Repairing Alliance Ruptures

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One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is one of the better predictors of outcome across the range of different treatment modalities (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Much of the original research on the therapeutic alliance focused on providing empirical evidence for what had long been established clinical wisdom, namely, that a strong alliance is a prerequisite for change in psychotherapy. In the last decade or so, a second generation of alliance research has emerged that attempts to clarify the factors leading to the development of the alliance, as well as those processes involved in repairing strains or ruptures in the alliance when they occur. In this chapter, we review the recent research in this second generation of alliance research and spell out what we consider the emerging practice guidelines.

The concept of the therapeutic alliance has a long and controversial history in the psychoanalytic tradition (see Safran & Muran, 2000a, for a detailed discussion). In the past two decades, the concept has spread to other traditions as well, in large part due to its prominence in the psychotherapy research literature. One of the important factors leading to the flourishing of the topic in psychotherapy research was Bordin’s (1979) seminal reformulation of the alliance in transtheoretical terms. Bordin theorized that there are three components to the alliance: agreement on tasks, agreement on goals, and the bond. For him, quality of the alliance is a function of the degree of agreement between therapist and patient about the tasks and goals of treatment, as well as the quality of the affective bond between them. These three components influence one another in an ongoing fashion. For example, an initial agreement about tasks or goals will tend to enhance the quality of the bond. Alternatively, when there are disagreements, the existence of an adequate bond will facilitate the negotiation of tasks and goals.

The idea that this type of negotiation is central to the change process is implicit in Bordin’s (1979) original thinking but is brought out more explicitly in the final article he wrote on the alliance concept (Bordin, 1994). His conceptualization of the alliance influenced our earliest thinking on the topic of therapeutic alliance ruptures (Safran, Crocker, McMain, & Murray, 1990), but it is only with hindsight that we have come to see more clearly how prescient his thinking was.

It is not difficult to make an argument on pragmatic grounds that if the quality of the alliance is critical to treatment outcome, then it makes sense to do research on the question of how best to address alliance ruptures when they occur. At a more general theoretical level, however, it has become increasingly clear to us that the negotia-
tion of ruptures in the alliance is at the heart of the change process, and Bordin's formulation helps to provide a theoretical framework for clarifying how and why this is the case.

Traditional psychoanalytic conceptualizations of the alliance give priority to one type of goal or task over others (see Greenbut, 1967; Sterba, 1934; Zetzel, 1956). Although they emphasized the importance of the therapist acting in a supportive fashion in order to facilitate the development of the alliance, ultimately, they assumed that the patient would identify with the therapist and adapt to his or her conceptualization of the tasks or goals of therapy (for example, the use of interpretation in order to gain insight). In contrast, Bordin's conceptualization is more dynamic and mutual. It assumes that there will be an ongoing negotiation between therapist and patient at both conscious and unconscious levels concerning the tasks and goals of therapy and that this process of negotiation both establishes the necessary conditions for change to take place and is an intrinsic part of the change process.

This conceptualization is consistent with an increasingly influential way of thinking about the therapeutic process that is emerging from contemporary relational psychoanalytic thinking (Mitchell & Aron, 1999). This perspective holds that learning to negotiate the needs of the self versus the needs of others is both a critical developmental task and an ongoing challenge of human existence. Many of the problems that people bring into therapy are thus influenced, at least in part, by difficulties they have in negotiating this tension in a constructive fashion. The development of a relationship with the therapist inevitably involves this type of ongoing negotiation between two different subjectivities at both conscious and unconscious levels. This process can have an important impact upon the patient's fundamental sense of the extent to which he or she lives in a potentially negotiable world or needs to compromise his or her own sense of integrity in order to hold onto relationships (J. Benjamin, 1990; Mitchell, 1993).

