Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis

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Background. Alliance ruptures and premature drop out from psychotherapy are very common with patients who have a diagnosis of borderline personality disorder, limiting the clinical effectiveness of treatment.

Aim. To test and refine a model of how therapists successfully resolve threats to the therapeutic alliance involving enactment of problematic relationship patterns in the cognitive analytic therapy of borderline personality disorder.

Method. Task analysis (Greenberg, 1984a) of 107 enactments from 66 sessions in four good outcome cases, compared with 35 enactments from 16 sessions in two poor outcome cases. This systematically compares a rational model of process with empirically coded transcripts of therapy sessions where independent raters have identified an alliance threat event.

Results. The process stages of the rational model were observed, and 20 refinements were made, including a new process stage, heuristic principles and ‘when–then’ steps. Therapists were found to cycle between stages. Therapists in good outcome cases recognized the majority of these enactments and focused attention to them in contrast to poor outcome cases where therapists usually failed to notice or draw attention to the alliance threat and did not adhere to the model.

Conclusion. Competent resolution of alliance-threatening events is crucially dependent on therapists’ ability to recognize them, and secondarily on their adherence to the principles in the refined model. The model is consistent with prior research and can be used in supervision and quality improvement strategies.

The quality of the therapeutic alliance is the most consistent predictor of outcome in psychotherapy (Martin, Garkse, & Davis, 2000). Indeed, a good working relationship is seen to represent a common therapeutic factor or pan-theoretical process variable.

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operating in all forms of psychotherapy (Lambert & Ogles, 2004). The alliance can be said to reflect the patient’s affective relationship to the therapist, his or her capacity to work purposefully in therapy, the therapist’s empathic understanding and involvement, and agreement between therapist and patient on goals and tasks of therapy (Gaston, 1990). Ackerman and Hilsenroth (2003) reviewed studies of therapists’ activity and attributes that positively influence the therapeutic alliance. Techniques include exploration, reflection, support, noting past therapy success, accurate interpretation, facilitating expression of affect, being active, affirming, understanding, and attending to patient’s experience. This is within a context of the therapist being perceived as flexible, honest, respectful, trustworthy, confident, warm, interested, and open. However, these global findings from correlational studies mask the vicissitudes of the therapeutic process. For example, it is possible for even experienced therapists to become caught in negative interactional cycles in which, for example, they respond to patient hostility with their own counter-hostility (Henry, Schacht, & Strupp, 1986; Strupp, 1980). Ruptures in the alliance are a normal part of the therapy process, and may in part reflect patients’ dysfunctional interpersonal patterns (Safran & Muran, 2004a). The resolution or repair of the relationship difficulty represents opportunities for therapeutic change and for deepening the alliance (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996).

The research programme of Safran and colleagues on alliance rupture and repair (Safran & Muran, 1996, 2004a; Safran et al., 1990) is based on the premise that both client and therapist contribute to problems in the alliance to varying degrees. Patients’ interpersonal expectations influence their behaviour, which, in turn, elicits predictable responses from others. Their results indicate the importance of meta-communication, which takes the existing interaction between therapist and patient as a focus of exploration. They have derived a stage-process model of rupture resolution, consisting of five client states and three therapist interventions that facilitate the transition between these states. According to this model, by the therapist focusing on client immediate experience, facilitating self-expression, and validating self-assertion, the patient will be enabled to explore the alliance rupture and achieve a state of individuation in the context of relatedness.

People with the severe relationship difficulties and self-care problems of borderline personality disorder understandably experience greater difficulty than most in making and maintaining a therapeutic alliance (Waldinger & Gunderson, 1984). Although these clients sometimes improve spontaneously irrespective of therapy (Grilo, Sanislow, Gunderson, Pagano, Yen, Zanarini et al., 2004; Zanarini et al., 2004) this is the exception in clinical practice (Stone, 1993). Because clients are vulnerable to iatrogenic deterioration and intolerant of therapeutic errors (Shearin & Linehan, 1993), therapist skill is likely to be a major factor. Irrespective of therapy type, competence in the task of resolving alliance threats and ruptures is a key to helping these clients towards a successful therapeutic outcome.

There have been a number of promising developments in the psychological treatment of borderline problems (Bateman & Fonagy, 1999; Benjamin, 2003; Davidson, 2002; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Ryle, 1997; Yeomans, Selzer, & Clarkin, 1992; Young, Klosko, & Weishaar, 2003). Although from meta-analysis, there is reason for optimism that a number of psychological methods may indeed be helpful (Perry, Banon, & Ianni, 1999), there are no grounds for complacency, given that between 42% and 67% of patients drop out of treatment prematurely (Gunderson, Frank, Ronningstam, Wahter, Lynch, & Wolf, 1989; Skodol, Buckley, & Charles, 1990),
Successful resolution of threats to the therapeutic alliance

and that their views of therapy are frequently negative (Castillo, 2003). In addition to studying the efficacy and effectiveness of psychological methods, it is therefore vital to understand better how therapists who work successfully with borderline clients act to resolve threats to the alliance during the course of therapy to promote a favourable outcome.

Choice of method

To study the treatment of borderline personality disorder with cognitive analytic therapy, we used the ‘events paradigm’ of psychotherapy research (Safran, Greenberg, & Rice, 1988). This approach uses the intensive study of significant therapy events to describe the change process and is concerned with discovering patterns of in-session patient and therapist behaviours. The paradigm focuses on context – the particular therapeutic task presented by the patient; a particular applicable technique and the patient’s response measured both as immediate in-session changes (sub-outcomes) and as later post-session or post-therapy outcomes.

