapeutic alliance is regarded as an intersubjective negotiation, rather than a mere collaboration. Notably, alliance would develop in a continuum of ruptures and resolutions, which would shape and delineate patient-therapist interactions (Safran & Muran, 2006).

Within this theoretical framework, ruptures are conceived as patient's behaviors or communications that represent critical points during the therapy; in fact, ruptures often emerge when the therapist unconsciously participates in a maladaptive interpersonal cycle that resembles the patient's dysfunctional interpersonal schemas (Safran, 1990a, 1990b). More specifically, an alliance rupture can be defined as *a breakdown in the collaborative process between therapist and patient, a poor quality of therapist-patient relatedness, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset* (Safran & Muran, 2006, p. 288). One of the innovative aspects of this conceptualization is the positive role of this relational moment in the psychotherapy context, because it can be conceived as an opportunity offered to the clinician to improve her/his understanding of client's world and, eventually, to promote therapeutic change. From this point of view, each rupture or disagreement on the shared task, goal or bond is not considered as a drawback anymore, rather as a starting point that might promote a new awareness of the client (Lingiardi, 2002). In addition, Benjamin (2009) considered ruptures as a breakdown of the process of mutual recognition and an opportunity to restore the intersubjective space. In such a dynamic, the active role of the therapist would not be sufficient to achieve the resolution process (Safran & Muran, 2003). Indeed, an active role of the patient would be also paramount. Thereof, understanding this maladaptive dynamic would allow a better comprehension of patient's representations of self-other interactions.

However, although ruptures can be identified as a key aspect in the understanding of the therapeutic process, collaborations might be informative as well. In fact, patient's collaboration has been defined as the extent to which the patient is bringing in significant issues and making good use of the therapist's efforts (Allen, Newsom, Gabbard & Coyne, 1984) or as *the patient's capacity to self-disclose intimate and salient information, to self-observe one's reactions, to explore contributions to problems, to experience emotions in a modulated fashion, to work actively with the therapist's comments, to deepen the exploration of salient themes* (Gaston & Marmar, 1994, p. 89). Similarly, Hatcher (1999) conceptualized collaboration as a joint achievement of the therapeutic dyad, an emergent feature that relies on both patient and therapist contributions.

Most alliance measures strongly focus on the degree of felt collaboration among the members of the dyad. In terms of in-therapy behaviors, it is common to observe that patient and therapist exchanges build upon each other's verbal contributions.

Brossart and colleagues demonstrated significant therapist influence on the alliance, at both short and medium term, whereas no patient influence was reported (Brossart, Willson, Patton, Kivlighan, & Multon, 1998). At the same time, Chen and Bernstein (2000) found evidence that complementary interactions between supervisor and trainee result in better alliance and better outcome. In another study, the alleged impact of collaborative activity was demonstrated by means of time series analysis of therapist-patient interaction (Kowalik Schiepek, Kumpf, Roberts, & Elbert, 1997). A recent review on therapeutic collaboration by Lepper and Mergenthaler (2007), suggested that the processes of coordination (Westerman, 1998) or complementarity (Tracey, 1993) are characterized by a specific quality of communicative action, particularly valuable at the clinical level. Together, these studies provide preliminary evidence linking collaboration and cooperation to better alliance and positive outcome.

Overall, these studies point to collaboration as another fundamental relational aspect in the understanding of the therapeutic process, along with ruptures. Whereas ruptures have been conceived as maladaptive interpersonal cycles, collaborations have been often conceived as adaptive cycles that would represent crucial opportunities for positive interactions.

Yet, in some specific cases, conceiving collaborations as uniquely positive may prevent a comprehensive insight on the therapeutic relationship, with this positive characterization that might represent only one side of the coin. Indeed, it is reasonable to hypothesize the existence of a flip side of collaboration that conceals some of the patient's dysfunctional interpersonal schemas. On these grounds, in the present single case we explored whether positive collaboration may even turn out to be negative. More specifically, we systematically addressed the relational meaning of collaborative alliance, and whether this specific type of alliance might be characterized by negative aspects, thus reflecting a non-authentic collaboration.

To better explore the quality of therapeutic collaboration, we used an intersubjective approach, by considering the integration of specific and non-specific factors in an interdependent way. In particular, we assessed different constructs of the therapeutic process and combined them through statistical methods able to investigate the micro and macro analytic processes that define each interaction (Locati, Rossi, & Parolin, 2017).