What we are thus arguing is that therapeutic tasks and goals, in Bordin's terms, provide an important part of the substance of the negotiation that inevitably takes place in any therapy. This negotiation is always taking place, sometimes explicitly and sometimes implicitly. When things are running smoothly, the negotiation may take place without conscious awareness. For example, the therapist may decide, without thinking, to not use a particular intervention because he or she has a sense that the patient will not find it helpful, or the patient may give the therapist the benefit of the doubt and try on an interpretation for size, or try a behavioral assignment even though he or she is initially skeptical. But when things break down and there is an overt rupture in the therapeutic alliance, this process of negotiation moves into the foreground.

It should be emphasized that as we see it, this process of negotiation is not a superficial negotiation toward consensus, but rather a genuine confrontation between individuals with conflicting views, needs, or agendas. Both patient and therapist struggle to sort out how much they can accommodate the other's view without compromising themselves in some important way. This conceptualization is thus less vulnerable to the previously mentioned criticism, which equates the alliance with compliance.

DEFINITION AND TAXONOMY

A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between patient and therapist. These ruptures vary in intensity from relatively minor tensions, of which one or both of the participants may be only vaguely aware, to major breakdowns in understanding and communication. The latter, if not addressed, may lead to premature termination or treatment failure.

Following Bordin's understanding of the alliance, we find it useful to conceptualize ruptures in the alliance as consisting of (1) disagreements about the tasks of treatment, (2) disagreements about the goals of treatment, or (3) strains in the bond. An example of a disagreement about the goal dimension would be a situation in which the patient begins treatment seeking immediate relief from his or her panic symptoms, but the therapist believes the goal should be one of obtaining insight rather than immediate symptom relief. An example of a disagreement about the task dimension would be a situation in which the
patient believes that it is important to spend time reviewing and making sense of his or her history, but the therapist has a present-focused, pragmatic orientation. An example of a strain in the bond dimension would be a situation in which the patient feels patronized or misunderstood by the therapist. These three types of ruptures are, of course, not mutually exclusive. For example, the patient whose therapist is unwilling to negotiate the tasks or goals of treatment may feel misunderstood or disrespected. Conversely, a patient who feels mistrusting of his or her therapist will be more likely to disagree with the therapist about a therapeutic task or goal.

Elsewhere, we have outlined a taxonomy for schematizing different types of interventions for addressing or resolving alliance ruptures, which follows from the above conceptualization (Safran & Muran, 2000a, 2000b). This taxonomy emerged out of our attempts to synthesize the contributions of theorists from a range of different therapeutic orientations. In table 12.1 and in the following discussion, we describe this taxonomy in brief, in order to provide the reader with a broad overview of the range of different types of alliance rupture interventions.

Dimension 1: Directness versus indirectness of intervention. Each of the three types of ruptures (disagreements about task, disagreements about goals, or strains in the bond) can be addressed by the therapist either directly or indirectly. For example, if the patient questions the relevance of completing homework between sessions, the therapist may respond directly by providing a therapeutic rationale or indirectly by changing the therapeutic task (in this case abandoning the task of completing homework assignments).

Table 12.1. Therapeutic Alliance Rupture Intervention Strategies

<table>
<thead>
<tr>
<th>Disagreements on Tasks and Goals</th>
<th>Strains in the Bond</th>
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<tbody>
<tr>
<td>Direct</td>
<td>Indirect</td>
</tr>
<tr>
<td>Indirect</td>
<td>Direct</td>
</tr>
<tr>
<td>Indirect</td>
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**Surface Level**
- Providing therapeutic rationale
- Reframing the meaning of tasks and goals
- Clarifying misunderstandings
- Allaying with the resistance

**Underlying Meaning**
- Exploring core relational themes I
- Changing tasks and goals
- Exploring core relational themes II
- New relational experience

Dimension 2: Surface versus underlying level of meaning. In addition, interventions may be targeted either at a surface or manifest level of meaning or at an underlying level of meaning that requires some degree of inference. For example, a disagreement about the task of therapy (for example, reporting whatever comes to mind) can be explored in its own terms (discussing the rationale underlying the task) or in terms of an underlying relational theme (the patient feels pressured to perform, which is a common theme in relationships with others, and can be traced back to features of his or her developmental history). In everyday practice, many of the most common alliance building or repairing interventions are directed to the surface level. For example, without giving it much conscious thought, but intuitively gauging that it will have a positive impact on the alliance, a therapist may answer a patient’s questions about the purpose of an intervention or apologize for a mistake. At the same time, some of the more important alliance mending interventions are addressed at the level of underlying meaning.