Cognitive analytic therapy lends itself to this research topic and paradigm, partly because in every routine CAT, there is a contemporaneous record of the clinical formulation agreed between therapist and patient. This in part consists of a diagram outlining the patient’s characteristic repertoire of interpersonal and intra-psychic patterns (known in CAT as ‘reciprocal roles’ and ‘problem procedures’). Each role is characterized by a particular subjectively experienced state of mind.

In cognitive analytic therapy, threats to the alliance are seen as re-enactments of dysfunctional interpersonal patterns in which the therapist is as active as the client (i.e. the difficulty is not located within the client but is seen as fully relational, or dialogical). In this respect, CAT is similar to Safran and Muran’s (2000b) brief relational therapy. This concept differs, although only slightly, from that of alliance rupture, in that the criteria for an alliance threat marker are based on the CAT concept of a reciprocal role enactment (such as ‘controlling–rebellious’) in a way which endangers the alliance. Therapists drawn into playing collusive roles which reinforce (by reciprocation) the client’s dysfunctional roles are opening the way to alliance rupture, even before a rupture actually occurs. The aim of the study was to identify clients’ recurrent dysfunctional patterns of relating (reciprocal role procedures’) and therapists’ reciprocations threatening alliance rupture and to observe how far therapists acted appropriately to avoid or repair such ruptures. The important but unanswered question is whether in practice they do so, and whether this is in fact characteristic of successful therapies compared with unsuccessful ones. We use the task analysis method (Greenberg, 1984b) to address this.

Task analysis draws on the events paradigm in psychotherapy research. As it is concerned with modelling the performance of individuals in specific situations, it is uniquely suited to the analysis of psychotherapeutic competence. It is a discovery-oriented research methodology, based on the intensive analysis of individual cases, using a rigorous, empirical, replicable method. The application of task analysis to psychotherapeutic events considers the patient’s process as a series of affective tasks to be resolved (Greenberg, 1984b; Rice & Greenberg, 1984). It is a powerful tool for describing and understanding theoretically crucial achievements made by patients in psychotherapy. Previous applications include the resolution of conflicts (Greenberg, 1984a); resolution of problematic reactions (Rice & Sapiera, 1984); changes in states of mind in therapy (Horowitz, 1987); resolution of core conflictual themes (Luborsky,
1984; the resolution of in-session conflict (impasses) between parents and adolescents in family therapy (Diamond & Liddle, 1996); and, most relevant to the current study, Safran and Muran’s (1996) research on the repair of alliance ruptures.

**Research aims**

1. To build an empirical model of how CAT therapists in routine clinical practice resolve threats to the therapeutic alliance during time-limited therapy of borderline personality disorder with good outcome.
2. To compare the actions of CAT therapists in poor outcome cases with this empirical model.

**Method**

**Overview of method**

We adopted the following research strategy:

1. Using standardized measures, we identified patients meeting diagnostic criteria for borderline personality disorder from routine clinical practice that exemplified good and poor outcomes of cognitive analytic therapy.
2. In good outcome cases, we examined the fluctuations in the alliance over the course of therapy, on the basis of a sessional alliance measure. We thereby identified sessions in which, independent of the underlying trend of alliance scores over the course of the therapy, there had been deterioration in the alliance.
3. Aided by the CAT formulation diagram and listening to audiotapes, independent judges identified points within these sessions that they deemed to be ‘event markers’ for threats to the therapeutic alliance.
4. Each alliance threat event was judged to be ‘resolved’, ‘unresolved’ or ‘partially resolved’ on the basis of pre-determined criteria.
5. We then used the task analysis method to develop an empirical model of therapist action as follows:
   (a) A panel of three psychotherapists first developed a ‘rational’ model of how such threats should ideally be resolved, based on clinical experience, research findings, and theory.
   (b) Although the ‘rational’ model predicted what therapists ought to do, it was then compared systematically with what therapists actually do to resolve alliance threats, and amended in the light of the empirical observations.
   (c) Each event was examined separately in relation to the ‘rational’ model, and amendments to this model were made reiteratively, on the basis of independent observations and subsequent discussion between the researchers to reach consensus.
   (d) The ‘rational’ model was reiteratively adjusted and events were sampled, until no further refinements were made (‘saturation’ of the model). The resulting empirical model was tested using event markers of alliance threats from poor outcome cases. It was predicted first, that significantly fewer alliance threats would be resolved in the poor outcome cases and, second, that therapist behaviour in these events would be discordant with the empirical model of threat resolution.
Successful resolution of threats to the therapeutic alliance

Case selection
Cases were people aged 18–50 years, referred to the cognitive analytic therapy clinic at Guy's Hospital, London, for whom assessment and outcome measures were available. All met criteria for the diagnosis of borderline personality disorder on the basis of a standard interview schedule (the personality assessment schedule [PAS]; Tyrer, Alexander, & Ferguson, 1987). Local research ethics approval was obtained. An assessor explained the nature of the therapy and of the research, and written consent to participate and to audiotaping of sessions was obtained. Patients withholding consent received the normal treatment offered in the clinic. Those with an unacceptably high potential for violence were excluded, while those with high and continuous levels of substance abuse were referred to appropriate agencies. Patients were treated by experienced, registered cognitive analytic therapists who received ongoing supervision. Therapy length was between 16 and 24 sessions, the final number being negotiated at Session 12, with follow-up at 1, 2, 3 and 6 months. In every case, the therapy was completed prior to the present research.

Patients completed the following measures administered at assessment (pre-therapy), at the end of the therapy and at each follow-up: Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); symptom checklist-90R (SCL-90R; Derogatis, Lipman, & Covi, 1973), and Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988).

Cases were considered to have a good outcome if they met criteria for statistically reliable and clinically significant improvement (Jacobson, 1988). The criterion for this, given the severity of disturbance in this group of patients, was movement greater than one standard deviation in the direction of functionality on all outcome measures. Following Jacobson and Truax (1991), patients failing to meet a reliable change criterion based on the standard error of measurement of the measures were excluded from the ‘good outcome’ group.