Methods

To explore the clinical and relational meaning of collaboration, we chose as a clinical case a patient that is typically defined as a *good patient* (Shapiro, 1965), characterized by a deferential behavior previously investigated in a single-case study (Locati, De Carli, Tarasconi, Lang, & Parolin, 2016). More specifically, these patients are mark out by high levels of compliance with therapists (Weiner & Bornstein, 2009), and avoid any real connection with their own feelings, by mostly adopting obsessive and neurotic defenses that keep away emotions from awareness. In this scenario, thus, mature defenses can be conceived as an obstacle to a real insight (McWilliams, 2011).

We conducted a mixed qualitative/quantitative study focused on the psychotherapy process in the first two years of treatment.

Patient

Sara is a 33-year-old lawyer. She came to therapy complaining about anxiety symptoms, insomnia and fear of losing control.

The psychological assessment, composed of Wechsler Adult Intelligence Scale – Revised (WAIS-R, Wechsler, 1981), Rorschach Test (Exner, 1993) and The Blacky Pictures Test (Blum, 1950), revealed that Sara has a high cognitive functioning level and a rigid thinking. This functioning is characterized by hypervigilance and emotional coarctation. The clinician believed that Sara's emotions are often replaced by anxiety states.

Sara was diagnosed with an Anxiety Disorder Not Otherwise Specified (ADNOS, American Psychiatric Association, 2000), and a neurotic personality organization with a rumination attitude.

Before starting the treatment, Sara gave her consent to audio-record the clinical sessions and to use them to research purposes. The patient was informed about the scientific publication on the treatment process, prior to de-identification of all sensitive information.

Therapist

Sara is actually undergoing a weekly psychodynamic therapy with an expert clinician. Dr. L. is a female 65-year-old clinical psychotherapist, with 35 years of clinical experience. She identifies herself as a psychodynamic oriented therapist.

Measures

Process measure

In the present study we used different instruments that were applied on 63 transcripts of the therapeutic sessions (24 months of treatment).

First, we applied the *Collaborative Interactions Scale* (CIS; Colli & Lingiardi, 2009) to measure therapeutic alliance. This is a transcript-based method, built on Safran and Muran (Safran & Muran, 2006) conceptualization of therapeutic alliance, structured into two main scales: a first one for the evaluation of patient's contributions to the process (CIS-P) and a second one for the therapist's contributions (CIS-T). The CIS-P is composed by three subscales evaluating patients' positive and negative contributions: the Collaborative Processes scale, the Direct Rupture Markers scale, and the Indirect Rupture Markers scale. Similarly, the CIS-T is composed of two subscales evaluating therapists' contributions to the psychotherapeutic process: the Positive Interventions scale and the Negative Interventions scale.

Second, in order to identify the interactive pattern, we introduced two different instruments to assess therapist interventions and defense mechanisms. *The Psychodynamic Intervention Rating Scale* (PIRS) developed by Cooper e Bond (1992) is a transcript-based tool aimed to categorize the technical interventions of the therapist. Interventions are divided into two scales: Interpretative Interventions Scale (defense interpretations, transference interpretations) and Noninterpretative Interventions Scale (questions, clarifications, associations, reflections, support strategies, work-enhancing statement, contractual arrangement, acknowledgments).

Third, *The Defense Mechanism Rating Scales* (DMRS, Perry, 1990; Perry & Henry, 2004) was used to assess defense mechanisms. The DMRS defenses are comparable to those listed by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). This instrument describes 30 defense mechanisms assigned to seven hierarchical levels of defensive functioning: high adaptive (mature), obses-

sional, other neurotic, minor image-distorting, disavowal, major image-distorting, and action defenses. We adopted the DMRS quantitative scoring to compute the Overall Defensive Functioning scores (ODF), used as an outcome measure of the therapy.

Fourth, the therapeutic alliance was then compared with the *Psychotherapy Process Q-set* (PQS; Jones, 2000), in order to identify the specific interaction structure between patient and therapist. PQS is a Q-sort methodology made of 100 items. PQS statements cover a wide range of several dimensions of the psychotherapy process, including both relational and technical aspects. Moreover, PQS contains items that separately describe patient's contributions to the psychotherapy process (*e.g.*, Q97 Patient is introspective, readily explores inner thoughts and feelings), therapist's contributions (*e.g.*, Q50 Therapist draws attention to feelings regarded by the patient as unacceptable, such as anger, envy, or excitement), and patient/therapist interactions (*e.g.*, Q39 There is a competitive quality to the relationship).