**CLINICAL EXAMPLES**

In accordance with the taxonomy just outlined and represented in table 12.1, alliance rupture interventions can take the following forms:

Providing therapeutic rationale. Outlining the therapeutic rationale at the beginning of treatment can play an important role in developing the alliance at the outset. Reiterating the rationale can help to repair a strained alliance. For example, the therapist can help to repair an alliance.
<table>
<thead>
<tr>
<th>Study</th>
<th>( N )</th>
<th>Method</th>
<th>Analysis</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Rennie (1994)</td>
<td>14</td>
<td>Psychotherapy clients in a variety of settings and treatment lengths.</td>
<td>Tape-assisted recalls of 14 patients, gathered immediately following an hour of therapy, analyzed using the grounded theory form of qualitative analysis.</td>
<td>Patient deference to therapists was the major category derived with 7 lower-level categories emerging: (1) concerns about the therapist's approach, (2) fear of criticizing the therapist, (3) understanding the therapist's frame of reference, (4) meeting the perceived expectations of the therapist, (5) accepting the therapist's limitations, (6) threatening the therapist's self-esteem, and (7) indebtedness to the therapist.</td>
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<td>Regan &amp; Hill (1992)</td>
<td>24</td>
<td>Six-session psychotherapy.</td>
<td>Patients and therapists reported on thoughts or feelings that they were unable to express in treatment using the Things Left Unsaid Inventory, the Session Evaluation Questionnaire, and the Personal Questionnaire. They asked the therapists to guess what patients had left unsaid and then matched the results.</td>
<td>Results indicated that for both patients and therapists, most things left unsaid were negative. In addition, therapists were only aware of 17% of the things patients left unsaid.</td>
</tr>
<tr>
<td>Rhodes et al. (1994)</td>
<td>19</td>
<td>Retrospective analysis of client satisfaction with past therapies (not from a single source).</td>
<td>Qualitative analysis comparing client satisfaction measured by Client Satisfaction Questionnaire and addressed vs. unaddressed misunderstanding events measured by Retrospective Misunderstanding Event Questionnaire.</td>
<td>Comparison of 11 resolved and 8 unresolved misunderstanding events suggested that a good relationship, patients' willingness to assert negative feelings about being misunderstood, and therapists' facilitation of a mutual repair effort led to resolution, whereas unwillingness or inability to engage in this process led to unresolved misunderstandings and unilateral termination.</td>
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<tr>
<td>Authors</td>
<td>Participants and Events</td>
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<tr>
<td>Hill, Thompson, Cogar, &amp; Denman</td>
<td>Patients in long-term psychotherapy</td>
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<td></td>
</tr>
<tr>
<td>Hill, Nutt-Williams, Heaton, Thompson, &amp; Rhodes</td>
<td>Therapists who had experienced impasse events ending in termination of therapy</td>
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Audio- and videotaped reviews of sessions in which patients and therapists talked about the helpfulness of interventions, described their own covert processes, and guessed the processes of the other. Written evaluations were also conducted. Eight measures and independent judges were used to evaluate and match the recalls.

Therapists were often unaware of patients' unexpressed reactions. They also found that patients are particularly likely to hide negative feelings. Therapists were only able to guess patients' hidden negative feelings 45% of the time; 65% of the patients in the study left something unsaid (most often negative), and only 27% of the therapists were accurate in their guesses about what their patients were withholding.

Variables associated with impasses include patient's history of interpersonal problems, lack of agreement about the tasks and goals of therapy, interference with therapy from the outside, transference, possible therapist mistakes, and therapists' personal issues. Additionally, they found that therapists were often unaware of their patients' dissatisfaction until they announced unilateral termination.
rupture resulting from his or her attempt to make a transference interpretation by reiterating that exploring parallels between the therapeutic relationship and other relationships can help the patient to become aware of self-defeating patterns.