Cases were considered as poor outcome where they demonstrated statistically reliable deterioration on at least two of the outcome measures, irrespective of the degree of change.

Session selection
After each session, patients completed the Therapy Experience Questionnaire (TEQ), a brief self-report measure, which focuses on the client’s experience of the therapeutic relationship and engagement in the therapy, and is sensitive to changes in the therapeutic alliance over the course of therapy (Ryle, 1995).

TEQ scores across therapy sessions were plotted for each patient and the technique of median smoothing (Tukey, 1977) was used to identify sessions for which the TEQ scores were unusual in relation to the underlying trend in scores.

In selecting sessions for identifying significant events and their resolution, two sampling decisions were made. As therapeutic work using the reformulation diagram was of primary interest and this is seldom established before Session 5, sampling started at Session 5. As the session prior to the identified alliance fluctuation may contain significant events and as work on resolution may continue over subsequent sessions, selected sessions included one session prior to each identified session and two sessions following this. In some cases, sessions were sampled until the smoothed curve indicated a return to stable values.
Event identification: Enactments
Within the selected sessions judges were asked to identify enactments: evidence of a relationship pattern in the patient–therapist interaction, which was specified in the CAT reformulation diagram, and which constituted a threat to the therapeutic alliance (an example of such a diagram is given in Fig. 1).

The diagram for ‘Tom’ incorporates terms that had emerged in the sessions. There are three separate reciprocal role patterns (self-states). One described the childhood-derived central reciprocal role as ‘rejecting critical fascist’ in relation to ‘waste of space’. This was derived from the physical and emotional abuse from his mother and stepfather; the internalized dismissive self-to-self procedure being identified as his ‘internal fascist’. He would escape from perceived threats or experiences of abuse to a ‘pink spectacles’ state in which he longed for and fantasized acceptance from others. This was followed by disillusion, involving either a return to the childhood state or by switching to the ‘sand dunes’ state when feelings were muted and it felt like there was nobody there, a state of ‘nobody in relation to nobody’, which was associated with the risk of self-destruction. Tom had retained two loyal friends but he could come to feel too needy and would disallow his own needs and mistrust and dismiss the care offered.

An example of an alliance threat event related to this diagram is as follows:
T1 How’s the week?
P2 Shit.
T3 Shit.

Figure 1. Self States Sequential Diagram (SSSD) – Tom.
Successful resolution of threats to the therapeutic alliance

P4 Started off shit and shit all the way through. Urr, I’m not coming next week.
T5 Why is that?
P6 Because I can’t be fucked. I can’t be fucked with anything. I couldn’t give a toss.
This experience is acknowledged and explored.
T7 Do you feel angry after last week?
P8 No.
T9 You seem uncertain about coming.
But continues within the session
P10 Just, no. Life is shit, life is shit, I don’t look forward to anything, I’ve no enjoyment.

P16 I’m angry, I’m going to kill myself.

A coding method (Ryle, 1992) was used with session transcripts and audiotapes to identify these events, according to raters’ identification of evidence of the patient’s relationship patterns as outlined in the diagram, emerging in the patient–therapist interaction. Raters are required to name the specific pattern from the diagram. The raters then code the therapist intervention and patient’s response in a structured format.

The above example was coded as an enactment of the patient fearing he would be disappointed by therapy, he wouldn’t get all he longed for (‘pink spectacles’) so he cut off (the ‘sand dunes’), placing him at risk of suicide.

The method we adopted for event identification relied on the agreement of three expert raters making independent observations. To maximize the likelihood of valid ratings, all raters were experienced CAT therapists and trainers, familiar with the task. Two of the three raters were blind to the classification of therapy outcome for the patients studied. To promote reliable ratings, the training of raters involved individual instruction and practice ratings of ‘precalibrated’ therapy sessions. Training and discussion continued until a high level of agreement (>90%) was reached on event identification in the practice cases, with rater reliability and consensus checks after each case. A consensus meeting allowed raters to review their independent ratings of enactment markers and resolution, in light of the other raters’ views.

Only those events for which there was independent agreement between at least two of three raters were selected for task analysis.

Identification of event resolution

Criteria for whether or not a threat to the alliance had been resolved were pre-set, requiring two indications of enactment resolution: (i) an explicit statement of understanding by the patient; and (ii) an affective shift, indicating emergence from the alliance-threatening enactment. An enactment was said to be resolved if both criteria were met; partially resolved if one or other but not both were met, and unresolved if neither criterion was met. An example of an enactment resolution in relation to the alliance threat illustrated above is given later.

Task analysis: The rational model

The rational model of the ‘ideal’ stages of successful alliance threat resolution was based on a consideration of relevant psychotherapy research and theory with CAT-specific
elements (such as the view of expert CAT therapists, clinical experience, observations of relevant task performances within CAT sessions).

The ‘expert’ consensus was developed by the first and third authors working independently, empathising with the therapist and patient through self-directed questions ‘What would I do now? What should I not do?’ Their independent versions were consolidated into an agreed draft, which was then modified through discussion with Professor David Shapiro, an independent clinician-researcher who was not a CAT therapist but was familiar with the research paradigm and the research evidence in this field.