Outcome measure

The Shedler-Westen Assessment Procedure-200 (SWAP-200, Westen & Shedler, 1999) is a Q-sort instrument designed to assess personality disorders. It is composed of 200 personality-descriptive items. A rater arranges the items into eight categories, following a fixed distribution. Thus, the procedure yields a numeric score from 0 (not descriptive) to 7 (most descriptive) for each of the 200 items. The resulting ordering of the items is then compared with 12 personality prototypes representing each DSM Axis II personality disorders, to establish the degree of match. The resulting SWAP descriptions were averaged to define a single prototype, representing the core clinical agreement on the features of each personality disorder (Westen & Shedler, 1999).

Aims and hypotheses

Three main aims guided the present study.

First, in order to explore the positive and negative quality of collaborative alliance, our first aim was to identify different patterns of defense mechanisms and technical interventions that characterize the presence of high collaborative levels of alliance during the therapy. Given the maladaptive meaning of the collaborative alliance in this kind of patient, we expected different kinds of defense mechanisms to be activated, from mature to primitive defense levels. This was achieved by two main steps: i) as a first step, we used sequential analysis (data analysis was done using the program GSeq 5.1; Bakeman & Quera, 1995) to identify defense and interventions variables co-occurring with collaborative alliance; ii) subsequently, we explored the trend of collaborative alliance over time, by means of time series analysis.

Second, we aimed to verify whether the patients' relational functioning, even if characterized by collaborative alliance, has a negative meaning. To address this possibility, we studied the association between the measure of collaborative alliance with an external criterion, in order to shed lights on the quality of the relationship between the therapist and the patient (PQS). We hypothesized to find a correspondence between collaborative alliance and negative interaction structures. This second aim was achieved by two further steps: i) we we extracted some PQS factors, by means of Principal Component Analysis; ii) we explored the trend of PQS and CIS variables over time, comparing positive alliance with the PSQ factor, by means of time series analysis.

Finally, we hypothesized to find significant changes during the therapy. This was achieved by two additional steps: i) we compared the SWAP-200 profile in the initial phase of the therapy with the one in the last phase; ii) we analyzed defense mechanism (ODF) trend across therapy, by means of autoregressive integrated moving average (ARIMA) model.

Procedure and statistical analysis

Two experienced judges blindly rated the transcripts of every therapy sessions with DMRS and PQS. Results showed a good inter-rater reliability (mean Cohen's K for DMRS=.79 and for PQS=.87). Two other judges rated all every session with PIRS and found a good agreement (mean Cohen's K=.85). After coding, the judges discussed the case and the scores to reach a complete agreement. Each of two other independent raters evaluated the SWAP profiles of the patient at the beginning pre and post treatment. The first evaluation was based on the transcripts of the first five sessions, while the second one on the last five sessions.

To test the first hypothesis, we built an empirically derived operationalization of the *Positive Alliance*, through a Sequential Analysis performed with the Generalized Sequential Querier program (GSeq5.1; Bakeman & Quera, 1995). This allowed us to test the co-occurrence of collaborative markers with specific therapist's interventions and patient's defensive processes. The choice not to add any lag analysis is due to the CIS coding instructions that forced coders to consider therapeutic interventions as an antecedent of patient's conversational turn. In this way, each discourse unit (and lag 0 of sequential analysis) is made by a therapist's intervention connected to subsequent patient's speech. All categories with less than 5 occurrences were eliminated prior to the analysis. The positive cycle collaboration measure (sum of highly collaborative categories) was tested to investigate its tendency during treatment with an ARIMA model.

Then, in order to test the second group of hypotheses, we followed the procedure explained by Jones, Ghannam, Nigg, and Dyer (1993): we performed a Principal Component Analysis (PCA) on the PQS ratings of each of the treatment hours (N=63) to identify some dimensions of the therapy process. In this way, we could test the effect

of different interpersonal structures (PQS factors) on our measure of collaboration (representing the positive cycle) using five different ARIMA models.

We used the SWAP assessment as outcome measure: we reported pre-post personality scores and tested the Reliable Change Index (Jacobson & Truax, 1991) for each of them. Finally, we tested the ARIMA model to analyze defense mechanism trend during the first 24 months of the therapy.