Exploring core-relational themes I. In some situations, the process of clarifying factors leading to disagreements about tasks or goals of therapy will lead to the exploration of core relational themes. For example, a patient may experience the therapist’s questions about her inner experience as intrusive. Exploring the meaning and nature of this experience for the patient may reveal that it is related to a more general experience on her part of feeling intruded upon by others. A patient who fails to do his homework assignments in cognitive therapy may have a particular sensitivity to feeling dominated and controlled by others.

Reframing the meaning of tasks or goals. Reframing the meaning of therapeutic tasks or goals in terms that are acceptable to the patient is a type of joining intervention commonly used by strategic and systemic approaches: For example, a patient who was receiving a cognitive-behavioral treatment for social anxiety was initially reluctant to complete any between-session assignments that involved increasing social contact because of a fear of rejection. When the therapist reframed the meaning of the assignment as one of “putting yourself into the anxiety-provoking situation in order to self-monitor your cognitive processes,” she was willing to complete the assignment.

Changing task or goals. In this type of intervention, the therapist attempts to work on tasks or goals that seem relevant to the patient rather than exploring factors underlying such disagreements. The therapist’s willingness to accommodate the patient by working in terms that are more meaningful to him or her can play an important role in building the alliance in the immediate context, and in helping the patient to develop trust in the possibility of getting his or her needs met in other relationships. For example, treating the patient’s phobia at a symptomatic level may help him to develop sufficient trust to engage in the task of self-exploration later on.

Clarifying misunderstandings at a surface level. For example, a therapist notices that her patient seems withdrawn and initiates an exploration of what is going on in the here-and-now of the therapeutic relationship. The patient admits to feeling criticized by the therapist. The therapist responds in a nondefensive fashion and acknowledges that she can see how the patient might have felt criticized by what she said.

Exploring core relational themes II. Just as the exploration of disagreements about tasks or goals can lead to an exploration of important underlying themes, the exploration of strains in the bond dimension of the alliance can ultimately lead to a working through of core relational themes. For example, a patient’s feeling of not being understood by the therapist may reflect a narcissistic sensitivity which becomes a major focus of the treatment.

Allying with the resistance. For example, a patient withdraws from the therapist because she experiences the attempt to explore her painful feelings as too threatening. The therapist retreats from the attempt to explore avoided feelings and emphasizes that the patient’s current efforts to “protect herself” are understandable.

New relational experience. The therapist acts in a way that he or she hypothesizes will provide the patient with an important new relational experience without explicitly exploring the underlying meaning of the interaction. This type of intervention is particularly important when the patient has difficulty exploring the therapeutic relationship in the here-and-now. For example, a therapist decides to answer a patient’s request for advice because she formulates the situation as one in which the decision to do so will provide an important contrast to the patient’s abandoning mother.

REVIEW OF EMPIRICAL EVIDENCE

In this section, we first review the research most relevant to the topic of alliance rupture and repair. The relevant studies are summarized in tables 12.2, 12.3, 12.4, and 12.5. Our own research program on the topic is reviewed subsequently.