Theoretical influences on model development included:

- Sullivan’s (1953) ‘participant-observer position’;
- Kiesler’s (1988) concept of therapeutic meta-communication;
- Hobson’s (1985) emphasis on a shared frame of reference, use of negotiation and the collaborative exploration of the patient’s problems;
- Klein, Mathieu-Coughlan, and Kiesler (1986) on client experiencing and engagement in therapy;
- Sandler (1976) and Wachtel (1991) on role-responsiveness and the therapist’s ability to hold this in awareness;
- Crits-Christoph, Barber, Baranackie, and Cooper (1993) and Butler and Strupp (1993) on repeatedly helping the patient to understand, rather than act out, the problematic interpersonal patterns;
- Evidence that exploratory interpretations are viewed as more empathic (Barkham & Shapiro, 1986) and tentative interpretations as more positive (Jones & Gelso, 1988);
- Benjamin’s (1993) emphasis on what she describes as a precarious stage of needing to accept that the ‘old adaptations’ are no longer useful before being able make a genuine choice to learn new more adaptive patterns.
- An important CAT-specific element was the view that CAT descriptive reformulation and the collaborative therapeutic stance aims to recruit the patient’s potential capacity for self-reflection, and avoids the risks associated with the misuse of interpretation, such as the denial of dialogue and establishing a power differential (Ryle, 1994).

Task analysis: Empirical phase
The empirical analysis had two stages – preparing and coding the text to reveal the ‘performance pathway’ in terms of therapist actions, followed by detailed comparison of the rational model with the actual performance.¹

Preparing and coding the text
Following from each marker, identified by raters, the therapist task was broken down into its simplest elements and then developed into a comprehensive descriptive account of the components and stages of each performance.² The verbatim transcript, following

¹ A fuller account of these procedures including a detailed description of the full procedure for preparing and coding the text, the Ryle coding system and an example of prepared text is available at http://www.sheffield.ac.uk/scharr/sections/mh/psychotherapy/alliance.html
² We acknowledge the contribution of Heather Harper following preliminary work in developing the empirical analysis. This assisted in clarifying the first three stages of the empirical analysis and extends the procedure described in Agnew, Harper, Shapiro, and Barkham (1994).
the identified marker, was first reduced to speech units and coded using a modified version of the Sheffield psychotherapy rating scale (SPRS; Shapiro & Startup, 1990) with 4 items from Ryle’s (1992) procedural coding measure.

A verbal commentary of the activities in each speech unit was added based on the operational codes. Accounts of each resolution performance were generated in terms of a series of functionally defined steps, each of which was given a title to reflect the main activity, for example, ‘T and P acknowledge therapy experience’. Each event marker identified by the independent raters was classified in terms of its location on the patient’s reformulation diagram.

To illustrate this stage in the analysis, the example of an alliance threat given earlier is continued, with the therapist performance pathway coded. The diagrammatic reformulation for this client is given in Fig. 1. The following dialogue followed shortly after the example given above. This also illustrates resolution of an alliance threat.

P76 Life is shit.
T77 Life isn’t only shit.
P78 I’m not going to get fucking caught out again. No fucking way.
T79 What, try again and be disappointed again?
P80 Yes. I have done therapy now and given that a try but life I won’t let anyone get near me.

Stages 1 and 2: Acknowledgement (of feelings) and exploration (focusing on this pattern)

T83 Are you saying that you can’t bear to try to get anything to work because the disappointment is so unbearable if it goes wrong?
P84 Yes.
... . .

Stage 2: Exploration (focusing in reference to therapy relationship)

T89 Therapy is now something that you don’t want to risk either?
P90 No.
T91 You said you didn’t want to come next week. . .
P92 Yes.
T93 What’s the reason you don’t want to come?
P94 Because I have come to the conclusion that me not coming to therapy/
P95 Would be?
P96 Probably suicide. I know that I have to cut myself off.
T97 Not coming is a step on the way to suicide? Are you going to take that step?
P98 Yes.

Stage 3: Linking and explanation (hypotheses and using language of CAT reformulation)

T99 So you are saying that you are not going to give therapy a chance, you can’t bear the risk of trying to change?
Silence

T100 You can’t make an informed choice to kill yourself, whilst you are under the power of the fascist in your head. We know that there is part of you that is dismissive and destructive towards yourself, it’s been there in different ways all your life and we know where it came from. Why, when
you have some chance to understand that better and have some help to defeat it do you then hand over, or why do you want to hand over?
P101 Because I'm not bothered.
T102 Being not bothered is just accepting a definition of yourself as a waste of space, rather than a definition as a human being with possibility and quality.
P103 Yes.

The therapist directly refers to Tom being dismissive of therapy, sustaining the therapeutic alliance whilst focusing on this alliance (and life) threatening enactment. Tom softens, reflects, and agrees which raters class as the beginning of a process of engagement.

Stage 4: Negotiation and stages 6/7: Further explanation to engage with alternatives to patterns

T104 Well, you can decide to accept the definition of yourself as a waste of space but there is a choice. There is another way of thinking about yourself that you have begun to do here.
Silence.

The therapist links to the CAT diagram and moves to consider alternatives to the old pattern (offering a rationale). This statement (104) conveys additional components to the ideal model (T explains that P has engaged differently, which conveys hope) as if capitalizing on the shift in Tom’s state that may be occurring. Silence is followed by exploration of the patient’s view of and doubts about change.

T109 If your choice was between living in shit and feeling a waste of space or being cut off on the sand-dunes, I wouldn’t be arguing for you to have a life, as that is no way to live.
P110 I've got no choice, I know what my choice is, to die, ( . . ) to go to the edge.

The therapist empathically, and within the relational context, focuses on the possibility of an alternative to the pattern, but the enactment remains alive.

Stages 1 and 2: ‘Cycling back’ to allow further acknowledgement and exploration of the enactment

P115 I have flashes of rage, I am so angry. I need to be out of my head to kill myself.
T116 But is it revenge on the world or revenge on yourself?
P117 Mmm.

T125 I hear the fascist in you again, destroy, destroy, you just turn tables on how it felt for you. It's terrible as it feels that it is all you can do.

Tom expresses the power of the destructive state, which the therapist explores and links (explicit link to CAT reformulation). The therapist is working hard to help Tom recognize and change the identified procedures, particularly the internalized fascist but although Tom has some recognition, he remains under the power of these internalized
destructive roles. There is a sense of being ‘stuck’ here, and raters consider that the therapist is in tune with Tom’s pointlessness.