Results

Process measures

Sequential analysis determines the probability of occurrence of a given behavior together with the occurrence of a target behavior, hence no causality effects are implied. Defenses Mechanisms and Therapeutic Alliance showed a significant association (χ^2 (28)=1611.58, P<.01) and the significant co-occurrences are presented in Appendix Table 1. Positive collaborations are characterized by the presence of Self-Observation, Suppression, Isolation of Affect, Intellectualization, Undoing, Repression, Displacement, Devaluation, Projection, Rationalization, Passive Aggression, and by less likely absence of defensive mechanisms. Appendix Table 2 shows the significant co-occurrences between Therapeutic Interventions and Therapeutic Alliance (χ^2 (16)=978.24, P<.01). Positive collaboration is likely to be positively associated with Acknowledgments and negatively with Defensive Interpretation, Contractual Arrangements, Support Strategies and Associations.

The trend of positive collaboration, measured by CIS was tested with an ARIMA (2,0,0) model that showed no significant change during therapy, *b*=0.25, *SE*=0.22, *t*(62)=1.13, P=.26. Visual inspection of the data suggested the presence of two different moments of positive collaboration, with an abrupt change between the 37 and the 38 sessions. An ARIMA (1,0,0) model with a dummy variable (coded as 1 until session 37, and as 1 from session 38) confirmed this significant change, *b*=15.15, *SE*=5.04, *t*(62)=3.00, P=.004. In particular, results indicated that whereas the positive collaboration was higher until session 37, it turned out to be lower from session 38.

The PCA yielded five factors after varimax rotation, able to account for 37% of variance (the most descriptive items for each factor are listed in Appendix Table 3). Factor 1, labelled *Empathic and Authentic Relationship*, describes the empathic effort of the therapist in understanding the emotional states of the patient, encouraging her description of emotions and conveying a sense of nonjudgmental acceptance. The patient is active and looks for therapist affection. Factor 2, labeled *Asynchronous Relationship*, represents a dimension of distance between patient and therapist, where the two of them seem to go in different directions. The patient tests the boundaries of therapy and the therapist moves toward the patient, although without any real empathic comprehension or supportive role. Factor 3, labeled *Toward the insight*, shows a patient struggling with feelings but able to explore her own emotions, helped by the active role of the therapist who actively exerts control over the interaction. Factor 4, labeled *The good therapy*, describes a dimension of high collaborative stance, where both patient and therapist are successfully focused on the task. Factor 5, labeled *Life outside the room*, describes the collusion of patient and therapist in avoiding the painful feeling of the patient focusing on specific activities and individuals outside the therapeutic session. The smoothed values of the factorial scores are presented in Figure 1.

The effects of the PQS factors on the positive collaboration measure was tested using five different ARIMA models, shown in Appendix Table 4. A significant negative association was found for Factor 1 and 5, while a positive association was found for Factor 4. The smoothed raw scores of positive collaboration and Factor 1, Factor 4 and Factor 5 are presented in Figure 2, Figure 3 and Figure 4, respectively.

Outcome measure

Results of the pre/post SWAP assessment are shown in Figure 5. There was no change in personality scores, as revealed by the Reliable Change Index (Jacobson & Truax, 1991).

A process variable that can be useful in understanding patient's change during therapy is the ODF calculated on the DMRS scores. We computed an ARIMA (0,0,0) model on the ODF to assess linear change, and we found a significant positive effect across time, *b*=0.005 SE=0.002, *t*=2.30, P=.02.

Discussion

The present study aimed to explore the therapeutic process from an intersubjective perspective, by considering multiple points of observation. Such approach, in fact, may allow a better understanding of patients' psychological functioning, along with a deeper comprehension of the clinical reality of the therapeutic process. This, in turn, may unveil the flip side of collaborative alliance, that has been traditionally considered only with its positive connotation. Results of a single case study indicated that the critical features of therapeutic alliance can be better understood by focusing on the interactions between patient alliance, defenses and relationship dynamics. Notably, within such complex scenario, the present findings pointed out that collaborative alliance does not always correspond to positive relationship.

According to clinical literature descriptions (Lorenzini & Sassaroli, 2000; McWilliams, 2011), indeed, Sara can be conceived as a compliant and collaborative patient. As hypothesized, however, this represents just one side of the

coin. Indeed, this functioning holds back many critical aspects that hardly conciliate with the classic positive definition of collaboration.