One of the most consistent findings coming out of research on the therapeutic alliance is that a strong or improving therapeutic alliance contributes to a positive treatment outcome (Horvath & Symonds 1991; Martin, Garske, & Davis, 1992).
<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Method</th>
<th>Analysis</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Castonguay et al. (1996)</td>
<td>30</td>
<td>Brief cognitive therapy (average 14.4 sessions)</td>
<td>The outcome measure (Beck Depression Inventory) and the WAI, Experiencing Scales, and Coding System of Therapist Feedback were correlated.</td>
<td>Alliance and patients’ emotional involvement predicted client improvement, but the therapist focus on the impact of distorted cognitions of depressive affect was found to be negatively correlated with outcome. Qualitative analysis suggests that therapists may attempt to address alliance strains by increasing their adherence to the cognitive model with the opposite result.</td>
</tr>
<tr>
<td>Piper, Azim, Joyce, &amp; McCallum (1991)</td>
<td>64</td>
<td>20 sessions of short-term individual psychotherapy in a controlled clinical trial investigation of manualized approaches based on Malan, Strupp &amp; Binder</td>
<td>Therapists Intervention Rating System was used to categorize interventions. A series of six 7-point items were used to assess alliance, and a comprehensive set of outcome measures was provided by patients, therapists, and independent assessors.</td>
<td>An inverse relationship was found between proportion of transference interpretations and measures of therapeutic alliance and favorable outcome. Additionally, qualitative analysis suggested that there may have been attempts by therapists to address weaknesses in the alliance by increasing transference interpretations and possibly becoming engaged in a vicious cycle.</td>
</tr>
<tr>
<td>Piper, Orodniczuk, Joyce, McCaullum, Rosie, O’Kelly, &amp; Steinberg (1999)</td>
<td>44</td>
<td>22 dropouts with 22 matched completers</td>
<td>Therapeutic alliance was measured using a series of six 7-point items. The Vanderbilt Psychotherapy Process Scale was used to assess positive and negative aspects of both therapist and patient behavior and attitudes. Process variables were assessed using a team of external raters. A qualitative analysis was done on the last session prior to termination.</td>
<td>No pretherapy predictors (demographics, diagnostic, initial disturbance) differentiated the dropouts from the completers. Dropouts were found to have weaker alliances, less exploration, less work, and a greater focus on transference. The qualitative analysis of the last session indicates a pattern of resistance and increased transference interpretation.</td>
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2000; see also Muran et al., 1995; Safran & Wallner, 1991, from our own research program. Similarly, there is ample evidence that weakened alliances are correlated with unilateral termination (Tryon & Kane, 1990, 1993, 1995). These findings suggest that the process of recognizing and addressing weakness or ruptures in the therapeutic alliance may play an important role in successful therapy. In practice, however, this task often proves difficult for even experienced therapists (see table 12.2). Patients are not always able or willing to reveal when they are uncomfortable or disagree with their therapist. Rennie (1994), us-
Table 12.4. Directly Addressing and Repairing Ruptures Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Method</th>
<th>Analysis</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Foreman &amp; Marmar</td>
<td>6</td>
<td>12-week dynamic psychotherapy of bereavement.</td>
<td>California Therapeutic Alliance Scale was correlated with patient, therapist, and independent ratings of outcome and compared to a list of therapist actions.</td>
<td>Interpretive actions which directly addressed weak alliances were related to cases with good outcome. Interpretive work that did not address alliance weakness did not improve alliance or result in good outcome.</td>
</tr>
<tr>
<td>Lansford (1986)</td>
<td>6</td>
<td>12-session, short-term psychotherapy</td>
<td>Measures of initial alliance, alliance weakness, and repair were correlated with observer ratings of outcome.</td>
<td>Raters were able to predict outcome from weakening and repair excerpts. Direct action by therapists to repair weakened alliances were followed by the highest levels of patient alliance ratings. Success in addressing weaknesses was predictive of outcome.</td>
</tr>
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</table>

...ing a qualitative research methodology, discovered that patients' deference to their therapists played a significant role in therapeutic interactions. He found a number of factors to be associated with patient deference, including fear of criticizing the therapist, need to meet the therapist's perceived expectations, acceptance of the therapist's limitations, fear of threatening the therapist's self-esteem, and a sense of indebtedness to the therapist, among others.

If, as Rennie's findings suggest, patients believe protecting their therapists is the best way to maintain the relationship, it is understandable that they would be reluctant to talk openly with them about their concerns regarding treatment. It is thus critical for therapists to be able to pick up on cues that the alliance is in trouble and address them in a way that allows the patient to participate without undue anxiety. Unfortunately, research has shown that even experienced therapists may have considerable difficulty recognizing such moments.