**Stage 3: Linking and Explanation (cut off, can’t risk closeness, needy)**

T160 I think what’s happening here, what happened then, what’s happening in you, is that part of you, that is desperately in need of some care, like you said last week, you wish to be able to be held and rocked and allowed to cry, which is understandable. That part of you, when you get any kind of sense of someone being there for you, you are so overwhelmed by the intensity of the feeling that you have to back off. There is such a well of neediness that you can’t risk letting anyone near enough to help you. So you back off and go off to the sand-dunes as if it is the only place to go.

P161 I disagree.

Silence

P162 Are we talking about the past or on the ward?

T163 The ward, friends, me. In all those contexts, people are allowed so near and then you break contact.

P164 I still disagree…

Silence

The therapist returns the focus to the therapy relationship with a clear linking and explanatory hypothesis, and generalizing (patterns in relationships). Although the therapist is empathic to Tom’s feelings and is accepting of the state (which amounts to the rejection of help), Tom disagrees and the raters identify him as unreachable (sand-dunes state). After a period of silence, Tom shows interest and the therapist explains again (linking and explanatory hypothesis), Tom still disagrees and describes a relationship with a woman who rejected him.

**Stage 4: Negotiation**

T165 Are you saying that that was one of the lessons not to get close to people because they are going to betray you?

P166 Yes. I still stood by her.

T167 With Anna, that was true, with Tina it wasn’t true, you wouldn’t go back and you still feel angry with her. What about the therapy, you haven’t felt betrayed yet, I hope you won’t be but you may feel it.

T168 Can you risk it?

The therapist uses this material to negotiate agreement (negotiating style), but this empathic exploration of Tom’s disagreement also seems to be preparatory work (classed as ‘alliance building’) before attempting further resolution of this enactment, which continues.

P169 No.

**Stages 4 and 6: Negotiation and Further explanation**

T170 Why is that more difficult?

P171 Because the things I want aren’t going to happen (crying).

T172 One of the problems about the degree of want that you have and degree of need that you have is that it is very hard to know what you could take that is less than you need. In a sense, that is what you have to do always,
get what you can from people, but nobody ever gets all they want, nobody ever gets everything made up for. In your case, it is so hard to take because there is so much deprivation there. But you have, for example, with Anna, not got all that you want but you got something, that’s what you have to do and not be so angry and disappointed that you just cut off from it.

P173: I disagree, I’ve been so shut on . . . I deserve a good deal.

T174: Yes, you do, but a good deal can only be what people can manage and not something that is magical, that makes everything better or gives all that you need. You may deserve that but can only get what people can give. It’s imperfect but human.

Silence

Stage 5: Consensus

T175: So you don’t disagree too much about that?

P176: (different tone of voice) I wonder how my judgment formed?

(Resolution marker: affective shift)

T177: Your judgment is informed by many things but of the many things, I still see traces of your history, although you have rejected what people did to you, you have also incorporated some of it into yourself. If you hadn’t lived your life in the way you were treated, you would get better, if you could give consideration to yourself like you do to others but part of you still treats yourself in the way you were treated, which I can understand but I am not on that side. I am on the side of repair rather than continuing damage. Do you understand that?

P178: Yes.

(Resolution marker: explicit statement of understanding)

There is a deepening of affect that goes beyond acknowledgement in this section where the therapist facilitates Tom to be in touch with painful previously avoided affect. This and the explicit self-disclosure also reflect a therapeutic relationship in which there is authentic human contact. These are refinements to the ideal model and are discussed later. The proposed alternative to the old pattern, running through this resolution attempt, is to engage with the therapist (and others) in a relationship that offers a realistic alternative to Tom’s wish for perfect care (implicit link to CAT tools).

Validating and refining the model

The rational–empirical comparison systematically compares the rational model and the performance descriptions obtained from the empirical analysis. Cumulative revisions to the rational model are derived from the analysis of events across cases made by independent judges, resulting in a refined model. Each reiteration from the conceptual stages of the rational model through a detailed inspection of a resolution performance produced a more informative and refined map of the stages that patient and therapist move through in achieving successful resolution.

All resolution performances from the available cases were used. Beginning with Enactment 1 in Case 1, consistencies and inconsistencies between the rational model and the resolution performance were evaluated. The rational model was then revised. The revised model was then used for comparison with the next resolution
performance, and so on for enactment events from the subsequent cases. As long as continuing reiteration produced new findings, it was considered worthwhile to continue. When the addition of further cases did not add any new discoveries or refinements, the process was judged to have reached a saturation point (Greenberg & Newman, 1996).

Four judges (including the authors) were involved in the rational-empirical comparison, all experienced therapists, trainers, and supervisors in CAT, but entirely independent of the evaluation or clinical management of the therapists who had conducted the therapies under study. After analysis of 107 enactments over four cases, all judges considered the model to be saturated.

**Study of poor outcome cases**

Poor outcome cases were selected from the same clinic population using the criterion of statistically reliable deterioration on at least two measures. The same methods for session selection, event markers, and reliability checks between judges of events were used. In this case, the rational-empirical comparison systematically compared the actual resolution performances in the poor outcome cases with the refined performance model.

The first author conducted an independent rational-empirical comparison beginning with case five, working through each alliance threat event. Consistencies and inconsistencies between the refined performance model and resolution performances for the 16 enactment events in Case 5 were noted. Consistencies and inconsistencies between the refined performance model and resolution performances for the 19 enactment events in Case 6 were noted. The judges performed an independent rational-empirical comparison, listing consistencies and inconsistencies. The first author evaluated the independent comparisons of all three judges, the three lists of consistencies and inconsistencies and the second and third judges' comments on the first author's analysis. The aim was to summarize areas of agreement and disagreement for a consensus review meeting. There was 100% agreement between the judges and hence no consensus meeting was held.

