Patterns of Alliance Development and the Rupture–Repair Hypothesis: Are Productive Relationships U-Shaped or V-Shaped?

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The alliance encompasses multiple interrelated dimensions or components of the therapeutic relationship, including the bond between client and therapist, their agreement on treatment tasks, and their agreement on treatment goals (Bordin, 1979, 1994). Researchers’ interest in the alliance has been stimulated and maintained by repeated findings that a strong alliance is associated with favorable treatment outcomes (for reviews of the alliance literature, see Horvath & Bedi, 2002; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Orlinsky, Grawe, & Parks, 1994). Investigating the alliance–outcome link, some theorists and investigators have focused on the alliance’s developmental course across sessions. They have suggested that treatment success may be distinctively associated with the strength of alliance early in treatment (Horvath & Symonds, 1991) or late in treatment (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998), with a pattern of strengthening alliance across sessions (Kivlighan & Shaughnessy, 1995), or with a high–low–high pattern representing alliance rupture and repair, in which, for example, previously hidden negative feelings emerge and are then resolved or in which the therapist makes a mistake and then acknowledges and addresses it (Agnew, Harper, Shapiro, & Barkham, 1994; Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996, 2000; Samstag, Muran, & Safran, 2004). We consider several of these alternative developmental patterns in subsequent sections.

In this study we addressed two questions concerning clients’ profiles of alliance development—that is, sequences of clients’ postsession ratings of the alliance—and their relationship to treatment outcomes. Question 1 was stimulated by an article by Kivlighan and Shaughnessy (2000), as described in the next section. Question 2 was stimulated by the answer we obtained to the first question. To address both questions, we drew data from the Second Sheffield Psychotherapy Project (SPP2; Shapiro et al., 1994), a clinical trial of time-limited treatments for depression. We emphasize that this study’s goals focused on patterns of alliance development; previous publications have reported the outcomes of the SPP2 treatments (Shapiro et al., 1994) and the direct relations of Agnew Relationship Measure scores with SPP2 outcomes (Stiles et al., 1998).

Question 1: Do Clients With U-Shaped Profiles Have the Best Outcomes?

Kivlighan and Shaughnessy (2000) reported that clients’ profiles of alliance development could be classified into three clusters: a stable alliance pattern (little change across sessions), a linear growth pattern (increasing strength across sessions), and a quadratic growth, or U-shaped, pattern (high scores in the first session, even higher scores in the fourth and last session, and lower scores in the middle sessions). In their study, clients in the quadratic growth cluster had significantly better outcomes than did the other participants, a result consistent with a conceptualization of alliance development proposed by Gelso and Carter (1994). We attempted...
to replicate and extend Kivlighan and Shaughnessy’s (2000) findings using the SPP2 data.

In their conceptual analysis of the alliance across time, Gelso and Carter (1994) suggested that forming a strong alliance early in therapy is important, particularly in brief therapies (Gelso & Johnson, 1983). They offered two possible reasons: First, “although the alliance is initially in the forefront of the relationship, it subsequently fades into the background, returning to the foreground only when needed” (Gelso & Carter, 1994, p. 301). For example, the alliance may fluctuate in connection with crises in therapy work, such as the therapist’s failures to understand or the client’s emerging resistances to understanding (Hartley & Strupp, 1982). At such times, a strong alliance may enable the dyad to work through and resolve the crisis. Second, particularly in time-limited treatments, the initially strong alliance may weaken toward the middle of therapy and rise again in the last phase of therapy, as illustrated in case studies by Golden and Robbins (1990) and described in Mann’s (1973) psychoanalytic theory of how clients’ initial optimism gives way to frustration with the imposed limits, which in its turn gives way to a positive and more realistic reaction to the therapist toward the end of treatment. Gelso and Carter’s (1994) summary emphasized the second possibility: “Especially in treatments that abbreviate duration, an initially sound working alliance will subsequently decline, but in successful therapy this decline will be followed by an increase to earlier, high levels” (pp. 301–302). This summary was used by Kivlighan and Shaughnessy (2000) as the basis for their primary hypothesis, which was supported.

Kivlighan and Shaughnessy (2000) sought to characterize the temporal patterns of alliance development observed in two samples of recruited participants (N = 41 and N = 38) working with novice (graduate student) counselors. Participants each had four sessions with their counselor and completed the Working Alliance Inventory (WAI; Horvath, 1981; Horvath & Greenberg, 1986, 1989) after each session. To identify patterns, Kivlighan and Shaughnessy (2000) used cluster analysis, a multivariate technique that forms homogeneous groups on the basis of their similarity on a set of variables specified by the researcher. In cluster analyses conducted separately on each sample, they identified and replicated three patterns of alliance development—stable alliance, linear growth, and quadratic growth—as noted earlier. Participants in the second sample completed the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureña, & Villaseñor, 1988) and the Battery of Interpersonal Capabilities (BIC; Paulhus & Martin, 1987) before beginning and immediately after the four counseling sessions. Participants in the quadratic growth cluster showed significantly more improvement across the four sessions (measured as residualized change scores on the IIP and BIC) than did participants in the other two clusters.

Our attempted replication and extension applied cluster analysis to clients’ session-by-session alliance ratings in SPP2 and compared the outcomes obtained by the resulting clusters of clients on a battery of standard measures including the IIP. Whereas Kivlighan and Shaughnessy’s (2000) participants were recruited undergraduates treated by novice counselors drawn from “prepracticum” classes (presumably, learning basic interviewing skills), SPP2 clients met inclusion criteria that included a diagnosis of major depressive episode and were treated by qualified, experienced clinical psychologists following manualized therapy protocols. Whereas Kivlighan and Shaughnessy’s participants received only 4 sessions, SPP2 clients received 8 or 16 sessions. Replication in the SPP2 sample would, we thought, strongly support the external validity of Kivlighan and Shaughnessy’s findings.