Regan and Hill (1992) asked patients and therapists to report on thoughts or feelings that they were unable to express in treatment. They then asked the therapists to guess what patients had left unsaid. Results indicated that for both patients and therapists, most things left unsaid were negative. In addition, therapists were only aware of 17% of the things patients left unsaid. Taking a different tack, Rhodes, Hill, Thompson, and Elliott (1994), in another study, asked therapists and therapists-in-training to recall events from their own treatment and performed a qualitative analysis of the events. Although some of the patients were able to talk openly about their negative feelings toward the therapist, patients who felt uncomfortable addressing misunderstandings were able to conceal them from their therapists so that the misunderstandings remained unaddressed, often leading to termination.

Hill, Thompson, Cogar, and Denman (1993) extended the investigation into patient covert processes (reactions to in-session events) to include things left unsaid and secrets. As in their previous studies, they found that therapists were often unaware of patients' unexpressed reactions. They also found that patients were particularly likely to hide negative feelings and that even experienced, long-term therapists were only able to guess when patients had hidden negative feelings 45% of the time. Furthermore, 65% of the patients in the study left something unsaid (most...
Table 12.5. Patterns of Alliance Development Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Method</th>
<th>Analysis</th>
<th>Outcome</th>
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<tr>
<td>Golden &amp; Robbins (1990)</td>
<td>2</td>
<td>Single-case analysis</td>
<td>Vanderbil Psychotherapy Process Scales and the WAI scores were examined to determine patterns of alliance development.</td>
<td>WA1 scores were found to be lowest in the middle phase of treatment in both cases studied.</td>
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<tr>
<td>Patton, Kivelghan, &amp; Mul-</td>
<td>13</td>
<td>Psychoanalytic college</td>
<td>Hierarchical linear model analyzed 4 factors: psychoanalytic technique, working alliance, client resistance, and client transference, for patterns of development and change.</td>
<td>The significant r tests for the quadratic coefficient indicated that client outcome was significantly related to a high-low-high pattern of alliance development.</td>
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<tr>
<td>ton (1997)</td>
<td></td>
<td>counseling over two</td>
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<td></td>
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<td></td>
<td></td>
<td>semesters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nagy, Safran, Muran, &amp;</td>
<td>75</td>
<td>Patients and therapists</td>
<td>Patients and therapists reported on ruptures, the extent they were resolved, and the WA1 after every session, as well as pre- and post- treatment measures regarding outcome.</td>
<td>Percentage of ruptures reported by patients ranged from 11% (cognitive-behavioral) to 38% (psychodynamic) and by therapists ranged from 25% (cognitive-behavioral) to 53% (psychodynamic). More ruptures were evidenced early in treatment. Patient-reported ruptures were negatively related to patient-rated alliance early in treatment. Correspondence between patient and therapist reportings of ruptures predicted outcome. Patient-rated rupture resolution predicted patient-rated alliance.</td>
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<tr>
<td>Winston (1998)</td>
<td></td>
<td>complete post-session</td>
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<td></td>
<td></td>
<td>questionnaire in three</td>
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<td></td>
<td></td>
<td>short-term psychotherapies</td>
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<tr>
<td>Kivelghan &amp; Shaughnessy</td>
<td>38</td>
<td>Four-session college</td>
<td>Cluster analysis was used to determine patterns of alliance development, which were then correlated with the Inventory of Interpersonal Problems and the Battery of Interpersonal Capabilities.</td>
<td>Three patterns of working alliance development were found: the stable alliance, linear alliance growth, and quadratic alliance growth. The high-low-high quadratic pattern was found to have the greatest association with treatment outcome.</td>
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<tr>
<td>(2000)</td>
<td></td>
<td>counseling with volunteer</td>
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<td></td>
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<td>subjects</td>
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</table>

often negative), and only 27% of the therapists were accurate in their guesses about what their patients were withholding:

In a later study, Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) conducted a qualitative analysis of therapists’ recollections of impasse events that had ended in termination. In retrospect, therapists identified multiple variables they associated with the impasses, including lack of agreement about the tasks and goals of therapy, transference, possible therapist mistakes, and therapists’ personal issues, among others. Perhaps most significant, however, was the finding that, as in the Rhodes, Hill, Thompson, and Elliott (1994)
study, patients did not reveal their dissatisfaction until they quit therapy. Moreover, therapists reported that they became aware of patients’ dissatisfaction only with the announcement of termination and were often taken by surprise.