First, sequential analysis described the interactive characteristics of the collaborative functioning during the therapy. On the one hand, high levels of collaboration are uniquely elicited by one specific therapist intervention: Acknowledgments. This finding suggests that the collabora-

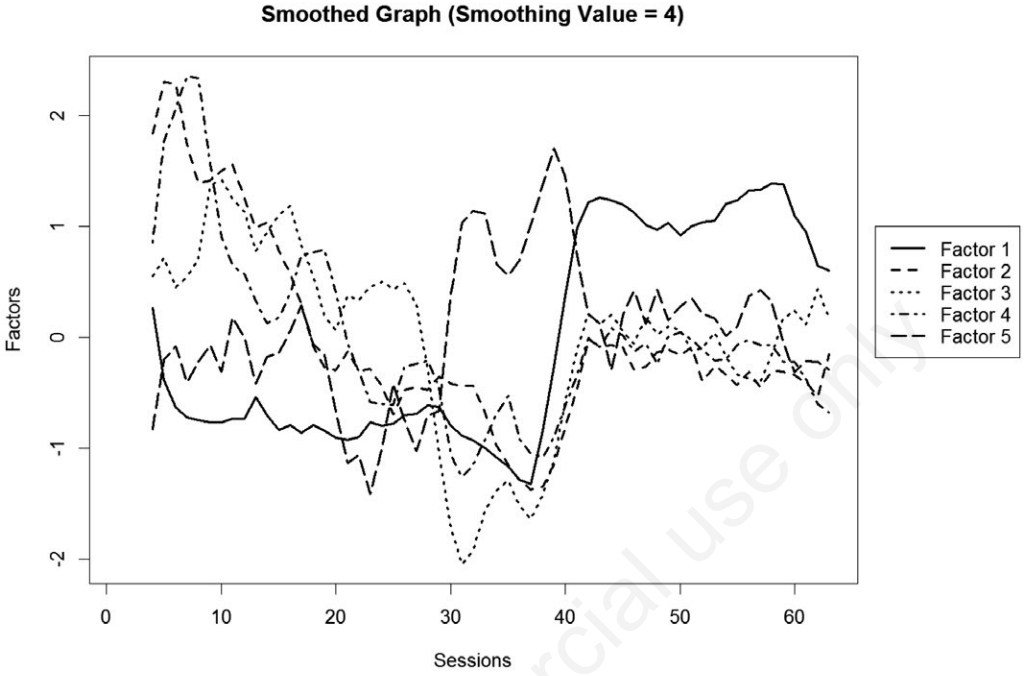

Figure 1. The smoothed raw scores of the five Psychotherapy Process Q-set factors in the 63 sessions of therapy. In particular, Factor 1 was labeled as *Empathic and Authentic Relationship*, Factor 2 as *Asynchronous Relationship*, Factor 3 as *Toward the insight*, Factor 4 as *The good therapy*, and Factor 5 as *Life outside the room*.

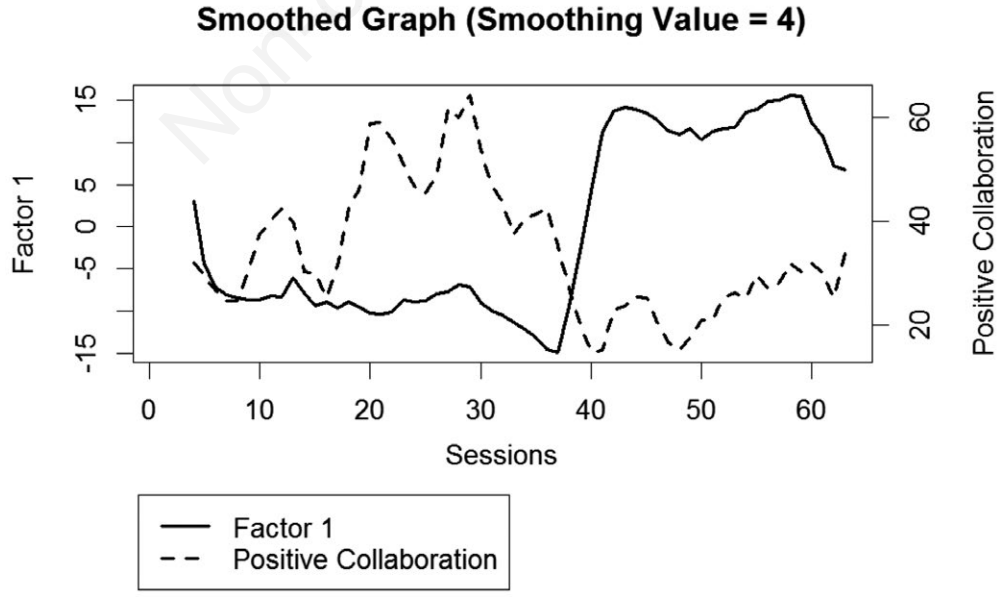

Figure 2. The negative association between the Psychotherapy Process Q-set Factor 1 (Empathic and Authentic Relationship) and the positive collaboration (Collaborative Interactions Scale Positive Collaboration), tested by the autoregressive integrated moving average model, in the 63 sessions of therapy.