Method

SPP2 was a comparative trial of two time-limited treatments for depression, a cognitive–behavioral (CB) treatment and a psychodynamic–interpersonal (PI) treatment, each offered in 8- and 16-session versions. Clients in all cells of the design averaged substantial improvement. CB and PI treatments appeared about equally effective; clients receiving 16 sessions averaged somewhat more improvement than clients receiving 8 sessions. These and other results of comparisons among the SPP2 conditions were reported previously (Shapiro et al., 1994).

For this study, we applied new analyses to SPP2 alliance data that have also been reported previously (Stiles et al., 1998). Thus, although our results are new, the following descriptions of the method, including participants, treatments, assessment measures, and procedures, largely repeat or summarize ones published earlier.

Participants

The clients (N = 79) were professional, managerial, and other white-collar workers who were self-referred or referred by general practitioners or occupational health workers to a research clinic for treatment of depression. Their average age was 41 (range = 23–60); 42 (53%) were women, and 51 (65%) were married or currently living with a partner. All participating clients gave written informed consent for their data to be used for research. Each was randomly assigned to one of the four treatment (CB or PI)-by-duration (8 or 16 sessions) conditions and, within scheduling restrictions, to one of five therapists.

The therapists were clinical psychologists, two of whom had 17 and 6 years’ professional clinical experience, respectively, and three of whom had had 1–3 years clinical experience in the research clinic by the beginning of data collection for this multiyear project. All were investigators in the project but did not have access to research data until after treatment was completed. Therapists were selected for, and encouraged to maintain, a balanced belief in the effectiveness of both CB and PI treatments. All therapists saw cases using each treatment approach and duration.

Treatments

The CB and PI treatments were selected to represent two broad classes of approaches frequently used by practitioners. They were implemented by treatment manuals (Firth & Shapiro, 1985; Shapiro & Firth, 1985). The PI treatment was based on Hobson’s conversational model (Goldberg et al., 1984; Hobson, 1985). Using psychodynamic, interpersonal, and experiential concepts, PI treatment focuses on the therapist–client relationship as a vehicle for revealing and resolving interpersonal difficulties, which are viewed as primary in the origins of depression. The CB treatment was a multimodal cognitive–behavioral method incorporating self-management (Goldfried & Merbaum, 1973), cognitive restructuring (Beck, Rush, Shaw, & Emery, 1979), and anxiety control training (Smith, 1974). Treatment integrity and competence were maintained via a weekly audiotape-based peer-supervision group. Ratings of a systematic sample of 220 sessions demonstrated satisfactory adherence to treatment protocols (Startup & Shapiro, 1993).

Assessment Measures

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was used to measure depressive symptoms. General symptomatology was measured by the global severity index of the Symp-
tom Checklist—Revised (SCL—90—R; Derogatis, 1983). Interpersonal difficulties were assessed by the mean total score of the IIP (Horowitz et al., 1988) and the Social subscale of the Social Adjustment Scale—Self Report (SAS; Cooper, Osborn, Gath, & Feggetter, 1982). Intraperonnel well-being was assessed by a short form of the Rosenberg Self-Esteem index (SE; O’Malley & Bachman, 1979). These are all widely used measures; evidence of their acceptable reliability and validity has been presented in the cited sources as well as in previous reports of SPP2 results (Shapiro et al., 1994).

Alliance Measure

The Agnew Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) assesses the alliance using 28 sentences (e.g., “My therapist is warm and friendly with me”), to which clients responded using 7-point scales anchored strongly disagree, moderately disagree, slightly disagree, neutral, slightly agree, moderately agree, and strongly agree. The ARM was constructed to include five subscales, called Bond, Partnership, Confidence, Openness, and Client Initiative. There is a parallel therapist form, but following Kivlighan and Shaughnessy (2000), we considered only client-rated alliance in this study.

We combined three of the ARM’s subscales into a core alliance index, which we used for all of our analyses. The three were Bond (friendliness, acceptance, understanding, and support in the relationship), Partnership (working jointly on therapeutic tasks and toward therapeutic goals), and Confidence (optimism and respect for the therapist’s professional competence); more specifically, ARM core alliance was measured as the mean of the 17 items that these three scales comprised (each item scored 1–7, reversed for negatively worded items). Internal consistency was high (α = .93).

Our use of the core alliance index followed Kivlighan and Shaughnessy’s (2000) combining the three WAI subscales, Bond, Tasks, and Goals, into a single alliance measure in their analyses. Like the three WAI subscales (Horvath, 1981; Horvath & Greenberg, 1989), ARM Bond, Partnership, and Confidence were highly intercorrelated (.84 ≤ r ≤ .87 in client data; Agnew-Davies et al., 1998). We did not include the ARM’s Openness or Client Initiative subscales in our core alliance index because these seemed conceptually and psychometrically distinct (.18 ≤ r ≤ .66 with the three included scales; Agnew-Davies et al., 1998). In a sample of 198 sessions of 18 clients who completed both alliance measures, client mean scores on the ARM core alliance index were correlated at .98 with client total WAI scores (Stiles et al., 2002). Across sessions, the within-client deviation scores on the ARM and the WAI, each calculated as the deviation of each raw score from the mean score on that measure for that client, were correlated at .79 (Stiles et al., 2002). Thus, we considered it appropriate to use the ARM in a replication and extension of a study that used the WAI.