**Results**

**Case, session and event selection**

The agreement between pairs of raters using the Ryle measure to identify the event markers was assessed using kappa (Cohen, 1968). Of the total 524 episodes within the six cases, 460 were scored as examples of alliance threat events by two or more raters. Analysing rater agreement for these episodes across rater-pairs (three raters) and by case (six cases) resulted in 18 inter-rater reliability calculations. With the exception of one value in the lower range (0.22), agreement was found to be fair or moderate (range 0.35–0.48; Landis & Koch, 1977) and adequate for the purpose of this study. Considering the enactment events, following consensus review all three raters agreed on 95% of events and at least two raters agreed on all enactments. Across the four good outcome cases, 107 events met the criterion that only those for which there was independent agreement between at least two raters were selected for task analysis. For poor outcome cases, 35 enactment events met this criterion.
Rational model

The rational model is summarized in Fig. 2. This hypothesizes five stages constituting an alliance threat resolution performance, and three further stages which allow further reflection on the alliance threat event, in the service of change. In the first stage, acknowledgment, the therapist makes explicit her or his recognition that there is an in-session experience or event, acknowledges the patient’s expressed feelings or describes his or her sense of the feelings. The therapist intervention directs the patient’s attention to the here-and-now of the therapeutic relationship and conveys empathy and acceptance for the patient’s experience. An example would be ‘how are you feeling

Figure 2. The rational model.
about what is going on between us right now?’ The intervention facilitates the 
exploration of the relationship enactment, which becomes the second stage.

Following from the therapist’s invitation is the second stage of exploration, where 
the nature of what is felt is explored and clarified in an open way. The therapist and 
patient express and explore their perceptions and feelings. Through the therapist 
fostering a collaborative, participative style, they clarify their separate understandings of 
the in-session event and ideally reach a shared understanding. This facilitates the third 
stage, linking and explanation, in which the therapist invites the patient to link the 
feelings with the CAT reformulation, or proposes how they might be linked. This may be 
extended by linking the episode to earlier examples in the therapy, to other shared tools 
or metaphors, to relationships with others or with childhood memories, but the link 
with the reformulation will be the main focus.

In the fourth stage, negotiation, the patient’s acceptance that a link exists is 
amplified and understandings of the link are elaborated. Doubts and objections are 
explored and the therapist invites disagreements and agrees modifications. On the basis 
of this negotiation, a fifth stage, consensus, is reached with a ‘resolved’ agreement about 
the in-session event and its association to other relationships or its origin in the past. 
This awareness emerges at an emotionally immediate level.

There are three additional stages constituting further explanation, new ways of 
relating, and closure. The relation of the identified relationship pattern to the whole 
reformulation or to the core repertoire of relationship patterns is established (extension/further explanation). In new ways of relating, alternatives to the identified 
maladaptive relationship pattern already exemplified by the collaborative work can be 
进一步 explored, for example, through discussion or role play, and this may lead to the 
identification of alternatives to the current pattern. In the final closure stage, the 
therapist uses the resolution to indicate to the patient that constructive change is 
possible and affirms the focus of therapy on the therapeutic relationship. While working 
towards resolution through the stages of the model the therapist does not collude with – 
that is, reciprocate – the expected role in the enacted relationship pattern nor does the 
therapist enact an alternative pattern identified in the patient’s reformulation diagram.

This rational model does not represent a fixed, linear order of resolution stages, 
but it is assumed that cycling within and between stages will occur. Neither was the 
rational model presented as a perfect resolution performance but as a ‘best guess’ at 
what may be required in CAT for resolution. As such, it served as a framework to guide 
the empirical analysis.

**Therapists’ recognition of alliance threat events**
We observed from the empirical analysis of sessions, that therapists in the good outcome 
cases recognized, and acknowledged to their clients, 90 of the 107 enactments. In other 
words, Stage 1 of the model was reached for 84% of enactments and only 17 (16%) 
enactments were not picked up by the therapists.

**Identification of resolution**
Methodological checks were made to establish whether the two predetermined criteria 
of alliance threat resolution did in fact appear. Raters identified the first (explicit 
statement of understanding) in 87 (80%) resolution performances. Here, the patient 
made a statement indicating that: (a) they recognized and agreed that an enactment had 
ocurred; and (b) they understood the form of the enactment, for example, location on
the reformulation diagram. Illustrations: ‘I can see what you are saying there and I agree’, ‘so, I am still running away’.

The second criterion of resolution (affective shift) was observed in 76 (70%) resolution performances. Here, the patient (a) emerges from the problematic states recognisable on their reformulation diagram (b) moves to a state marked by feelings of: calmness and relief (‘all these things are starting to make sense’); trusting and sharing (‘I know what do to but I find it hard’); optimism, possibility and hope (‘it is something inside me saying I want to die . . . that’s how I felt about myself. Now, I feel it is curable’) and warmth and humour ([laughing] ‘that’s why I slagged you off last week . . . not caring for me enough’)

The two criteria were accepted as reliable resolution markers, and raters classed 57 of the 107 alliance threat enactments as resolved (53%), 36 as partially resolved (34%), and 14 as unresolved (13%).

**Empirical analysis**

To achieve saturation of the empirical model, a total of 107 alliance threat enactments, in 66 sessions, from four good outcome cases were required. There was confirmation in each of the cases for the eight stages of the rational model. Case 1 added 16 refinements, Case 2 confirmed 13 of these and added a further three, Case 3 confirmed all 19 refinements added by the previous cases and contributed one further refinement, and Case 4 provided confirmation for 19 of the 20 refinements but did not add anything further. Sampling stopped at this point.