tive alliance is reinforced by soft interventions, which encourage Sara's elaboration and allow her to enhance the intimacy of the conversation. On the other hand, this level of alliance is associated with the activation of several defensive mechanisms, such as Self-Observation, Suppression, Isolation of Affect, Intellectualization, Undoing, Repression, Displacement, Devaluation, Projection, Rationalization, Passive Aggression. This pattern indicates that the increasing of the quality of alliance is linked to the activation of different types of defense mechanisms, located at both mature and primitive levels. Such an *uncommon* dynamic, not only led us to be suspicious about Sara's authentic and

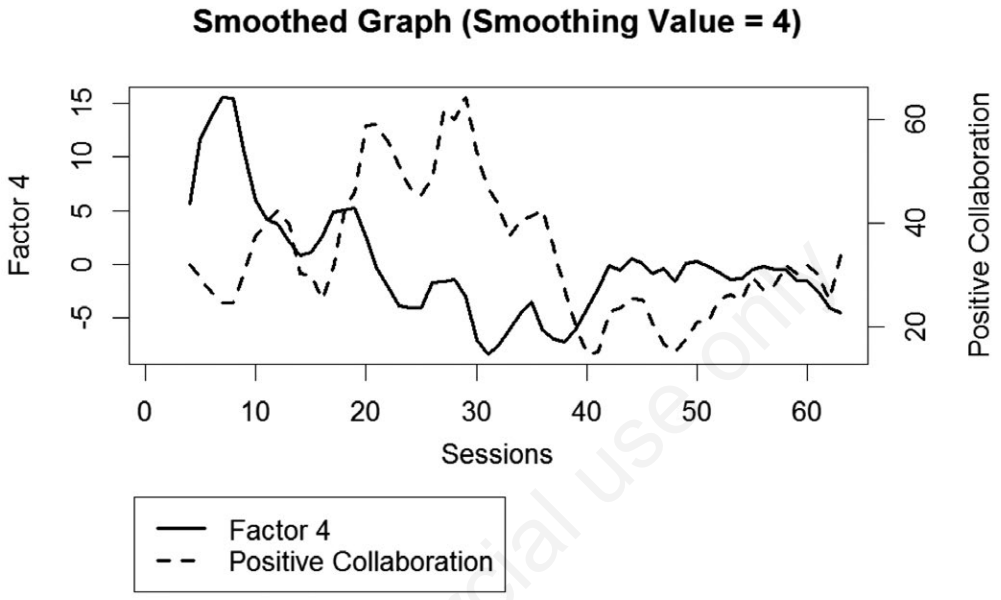

Figure 3. The positive association between the Psychotherapy Process Q-set Factor 4 (The good therapy) and the positive collaboration (Collaborative Interactions Scale Positive Collaboration), tested by the autoregressive integrated moving average model, in the 63 sessions of therapy.