Procedure

Clients who met screening criteria (principally BDI ≥ 16) were invited for an assessment interview at which the battery of assessment measures was administered. Clients who met project criteria (principally, a diagnosis of major depressive episode) were randomly assigned to one of the four treatment-by-duration conditions and to one of the five project therapists (see Shapiro et al., 1994, for details).

Clients were seen weekly, insofar as practicable. Missed sessions were rescheduled. Batteries of assessment measures, including the BDI, SCL—90—R, IIP, SAS, and SE, were administered at the initial assessment and at end of treatment as well as at other assessment points not dealt with in this study (see Shapiro et al., 1994, for details).

Clients completed the ARM immediately after each session. Clients gave their completed forms to the clinic secretary and were assured that their therapist would not see their responses until after treatment was concluded. Because the ARM was being developed during the early part of the project, the final version of the ARM was used by only 79 of the 117 SPP2 clients (the other SPP2 clients used pilot versions, which contained different items; see Agnew-Davies et al., 1998). Because some of the therapists joined the project late or left early, they saw unequal numbers of the clients who completed the final ARM version, ranging from 11 to 27 clients.

Results

Describing Profiles of Alliance Development Using Shape-of-Change Parameters

Cluster analyses require quantitative descriptors of each client’s profile of alliance development (alliance scores plotted across sessions). Kivlighan and Shaughnessy (2000) used the client’s WAI scores for each of the four sessions. Treating each session’s score as a unique variable seemed sensible because all of their participants had exactly four sessions. Treating each session number as distinct appeared impractical in the SPP2 sample, however, because it would have yielded too many variables and different numbers of variables for 8- and 16-session clients. Furthermore, the implicit assumption that the alliance score at each numbered session was a distinctive descriptor seemed less tenable in these longer treatments. That is, the alliance in Sessions 1, 2, 3, and 4 may each have a distinctive clinical meaning in a 4-session treatment, whereas in a 16-session treatment, the clinical meanings of the alliance in Sessions 11, 12, 13, and 14, for example, seemed less likely to be distinctive from each other or uniform across clients.

As an alternative way to describe the profiles of ARM core alliance scores, we adapted an approach used previously to describe the shape of change in symptom intensity (Barkham, Stiles, & Shapiro, 1993). We used regression equations to compute four descriptive parameters for each client’s profile: (a) the mid-treatment intercept, (b) the slope (positive or negative linear trend), (c) the curve (degree of U-shaped or inverted-U-shaped quadratic trend), and (d) the variability (the root-mean-square error, RMSE, which can be understood as a standard deviation around the curved regression line). Note that these parameters included the slope and curve components of alliance development deemed relevant by Gelso and Carter (1994) and Kivlighan and Shaughnessy (2000). The variability parameter was, in effect, an aggregate of cubic and higher order curvilinear possibilities afforded by our 8- or 16-session treatments. With only four sessions, cubic curves were the most complex that Kivlighan and Shaughnessy could have found.

To compute the parameters, we first centered the session numbers, so that each client had a mean session number of zero. We did this by subtracting that client’s mean session number (4.5 for 8-session clients, 8.5 for 16-session clients), thus renumbering the sessions from −3.5 to 3.5 for 8-session clients and from −7.5 to 7.5 for 16-session clients. This placed the intercept in the middle of treatment and centered the profile, so that the quadratic parameter described degrees of symmetrically positively accelerated (U-shaped) or negatively accelerated (inverted-U-shaped) curvature. To calculate parameter values for each client, we used a quadratic regression equation predicting the ARM core alliance score from the centered session number (CS). In other words, we fitted a quadratic curve to each client’s profile of alliance development:
ARM = intercept + slope(CS) + curve(CS²) + residual.

The regressions thus yielded, for each client, (a) a constant, interpretable as the level of the curve at midtreatment, because the sessions were centered; (b) a coefficient for the linear term, interpretable as the slope of the line; (c) a coefficient for the quadratic (squared) term, interpretable as the direction and degree of curve; and (d) a set of errors or residuals, interpretable as the deviation of each ARM raw score from the fitted curve. The square root of the mean of the squares of these residuals (i.e., the RMSE) reflected the amount of additional variability not captured by the linear and quadratic components.

Following Kivlighan and Shaughnessy (2000), we sought to describe the shape of each client’s profile independently of its average level. To separate the shape from the average level, Kivlighan and Shaughnessy ipsatized each client’s profile by subtracting the WAI score for each session from that client’s mean WAI score. This resulted in a deviation profile that described how each of the four WAI scores deviated from the client’s average WAI score. The deviation scores were used in their cluster analyses. Our regression-based shape-of-change parameters allowed us to accomplish the same thing by simply omitting the intercept term and describing each profile by its slope, curve, and variability parameters.

Cluster Analyses

Like Kivlighan and Shaughnessy (2000), we used cluster analysis to identify subgroups of participants who followed distinct patterns of alliance development.

Clusters based on the full sample. We entered the 79 clients’ slope, curve, and variability parameters into a cluster analysis, conducted using SPSS for Windows, Release 11 (SPSS, 2001). Before entering the values, we rescaled all three parameters to a 0-to-1 interval, to equalize their potential weight in determining the clusters. Following Kivlighan and Shaughnessy (2000) and recommendations by Borgen and Barnett (1987), we used Ward’s (1963) clustering method, which forms hierarchical clusters that have minimum within-group and maximum between-group variance.