The final, empirical performance model is summarized in Fig. 3.

The refinements reflect modifications in both content and form. Of the 20 refinements to the model, 9 elaborated the eight stages of the rational model, 5 identified new tangential ‘when–then’ steps, 1 represented a new stage, and 5 were heuristic guiding principles. The rational, linear stage model was therefore altered to construct a performance model with tangential phases and cycling between stages, and a set of heuristic guiding principles. The refined performance model contains algorithmic (‘when–then’) and heuristic (‘whenever and always’) rules. The refinements are identified below in italics.

**The new tangential when–then steps**

There were five tangential steps – interventions that the therapist engages in at specific junctures, before resuming the focus on the alliance threat enactment. The therapist’s focus on outside events and establishing a reality base to the enactment, occur early in the process, before or after an initial acknowledgement of the enactment. These and similar supportive gestures attend to the alliance as they address a concern of the patient and can prevent or be used in response to patient disengagement with the in-session focus. It appeared that only by allowing space for patient-produced material at points of disengagement were successive attempts at resolution possible.

There was repeated cycling between stages as the therapist facilitated the patient’s engagement in enactment resolution; for example, the performance did not proceed beyond the linking stage without securing a consensual acknowledgement of the in-session experience. Therapist and patient were engaged in a progression through different levels of understanding, emotional awareness, and assimilation, demonstrating the inadequacy of a linear stage model. After consensus, therapists made an inquiry to assess resolution or continued presence of the alliance threat enactment.
Following consensus recognition, the patient was helped to understand and assimilate the feelings of the core state(s) and the problematic experiences that the concept represents. These feelings and experiences had usually been warded off and they had caused psychological distress when brought to awareness. The therapists offered validation and support to engage the patient in relearning how to approach feelings and they used the individualized reformulation tools, developed with the patient’s collaboration, to explain why the problematic experiences could not be, and had not been, assimilated. This new stage, in which the therapist uses these tools to facilitate experiencing while offering an explanation and rationale for this, is a context that holds and focuses the patient’s attention on these avoided experiences.

**Components within stages**

Identified within explanatory stages, (a) CAT-specific explanations are used to explain the CAT theoretical understandings in reference to the patient’s reformulation. They involve the therapist giving detailed explanations of CAT understandings of the patient’s current situation; the recurrent nature of procedures and that they occur with the
therapist; the use of counter-transference disclosure to illustrate and explain the emergence of Reciprocal Role Procedures (RRPs) within the therapy relationship and the development and need for procedures (as survival strategies) given the patient’s history.

Identified within the final stage, therapists (b) facilitated the patient’s engagement in change through alternatives to identified patterns. These refinements to the rational model involved the therapist explaining alternatives the patient had and could engage in, with others and the therapist; anticipating difficulty with, or rejection of these and supportive interventions as the patient considers or engages in the difficult process of revising interpersonal or intra personal patterns.

The heuristic guiding principles
The refined performance model elaborated the collaborative and non-collusive therapeutic stance of the rational model. The therapist used invitations to enlist the patient’s participation directly and to verify understandings reached through a specific intervention of inviting and following the patient’s view at times of disengagement with the model. Related to the collaborative stance was the observation that therapists used the patient’s most benign relationship patterns to achieve the work of therapy, but observed those aspects of the working alliance that risked enacting procedures (e.g. a patient who appears to be ‘responsible’ and engaged in the work of therapy, may become ‘anxiously striving’ if they perceive the therapist as critical).

Non-collusion involved refraining from enacting a damaging pattern or pointing it out if this occurred (meta-communication). The rational model had proposed that it was not possible to disconfirm patients’ role expectations perfectly. This was refined through the empirical phase and a form of permissible collusion was defined as a reciprocal role, which the therapist was aware of and used to secure an alliance when model-consistent performance had failed to resolve an alliance threatening enactment.

The refined performance model proposes that therapist competence would reflect that the therapist had awareness of and discussed this with the patient.

There were two new heuristic principles: First, silence, which facilitated a self-observing capacity with subsequent contributions by the patient advancing the work of therapy. Reflective and linking statements were offered within an empathic and respectful relationship in which the therapist was in tune with the patient’s experience and affect. This form of relating was identified as authentic human contact. The therapist demonstrated their identification with the patient (their experience of the patient’s situation), and this guided their entire approach. Therapists used self-disclosure and showed vulnerability and aspects of their real self in the service of modelling a new way of being to the patient. Therapists’ behaviour consistently disconfirmed patient’s negative self-expectations and there were specific attempts to keep alive this new, less problematic, reciprocal role procedure, through promoting the use of the reformulation tools at the end of therapy.

The therapist also engaged in this authentic relationship at points of life-threatening or therapy-threatening enactments. It may have allowed the therapist in the case illustrated in this paper (Case 3) to be heard when challenging the patient to consider change (e.g. through questioning how he was treating himself). The refined performance model in this context is non-confrontational. The therapist was observed to work against the internalized roles.
Successful resolution of threats to the therapeutic alliance

**Verification phase: Alliance threat in poor outcome cases**

For Case 5, 95% of alliance threat enactments were identified by all three raters and 100% were identified by at least two of three raters. For Case 6, 87.5% of enactments were identified by all three raters, and 100% were identified by at least two of three raters. Across these two cases, all 35 enactments met the selection criteria for task analysis.

The judges were able to locate only 18 of the 35 enactments (51%) on the patient’s reformulation diagram. Six of the 15 enactments in Case 1 and 12 of the 19 enactments in Case 2 were not adequately represented on the diagrams. In contrast, the judges were able to locate all of the 107 enactments of the good outcome cases on the patient’s respective diagrams. This difference was statistically significant ($\chi^2 = 64.06, df = 1, p < .001$).