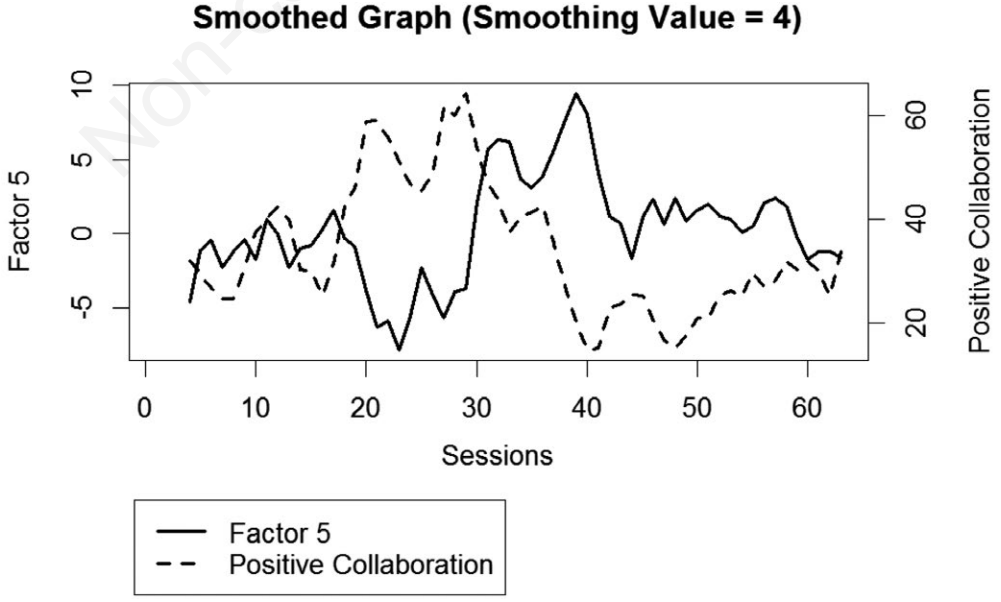

Figure 4. The negative association between the Psychotherapy Process Q-set Factor 5 (Life outside the room) and the positive collaboration (Collaborative Interactions Scale Positive Collaboration), tested by the autoregressive integrated moving average model, in the 63 sessions of therapy.

positive collaborative alliance, but also moved us to suggest that this cooperative interaction holds back some negative meanings (Appendix Table 5).

Second, the time series analysis described the change of therapeutic alliance over the course of therapy. Results showed that collaborative alliance did not statistically decrease over time. At a closer look, however, qualitative data indicated that whereas collaborative alliance increased during the first phase of the therapy, it decreased in a subsequent second phase. This points to the evidence that collaborative alliance is informative about therapy evolution, and suggests that collaborations should be considered as well, together with ruptures, for a more complete understanding of therapeutic process. In fact, if we consider collaborative alliance in its maladaptive meanings, the reduction across time can be interpreted as a positive sign in the therapy.

Finally, the comparison between collaborative levels of alliance and an external measure, focused on the relational interaction, confirms the negative quality of patient's collaboration. Indeed, PQS's analysis revealed the different interaction structures that characterize the therapist-patient dyad. More specifically, whereas a first factor, named as *The good therapy* (*i.e.*, Factor 4), was positively associated with collaborative alliance, two factors were found to be negatively associated with it. These factors were respectively the *Authentic and emphatic relationship* (*i.e.*, Factor 1) and the *Life outside the room* (*i.e.*, Factor 5). The reported scenario, therefore, confirms the results of the previous analyses, and suggests that such collaboration is likely to reflect an acquiescent and forced style of interaction with the other (Appendix Table 5).

It is also worth noticing that outcome measures revealed an improvement in defense mechanisms functioning, as indicated by the ODF analysis. In fact, Sara showed a global progress of defense structure during the first 24 months of therapy. Nonetheless, these changes did not imply a significant variation in terms of personality structure, as indicated by the comparison of the SWAP profiles in the first and in the last phases of the therapy. This suggests that the therapy mainly affected the rigid resistant and detached defense structure, although it did not influence the personality structure at this stage. Hence, modifications of the defense structure may represent a first aim of the therapy: in fact, Sara's therapy is still ongoing.

Conclusions

Overall, these findings indicate that Sara's collaborative alliance works as a Pseudo-alliance. Pseudo-alliance can be defined as a specific psychopathological functioning characterized by hidden aggressive feelings and narcissistic tendencies oriented to attack the relationship, as