The cluster analysis program sequentially agglomerated the client profiles (as described by the parameters) into ever smaller numbers of clusters on the basis of their proximities (squared euclidian distance from each other) in the three-dimensional space defined by the parameters. Visual inspection of graphic representations of the clustering process (the vertical icicle plot and dendrogram) led us to choose the four-cluster solution. Considerations in this choice included our desire for a manageable number of clusters similar to that chosen by Kivlighan and Shaughnessy (2000) and noting sudden increases in the error term (decrease in the proportion of variance accounted for when two clusters are joined), as shown in the graphical representations. The dendrogram of the cluster analysis results, indicating our selected four-cluster solution, is shown in Figure 1.

Table 1 shows the means and standard deviations of the parameters for the four clusters of profiles (including the intercept, which was not used in the cluster analysis). The table shows the original parameter values rather than the rescaled (0 to 1) values entered in the cluster analysis. Table 1 also shows the mean age and the gender and marital status of clients in each cluster and distributions of clients across the SPP2 experimental conditions (CB vs. PI therapy and 8-session vs. 16-session duration) and the five therapists. In general, clients in the four groups were demographically similar and similarly distributed across the two therapies. Clusters 1, 2, and 3 had similar proportions of clients who received 8 and 16 sessions; however, Cluster 4 included no clients from the 16-session group, \( \chi^2(3, N = 79) = 15.14, p = .002 \). Most of the clients in Cluster 3 were seen by Therapist 4; however, the therapist-by-cluster chi-square test was not significant and was of doubtful validity anyway because of small expected values in many cells.

Cluster 1 was characterized by a modestly positive slope, a very slightly negatively accelerated (inverted-U-shaped) curve, and relatively high variability. This cluster had some resemblance to Kivlighan and Shaughnessy’s (2000) linear growth cluster.

Cluster 2 was characterized by very little slope, virtually no curve, and low variability. It appeared similar to Kivlighan and Shaughnessy’s (2000) stable alliance cluster.

Cluster 3 was characterized by a negative slope, a slightly positively accelerated curve, and high variability. Although this was the only cluster exhibiting any U-shaped curve, its shallowness and negative slope made it a poor match for Kivlighan and Shaughnessy’s (2000) quadratic growth cluster.

Cluster 4 was characterized by a positive slope, a negatively accelerated curve, and low variability. This cluster had no obvious counterpart in Kivlighan and Shaughnessy’s (2000) results.

Figure 2 offers graphic representations of the four clusters of profiles. In these illustrative graphs, the parameters were plotted across only 8 sessions. In each graph, the center (solid) line represents the fitted curve defined by the mean intercept, slope, and curve values for each cluster as shown in Table 1. The dotted lines above and below this represent the variability, or RMSE—in effect, the standard deviation around the curve. Because the parameters were based on centered session numbers, plots across 16 sessions (not shown) would extend these curves in both directions. Visually, the lines would appear to be somewhat more curved, insofar as the plotted value increases (or decreases) with the square of the centered session number.

Clusters based on separate 8- and 16-session samples. As a check on the consistency of our clusters, we reanalyzed data for the 8-session clients \( (n = 39) \) and 16-session clients \( (n = 40) \) separately. Procedures were identical to the full-sample analysis in other respects. We then compared the clusters derived from these separate analyses with those derived from the full-sample cluster analysis. For the 8-session clients, when we compared the four-cluster solution with the original clusters, we found that all of the clients except 1 were classified in corresponding clusters. For the 16-session clients, when we compared the three-cluster solution with the original clusters (in which no 16-session clients were classified in Cluster 4), all of the clients except 2 were classified in corresponding clusters. We concluded that the full-sample clusters were adequately representative of patterns of alliance development in SPP2, and we used them for our subsequent analyses.

It is worth noting that the 3 clients who were classified differently in the separate and full-sample cluster analyses would have formed separate one- and two-client clusters had we chosen a six-cluster solution in the full-sample analysis. That is, these 3 clients appeared to have somewhat distinctive profiles of alliance
development that were each intermediate between two of the four clusters we chose to present.

Exploratory inquiry regarding Cluster 3. Whereas Clusters 1 and 2 appeared to replicate ones found by Kivlighan and Shaughnessy (2000) and together accounted for most (57, or 72%) of the 79 profiles, Clusters 3 and 4 were unexpected. Our speculations regarding these unexpected clusters are discussed later. Those regarding Cluster 3, however, suggested a test using an available measure that could support one explanation, and we report that test here.

Cluster 3 clients apparently experienced their therapeutic relationships as stormy. Their initially strong alliance quickly deteri-
Patterns of Alliance Development

Treatment Distributions for Clients in the Four Cluster-Based ARM Core Alliance Parameters and Demographic and Treatment Patterns of Alliance Development

<table>
<thead>
<tr>
<th>Parameter or characteristic</th>
<th>Cluster 1</th>
<th>Cluster 2</th>
<th>Cluster 3</th>
<th>Cluster 4</th>
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<tr>
<td>Number of clients</td>
<td>28</td>
<td>29</td>
<td>10</td>
<td>12</td>
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<tr>
<td>Midtreatment intercept</td>
<td></td>
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<tr>
<td>$M$</td>
<td>5.81</td>
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<td>6.27</td>
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<tr>
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<tr>
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<td>0.031</td>
<td>−0.116</td>
<td>0.136</td>
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<tr>
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<td>0.073</td>
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<tr>
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<tr>
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<td>7</td>
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<td>7</td>
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<td>2</td>
<td>2</td>
<td>3</td>
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</table>


Correlated, with great session-to-session variability. To us, this recalled descriptions of an intensely dependent style of interpersonal relating that has been called overinvolvement in relationships (Hardy, Stiles, Barkham, & Startup, 1998), anancitic depression (Blatt & Homann, 1992), and anxious–ambivalent attachment (Bowlby, 1988). Overinvolved clients might be expected to rapidly form intense but ambivalent attachments to their therapists, with unrealistically high expectations that are subsequently disappointed, along with extreme emotional reactions to the events of treatment. To assess this style, we used a previously described seven-item factor-based Overinvolved Scale scored on the IIP (sample items: “Influenced too much by another person’s thoughts and feelings,” “Too sensitive to rejection”; reported alpha = .76; Hardy & Barkham, 1994). At the pretreatment assessment, Cluster 3 clients scored significantly higher than the other clients on the Overinvolved Scale ($M$s = 2.63 vs. 1.95), ($t(78) = 2.69$, $p = .009$, consistent with our speculation that this pattern of alliance development reflected the clients’ distinct interpersonal style.