**Therapists’ recognition of alliance threat enactments**

Therapists in the poor outcome cases recognized, and acknowledged to their clients, only 12 (34%) of the 35 enactments. This is significantly different from therapists in the good outcome cases who picked up in the sessions 90 (84%) of the 107 enactments ($\chi^2 = 32.36, df = 1, p < .001$). That is, these therapists often did not even reach Stage 1 of the model for successful resolution of alliance threats.

**Identification of resolution**

In the poor outcome cases, 1 (3%) enactment was classed as resolved, 7 (20%) were partially resolved, and 27 (77%) were unresolved, indeed predominantly unrecognized. In contrast, for the good outcome cases, 57 (53%) enactments were resolved, 36 (34%) partially resolved, and 14 (13%) unresolved. The difference between therapists of good and poor outcome cases was statistically significant ($\chi^2 = 55.5, df = 2, p < .001$).

**Rational–empirical comparison**

The rational–empirical comparison based on resolution performances of poor outcome cases showed that:

(a) the majority of alliance threat enactments were not recognized or acknowledged by the therapists;
(b) they were frequently colluded with;
(c) if acknowledged, they were only partially or poorly explained to patients; and
(d) such attempts at explanations were misunderstood or rejected by the patients.

In summary, the components of the refined performance model were infrequently observed in these resolution attempts. An example is given here:

```
T    How are you feeling now?
P    Just yucky. I’m not able to describe it, pissed off.
T    You look quite tense. . .
P    I suppose I am, I feel tense. I’ve got my guard up.
T    Have you?
```

The therapist’s surprise suggests that she had made a general process inquiry rather than an intentional acknowledgement of an in-session alliance threat enactment. Her
statement nevertheless facilitates exploration in which the client confirms that she has to keep up her guard to prevent showing her feelings to the therapist. They reach an understanding that the client is attempting not to show any vulnerability or feelings in the therapy, but although this pattern is clearly shown on the reformulation diagram, this link is not made, and the alliance threat continues to be enacted.

Discussion
The task analysis reported here supported the rational model of alliance threat resolution in cognitive analytic therapy; each of the posited stages was independently observed, and several refinements were added.

One salient addition to the rational model was that successful resolution of these alliance threats involved facilitating the patient to process previously avoided feelings and memories. This is held to be a component of many psychotherapies and a common change mechanism (Greenberg & Safran, 1987; Stiles et al., 1990). This was consistent with the assimilation model of change in psychotherapy, in which problematic experiences are seen as being processed through eight stages, from being warded off to mastery, as they are assimilated into schemata (Stiles et al., 1990). Psychotherapeutic approaches differ in where, along the assimilation continuum, they focus.

A striking finding was that therapists in good outcome cases identified a very high proportion of alliance-threatening enactments. In addition, although a relatively sophisticated clinical judgment, there was high agreement among the independent raters on the markers indicating enactment occurrence. The contrasting results from therapy sessions in good and poor outcome cases suggests that competent resolution of alliance-threatening enactments is crucially dependent on therapists’ ability to recognize them.

An unexpected finding was that there were times when a therapist’s interventions temporarily encouraged and reciprocated some problem patterns where they were necessary to maintain collaboration. For example, supportive interventions were used to preserve the therapy relationship. In accepting that the therapeutic alliance is necessary for the work of therapy to proceed, its preservation would have priority over everything else (Benjamin, 1993). Model-consistent interventions would be those that indicate that the therapist has awareness of their own role within the interaction, can communicate this, and can facilitate understanding and resolution of collusive processes.

One limitation of the task analytic method is that it is difficult to judge how far the findings relate only to its participants; that is, whether the findings are idiosyncratic refinements because of the particular therapists involved, or whether ‘saturation’ of the model depends on a particular set of judges. It is also unclear whether the findings can be understood or applied outside a cognitive analytic context, although the strong links to previous research suggest that they can. To overcome these limitations, independent replication in other therapeutic modalities is required. To some extent, this task analysis does provide an independent test of the alliance rupture resolution model of Safran and Muran (1996, 2000a). Their studies are linked to brief relational therapy, which unlike CAT, resists early formulation of the central difficulty. Instead therapists work with a process focus, emphasizing the importance of developing mindfulness, the capacity to observe internal processes and actions in relation to other people. Despite this difference in emphasis on the therapist’s task, our results replicate some aspects of their findings within a different therapeutic modality: the importance of meta-communication, of
focusing the client on the immediate experience, of collaborative exploration of the difficulty and of therapists acknowledging their contribution to it. This suggests these aspects at least have a broader applicability.

The extent to which it is possible to derive a generic model of alliance rupture and repair, or if such models are bound to be modality-specific, is an open question. This could be seen as an epistemological limitation of task analysis, since this ‘discovery-oriented’ method constructs a new rational model for each ‘experiment’, the results of which have to be integrated at a later stage. An alternative might be to build on current knowledge by undertaking a task analysis that explicitly aimed to build a generic model, to be tested across successive cases from very different modalities, for example, relational therapy, cognitive behavioural therapy, transference focused therapy and so on. This would of course require extensive collaboration between research groups from different therapeutic backgrounds.

Within cognitive analytic therapy, the empirically tested model is being used by therapists to develop their competence in resolving alliance ruptures, by attending to their own processes. Practical tools have been developed which draw on this work; for example, the therapist intervention checklist (TIC; described in Bennett & Parry, 2004a) provides a way for supervisors and trainees to examine small segments of therapy in great detail (termed microsupervision) to examine where the therapist’s performance is failing to resolve alliance threats arising from ‘reciprocal role enactments’. There is now no reason why any formal model of competent performance, or reliable and valid measure of therapist competence (Bennett & Parry, 2004b), should not be incorporated into a quality improvement system of feedback to therapists as a clinical support tool (Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003).

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