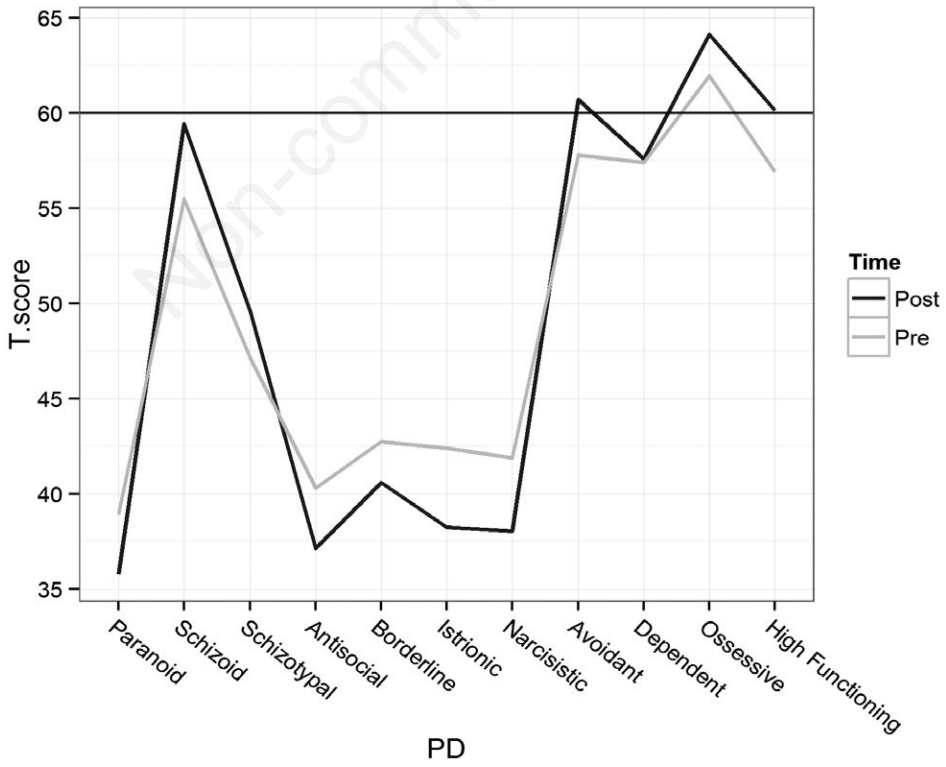

Figure 5. Shedler-Westen Assessment Procedure-200' T-scores did not show any significant change between the first and last phases of the therapy. PD, personality disorder.

well as the therapist and the therapeutic work (Etchegoyen, 2018). These results can be also well interpreted in terms of therapeutic misalliance, defined as a relational interaction aimed to undermine therapeutic goals or symptom modifications (Langs, 1975).

Pseudo-alliance or Pseudo-collaboration characterizes specific pathological configurations, giving prominence to the influence of the personality structure in the understanding of the alliance dynamics (Lingiardi, Filippucci, & Baiocco, 2005; Taft, Murphy, Musser, & Remington, 2004; Zuroff et al., 2000). The present study provides further evidence about the influence of personality structure to the development of alliance, and, in this case, of Pseudo-Alliance. It seems to reflect a deferential behavior, characterized by fear of hurting the other; need to support his hypothesis, acceptance of his/her limits, fear to criticize and fear to be unthankful (Rennie, 1994). From an attachment theory perspective, it may be interpreted as a disconnection between the episodic and semantic thinking that results in a difficulty in accessing the most emotionally authentic contents (De Carli et al., 2018; De Carli, Tagini, Sarracino, Santona, & Parolin, 2016; Main, Kaplan, Cassidy, 1985). Accordingly, only a pre-treatment assessment would allow a more comprehensive understanding of the specific type of therapeutic alliance and of the real patient's motivations to the therapy.

This flip side of Sara's alliance, indeed, has been developed within an intersubjective perspective and has similarities with different constructs, such as transference and countertransference gratification, resistance, mutual acting out and acting in. In particular, under a relational conceptualization, the resistance becomes an obstacle to the therapeutic process that can be understood as an interactive function between patient and therapist (Safran & Muran, 2003).

However, in Sara's case, the acquiescent alliance cannot be identified simply as a resistance. Rather, it identifies a relational way of interacting with the therapist that goes beyond a mere obstacle to the therapy. Sara's transference, indeed, is based on avoidance, extreme intellectualization and emotional closure that defines a negative transference (Locati et al., 2016). In other words, pseudo-alliance would better resemble a transference – countertransference dynamic (Locati et al., 2016) that can affect the therapeutic genuineness of the therapeutic relationship, such as the real relationship (Couch, 1999; Frank, 2005; Greenberg, 1994). The collaboration flip side seems a crossroads in which different concepts overlap: the boundaries between collaboration and rupture, negative transference, real relationship. This description may meet Gelso and Hayes (1998) explanation of psychotherapy process as composed by three components: alliance, transference and countertransference configuration, and, real relationship. Previous literature highlighted how the real relation significantly correlates with alliance measures (Fuertes et al., 2007; Gelso et al., 2005; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010) or that client's attachment avoidance toward the therapist was negatively related to the real relationship (Fuertes et al., 2007; Gelso et al., 2005). It was shown that the greater the negative transference rated by the therapist, the weaker the real relationship, in a negative association (Gelso et al., 2005; Marmarosh et al., 2009). On the contrary, Sara case-study may reveal an exceptional dynamic in which the deferent patient, in light of his transference quality may convey through the collaborative alliance element of distortion of the intersubjectivity of the relationship.

To conclude, whereas collaborative alliance has been traditionally considered under a positive meaning, here we showed that this conceptualization represents just one side of the coin. The flip side of collaboration, indeed, exceptionally can have a dysfunctional role in the therapeutic alliance. This finding therefore challenges the classic view of collaborative alliance and provides new horizons in the study of therapeutic alliance (Locati et al., 2017). Future studies, possibly involving group of patients, are in any case required to further explore this issue.

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