Outcomes of the Four Clusters

Because none of our clusters resembled Kivlighan and Shaughnessy’s (2000) quadratic growth cluster, we could not sensibly replicate their finding that those clients had the best outcomes. Nevertheless, we investigated whether clients in some of our clusters improved more than clients in other clusters.

As indexes of outcome, we computed residual gain scores for the five assessment measures, the BDI, SCL–90—R, IIP, SAS, and SE. These were the deviations from the prediction in regression equations where the dependent variables were the end-of-treatment scores and the independent variables were the corresponding pretreatment scores and the duration of treatment (8 or 16 sessions). Thus, the residual gain scores reflected the relative degree to which each client’s ending assessment score was higher or lower than would have been expected from their pretreatment assessment score and the amount of treatment they received. We then investigated the extent to which these differential gains were associated with patterns of alliance development.

We found no significant differences in outcome, thus measured, among the four clusters. We compared the outcomes of our four clusters in four-level one-way analyses of covariance (ANCOVAs). The client’s average ARM core alliance score was the covariate in each analysis, and the residual gains on the BDI, SCL–90—R, IIP, SAS, and SE were the dependent variables. Following Kivlighan and Shaughnessy (2000), we used the covariate to partial out effects on outcome due to the level or overall strength of the alliance, yielding a more sensitive test of the effect of patterns of alliance development. The ANCOVAs all yielded $F$ values less than 1, indicating no significant effect of cluster differences on residual gains on these measures.

Correlations of Residual Gains With Profile Parameters

Directly correlating the five residual gain scores with the curve parameter offered an alternative test of Kivlighan and Shaughnessy’s (2000) central hypotheses, based on Gelso and Carter’s (1994) conceptualization, that a U-shaped profile would be associated with improvement. That is, even if there were no cluster of U-shaped profiles, there might be an association between the degree of curve and improvement in treatment. However, the obtained correlations failed to support this hypothesis, showing no suggestion of the hypothesized positive association ($−.10 \leq r \leq .05$).

We also computed correlations of the residual gain scores on the five measures (BDI, SCL–90—R, IIP, SAS, and IIP) with each of the other three profile parameters—intercept, slope, and variability. Each of these tested a different hypothesis.

The correlations with the intercept tested the hypothesis that the midtreatment level of the alliance is associated with outcome. This hypothesis was supported by significant associations with residual gains on three of the five measures, the BDI ($r = .24$, $n = 76$, $p = .040$), the SAS ($r = .32$, $n = 74$, $p = .006$), and the SE ($r = .40$, $n = 76$, $p < .001$). (Note that sample size varied because of missing outcome data; directionality was reversed on some measures so that positive correlations indicate that larger parameter values were associated with improvement.) The midtreatment intercept values were closely related to the mean ARM core alliance index, conceptually and statistically ($r = .98$; the midtreatment intercepts in linear regressions would be identical to mean ARM scores). These correlations thus essentially repeat the previously reported finding that the strength of the alliance was associated with client improvement on some measures in this sample (Stiles et al., 1998), as in many studies (Horvath & Bedi, 2002).
The correlations with the slope parameter tested the hypothesis that an improving alliance is associated with symptomatic improvement, as suggested in an earlier study by Kivlighan and Shaughnessy (1995). In our sample, none of the correlations of the residual gains with slope reached statistical significance, though all of them were positive (.06 ≤ r ≤ .17).

Positive or negative correlations with the variability parameter would suggest that lability or stability of the alliance was associated with gains in treatment. There was no support for such a suggestion in these data (−.05 ≤ r ≤ .04).

**Question 2: Do Clients With V-Shaped Profiles Have the Best Outcomes?**

Chastened by our failures in replicating Kivlighan and Shaughnessy’s (2000) findings, we sought other ways to assess links between alliance development and treatment outcome. Although Kivlighan and Shaughnessy, following Gelso and Carter (1994), formulated their hypotheses in terms of the overall U shape of the profile, the conceptualization could be reformulated as a process of rupture and repair (Agnew et al., 1994; Safran et al., 1990; Safran & Muran, 1996, 2000; Samstag et al., 2004). On reflection, we considered that a rupture-and-repair sequence in treatments lasting 8 or 16 sessions might not be adequately distinguished by cluster analyses of either session-denominated scores or shape-of-change parameters. Rather than a decrease associated with particular session numbers or a gradual decline and a subsequent gradual increase across several sessions, ruptures seemed more likely to occur haphazardly (i.e., at differently numbered sessions for different clients) and to be repaired relatively quickly, within one or two sessions. The alliance profiles of clients who had such ruptures should thus have large downward deflections or spikes at some

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*Figure 2.* Idealized representations of patterns of alliance development for the four clusters, plotted across eight sessions, based on mean parameter values (intercept, slope, curve, and variability) for clients assigned to each cluster. Dotted lines represent variability (± root-mean-square error). ARM = Agnew Relationship Measure.
occurred mainly in early sessions (Sessions 2 included two rupture

–

previous or higher levels. In other words, rather than being

U-shaped, the profiles should have V-shaped segments.

Rupture–Repair Criteria

Using the ARM core alliance scores and the shape-of-change

parameters (intercept, slope, curve, and variability) that we used to

address Question 1, we sought to characterize ruptures quantita-

tively. We developed the following criteria to define a rupture–

repair sequence:

1. The core alliance score was lower than the value predicted

from the client’s intercept, slope, and curve parameters by at least

two times the client’s RMSE (conceptually, at least 2 standard

deviations below the fitted curve). That is,

\[
\text{ARM} < y^* - 2(\text{RMSE}),
\]

where \(y^*\) was the prediction from intercept, slope, and curve

parameters. This was our basic specification that an alliance rup-
ture should be signaled by an unusually low score.

2. This low score was not in the first or last session. Logically, rupture and repair requires at least one higher alliance score preceding and one succeeding the rupture.

3. The overall slope was nonnegative. This specification was intended to eliminate clients whose ruptures were not fully re-
paired but were part of a more generally deteriorating therapeutic

relationship.

4. The low (rupture) score was numerically lower than the preceding score and lower than 6.0 on the 7-point ARM scale. These specifications were intended to eliminate a few cases that did not represent ruptures as we understood them: (a) an alliance score that was no lower than the preceding score but was two RMSEs or more below the predicted score because the profile was strongly positively sloped or (b) very high (at or near the maxi-
mum 7.0 ARM score), low-variability profiles, in which slight downward deflections met Criterion 1.

Results of the Rupture–Repair Investigation

Applying the rupture–repair criteria to our sample of 79 clients yielded 17 clients who had rupture–repair profiles, one of which included two rupture–repair sequences. Figure 3 presents four of these profiles as illustrations. The 18 ruptures that met criteria occurred mainly in early sessions (Sessions 2–4 in 8-session treatments, with only one exception; Sessions 2–7 in 16-session treatments, with only two exceptions.)

Outcomes Following Rupture and Repair

We compared the outcomes of the 17 clients who had rupture profiles with those who did not in another series of ANCOVAs. As in the previous analyses, the client’s mean ARM core alliance score was the covariate, and the residual gains on the five assessment measures were the dependent variables. Results, presented in Table 2, showed that the clients with rupture profiles averaged significantly greater gains than clients with no-rupture profiles on three of the measures, the BDI, the SCL–90—R, and the IIP.

Characteristics of Rupture and No-Rupture Groups

Table 2 also shows the mean age and the gender and marital

status of clients who did or did not experience rupture–repair

sequences and distributions of these clients across SPP2 experi-

mental conditions and therapists. Rupture and no-rupture clients were similar in gender and age; however, rupture clients were significantly more likely than no-rupture clients to have a current partner (i.e., to be married or living with a partner vs. being single, separated, divorced, or widowed), \(\chi^2(1, N = 79) = 5.31, p = .021\). Rupture–repair sequences were numerically, but not significantly, more common in PI therapy than in CB therapy, \(\chi^2(1, N = 79) = 2.04, p = .153\), and in 16-session treatments than in 8-session treatments, \(\chi^2(1, N = 79) = 3.45, p = .063\). The five therapists saw 2–6 rupture–repair clients each (a chi-square test was inap-

propriate because of small expected values). Clients who experi-

enced rupture–repair sequences were unequally distributed across the four cluster-based patterns, with the largest number (11/17) in Cluster 1 and one or none in Clusters 3 and 4, respectively, \(\chi^2(3, N = 79) = 9.62, p = .022\).

Discussion

Four clusters of profiles of alliance development were distin-
guished by different combinations of positive or negative slope,

degree and direction of quadratic curve, and residual variability

across sessions. Finding that three of the four clusters were repli-
cated in the 8- and 16-session groups independently lends confi-
dence to the classification. Two of the four resembled clusters identified by Kivlghan and Shaughnessy (2000), and these two accounted for 72% of our profiles: Our Cluster 1 and their linear growth cluster depict client–therapist relationships that improved across sessions (positive slope), albeit with high session-to-session variability. Our Cluster 2 and their stable alliance cluster depict relationships that began and remained strong across sessions (little slope), without substantial perturbations.

Clients in Cluster 4, which we found only in 8-session treat-
ments, experienced moderate alliances in their first session, but these relationships rapidly improved and then remained strong, with little session-to-session variation (see Figure 2). We could find no fully satisfactory account of this pattern, though we noted that it shared some characteristics with Clusters 1 and 2. For example, it may represent clients who would have been in Cluster 2 (stable alliance) except that they were initially disappointed with their assignment to the briefier therapy (as part of informed consent procedures, prior to randomization, all of the experimental condi-
tions were described to clients). Alternatively, it may represent an early acceleration of alliance growth in response to the shorter treatment. Previous work has found evidence of acceleration of other therapeutic processes in the 8-session conditions of SPP2 relative to the 16-session conditions (Reynolds et al., 1996).

Clients in Cluster 3 enacted a pattern of relationship develop-
ment classically characteristic of an overinvolved or anxious–
ambivalent interpersonal style: They experienced an initially

strong alliance that subsequently deteriorated, with large session-
to-session fluctuations. Finding that Cluster 3 clients averaged

significantly higher scores than the other clients on the IIP-derived

Overinvolved Scale (Hardy & Barkham, 1994) confirmed this intepretation. Despite their stormy relationships, this cluster’s
outcomes were not significantly worse than the other clusters’ outcomes. Previous work has shown that therapists responsively accommodate to overinvolved clients by placing a greater focus on resistance and emotional issues, encouraging emotional experiencing, enhancing insight, and providing structure (Hardy et al., 1998).

None of our clusters resembled Kivlighan and Shaughnessy’s (2000) quadratic growth cluster, and our perusal of the SPP2 alliance profiles revealed no clearly U-shaped ones. Thus, finding none of our clusters distinctively associated with good outcomes was less a failure to replicate their result than a failure to establish their premise.

We did find clients with V-shaped profiles—or, more precisely, clients whose profiles met rupture-repair criteria that entailed V-shaped segments within them (e.g., see Figure 3). Our finding that these clients averaged larger gains than did other clients (Table 2) is consistent with the hypothesis that alliance ruptures represent opportunities for clients to learn about their problems relating to others, and repairs represent such opportunities having been taken in the here-and-now of the therapeutic relationship (Agnew et al., 1994; Safran et al., 1990; Safran & Muran, 1996, 2000; Samstag et al., 2004). To our knowledge, ours is the first nomothetic (statistical) demonstration of this theoretically expected effect. We hasten to add that our rupture-repair criteria

\[ \text{(1) Despite our title, we did not mean to argue or hypothesize that the mathematical or geometrical nature of relationships determines whether they are productive. The terms U-shaped and V-shaped were meant to refer, respectively, to alternative psychological conceptualizations of high-low-high patterns of alliance strength. The first one, a U-shaped pattern consisting of a strong alliance in early and late sessions with a weaker alliance in middle sessions, was described by Gelso and Carter (1994) and investigated by Kivlighan and Shaughnessy (2000). The second one, a V-shaped rupture-repair pattern consisting of a strong alliance interrupted by a brief period of doubt or antagonism, was described by Safran and Muran (1996, 1998, 2000) and others.}\]
Residual Gains, Demographic Characteristics, and Distributions Across Groups for Clients Who Did or Did Not Experience Alliance Rupture–Repair Sequences

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rupture</th>
<th>No rupture</th>
<th>F(1, 73)*</th>
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</thead>
<tbody>
<tr>
<td>Number of clients</td>
<td>17</td>
<td>62</td>
<td></td>
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<tr>
<td>Mean residual gain</td>
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<tr>
<td>BDI</td>
<td>3.526</td>
<td>-1.016a</td>
<td>5.37*</td>
</tr>
<tr>
<td>SCL–90–R</td>
<td>0.217</td>
<td>-0.062a</td>
<td>5.21*</td>
</tr>
<tr>
<td>IIP</td>
<td>0.189</td>
<td>-0.054a</td>
<td>4.21*</td>
</tr>
<tr>
<td>SAS</td>
<td>0.107</td>
<td>-0.032b</td>
<td>0.33b</td>
</tr>
<tr>
<td>SE</td>
<td>0.359</td>
<td>-0.103a</td>
<td>0.97</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>40.6</td>
<td>42.4</td>
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</tr>
<tr>
<td>Gender</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
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<tr>
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</tr>
<tr>
<td>Duration</td>
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<tr>
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Note. Residual gains were calculated as deviations from expectations based on initial scores and duration of treatment. Directionality was reversed on some measures so that positive scores indicate improvement. F tests are based on analyses of covariance in which the client’s mean Agnew Relationship Measure core alliance index was a covariate. BDI = Beck Depression Inventory; SCL–90–R = Symptom Checklist–90–Revised; IIP = Inventory of Interpersonal Problems; SAS = Social Adjustment Scale; SE = Rosenberg Self-Esteem Scale; CB = cognitive–behavioral treatment; PI = psychodynamic–interpersonal treatment.

* Only 59 no-rupture clients completed the posttreatment BDI, SCL–90–R, IIP, and SE. Only 57 no-rupture clients completed the posttreatment SAS, so for the F test, df = 1, 71.

*p < .05.

were developed ad hoc and should be regarded as preliminary, pending application to other samples.

We also note that this study’s design was correlational rather than experimental, in contrast to that of the SPP2 comparison of treatments from which our data were drawn (Shapiro et al., 1994). That is, having a rupture–repair sequence was not a manipulated variable. Our results were consistent with the theory that rupture–repair sequences are therapeutic, but by themselves, our results do not demonstrate that these sequences caused the better outcomes. As a possible alternative account, it could be that clients who were improving for other reasons were better able to repair alliance ruptures.

In our statistical comparisons of rupture–repair sequences with outcomes, the unit of analysis was the dyad. The 79 alliances we studied, however, were drawn from only five therapists and only two therapeutic approaches, and in this sense, the observations were not independent. Because of this lack of independence, there is a possibility that the results of these statistical comparisons were spurious, attributable to characteristics of these particular therapists, for example, rather than to the rupture–repair sequences.

We cannot conclude—nor would we wish to conclude—that the therapeutic relationship is independent of the personality of the therapist or the theoretical approach. Theoretically, therapist and treatment characteristics are essential contributors to the therapeutic relationship. Distinctive developmental patterns, such as occasional rupture–repair sequences, may tend to characterize some therapists, certain treatments, or some therapists only when they deliver particular treatments. Statistically partialing out such factors would misleadingly attenuate the main phenomenon of interest (cf. Meehl, 1971). The therapeutic relationship, of which rupture–repair sequences are one aspect, can be considered as a broad common path through which therapist, client, and treatment factors exert their effects (linear or nonlinear) on psychotherapy outcome. From a modeling perspective, we studied only one link in a chain of effects. Models need to be elaborated to respect the complexity and responsiveness of the therapeutic relationship; results have outstripped theory in this area (Stiles et al., 1998).

Careful qualitative investigations might be productive of such models. Models built in such investigations could be tested using multilevel modeling techniques (Heck & Thomas, 2000) if future researchers can develop models in the form of sequences of linear effects and can collect data from larger numbers of therapists and treatments (typical recommendations require 20 or more levels).

Rupture–repair sequences exemplify interpersonal learning, which is theoretically central in PI therapy (Firth & Shapiro, 1985; Hobson, 1985). Repairing ruptures probably has more immediacy and more impact than reworking events that occurred outside or in the past, PI’s alternative arena. Rupture–repair sequences were numerically more common in PI than in CB (Table 2), though this was within chance limits, and their occurrence in both treatments suggests that they represent a common change process. Finding that clients who were married or living with a partner were more likely to experience rupture–repair sequences than were clients without a partner (Table 2) suggests that repairing ruptures may be associated with maintaining intimate relationships more generally.

Kivlighan and Shaughnessy’s (2000) quadratic growth cluster might actually have involved repaired ruptures. U-shaped and V-shaped profiles could not be clearly distinguished from each other in the 4-session treatments they studied. In studying treatments of 8 or 16 sessions, however, we were able to distinguish rupture events from U-shaped trends. In retrospect, it seems less plausible that maintaining a poor relationship for the entire midsection of treatment (i.e., a U-shaped profile) would be therapeutically productive. Gelso and Carter’s (1994) theoretical account of the alliance over the course of therapy, which suggested that alliance development is U-shaped in successful cases, also noted the fluctuating salience of the relationship and the importance of the alliance for addressing crises. As a refinement of their theory and a reconciliation with the rupture–repair hypothesis, we suggest that the middle of productive treatment may be characterized by occasional alliance ruptures rather than a sustained decline.

The rupture–repair hypothesis does not require that the process extend over exactly two sessions, but our criteria tended to select...
ones that did. Rupture–repair sequences that took place within a single session would not have been detected, because the postsession alliance ratings would not have dropped. Sequences of more than one relatively low rating, on the other hand, would likely have increased the variability so that no score would fall below the two-RMSE threshold. In this sense, our criteria were crude, justified by making use of ratings that were gathered only once for each session. Moment-by-moment ratings of the session process are potentially much more sensitive, albeit more laborious (e.g., the Rupture Resolution Scale; Samstag, Safran, & Muran, 2000; Samstag et al., 2004).

Finding that a majority of the rupture–repair clients were in our Cluster 1 (see Table 2) presumably reflected a convergence of cluster characteristics with the rupture–repair criteria. Cluster 1 clients were characterized by a positive slope and high variability (see Figure 2 and Table 1). The rupture–repair criteria specified a nondescending slope, and the presence of a rupture would, by definition, contribute to variability. Incidentally, the profiles in Kivlghan and Shaughnessy’s (2000) quadratic growth cluster could be described as having high variability around a positive linear slope. As a way of reconciling their results with ours, perhaps their quadratic growth cluster could be considered as a subgroup within the linear growth cluster who happened to experience a rupture–repair sequence within the limited (4-session) duration of their treatments.

The trend toward larger numbers of rupture–repair sequences in 16-session than in 8-session treatments (Table 2) could simply reflect the larger number of sessions in which ruptures could occur. Only 2 of the 18 ruptures were in Sessions 9–16 of 16-session treatments. However, ruptures seemed to occur mainly in the first half, both 8- and 16-session treatments. It is not clear whether this was an artifact of our criteria (a rupture in the first half would make a nondescending slope more likely) or a more substantive feature of the rupture–repair process. In either case, having a longer first half offered more opportunity for ruptures in the longer treatments.

As noted, the midtreatment intercept closely approximated the client’s mean ARM score, and its correlation with client gains replicated the frequent finding that alliance strength is associated with treatment outcome. The statistical control for alliance strength in our comparisons of outcomes among the clusters and between the rupture versus no-rupture groups guarded against the possibility that any group differences reflected alliance strength rather than the pattern of alliance development.

The lack of a significant correlation of the slope parameter with outcomes replicated Kivlghan and Shaughnessy’s (1995) failure to find outcome associated with linear growth in client alliance ratings. They found, however, a significant association with linear growth in therapist alliance ratings. This study did not consider therapists’ alliance ratings; however, an earlier article reported a similar association of slope in therapist alliance ratings with outcome on some measures (Stiles et al., 1998).

This study’s limitations include a sample restricted to depressed clients from a single city, a small number of therapists who were also investigators on the project, and outcome assessed only by change on self-report instruments. Conclusions based on our findings are accordingly tentative, pending further examination of relationship patterns in other groups with other measures. Other diagnostic groups might show different patterns of relationship development; for example, ARM scores of borderline clients might vary far more from session to session, though successfully repaired ruptures should still be therapeutic. Larger, more heterogeneous samples would permit investigation of patterns of relationship development as a function of therapist–client similarity or difference in background characteristics, such as age, ethnicity, gender, or sexual orientation.

In summary, nearly three quarters of the 79 alliance development profiles we studied were classified in two clusters that resembled Kivlghan and Shaughnessy’s (2000) linear growth and stable alliance patterns, respectively. We also identified two further clusters. One, in which the alliance improved quickly and then remained stable, was confined to 8-session treatments. The other one, in which the alliance tended to decline with large session-to-session variability, was populated by clients who tended to score as overinvolved in relationships. We did not find Kivlghan and Shaughnessy’s quadratic, or U-shaped, growth cluster; however, we did identify a group of clients who experienced V-shaped rupture–repair sequences and who, like Kivlghan and Shaughnessy’s quadratic growth clients, tended to have better outcomes than other clients.

References