Even if therapists do become aware of their patients’ reservations, it may prove quite difficult to address them in a way that is beneficial to the treatment. A number of studies have suggested that therapists’ awareness of patients’ negative reactions can be detrimental to outcome (see Fuller & Hill, 1985; Martin, Martin, Meyer, & Slemmon, 1986; Martin, Martin, & Slemmon, 1987). There is empirical evidence (see table 12.3 and below) to support various interpretations of this type of finding. One is that therapists may increase their adherence to their preferred treatment model in a rigid fashion, rather than responding flexibly to a perceived rupture in the alliance. Another is that therapists may respond to patients’ negative feelings by expressing their own negative feelings in a defensive fashion.

In an investigation of the process of change in cognitive therapy, Castonguay, Goldfried, Wiser, Rau, and Hayes (1996) found that while alliance and patients’ emotional involvement predicted improvement, therapists’ focus on distorted cognitions was negatively correlated with outcome. Using qualitative analysis in an attempt to understand these counterintuitive findings, they found that in poor outcome cases, therapists often attempted to address alliance ruptures by increasing their adherence to the cognitive model (challenging distorted cognitions), rather than responding more flexibly.

Piper, Azim, Joyce, and McCallum (1991) found an inverse relationship between the proportion of transference interpretations and both alliance and outcome for patients with a history of high-quality object relations. Examining the findings, they hypothesized that increased concentrations of transference interpretations may have been attempts to repair weakened alliances. They observed an alternating pattern of silences and transference interpretations and found that the inverse relationship between transference interpretations and alliance strengthened over the course of the treatment. This suggests that the patients and therapists may have been engaged in a vicious cycle in which, as therapists intensified their transference interpretations in a counterproductive attempt to remedy the situation, the alliance continued to weaken. They concluded, “The continuation of the cycle during the course of therapy suggests that the use of increased transference interpretations was not successful in resolving the impasse in the working relationship” (p. 951).

In a later study, Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O’Kelly, and Steinberg (1999) compared a sample of 22 dropouts with 22 matched completers on pretherapy and therapy process variables. In addition to assessing patient hostility and patient and therapist exploration and focus on transference, they examined the last session prior to dropout for typical patterns. Qualitative analysis of the therapeutic process indicated that these sessions typically started with patients expressing dissatisfaction or disappointment with treatment, to which therapists responded with transference interpretations. As the patients continued to withdraw or express resistance, therapists often continued to focus on transference issues. Sessions often ended with patients agreeing to continue treatment at the recommendation of the therapist, but never returning.

The findings in these studies are consistent with those of the Vanderbilt II study conducted by Strupp and colleagues (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder 1993; Strupp, 1993). In this study, a group of experienced therapists treated a cohort of patients and were subsequently given a year of intensive training in a manualized form of psychodynamic treatment. The training paid special attention to helping therapists detect and manage maladaptive interpersonal patterns as they are enacted in the therapeutic relationship. Following their training, the therapists treated a second cohort of patients. Evaluation of the differences in the therapeutic process and outcome showed that therapists were, in fact, able to shift their work to correspond more closely with the treatment manual. At the same time, however, the researchers found that rather than being able to treat their patients more skillfully, therapists displayed more hostile negative interactions and
complex communications (interpretations that can be seen as both helpful and critical). Thus, even when therapists recognize patients' negative feelings about the treatment, they often respond defensively by adhering rigidly to their preferred treatment model or by acting out their own counterhostility.

In contrast, several studies suggest that when therapists are able to respond nondefensively, attend directly to the alliance, adjust their behavior, and address rifts as they occur, the alliance improves. Foreman and Marmar (1985), for example, in a small sample study, found that when therapists directly addressed the patient's defenses against feelings toward the therapist, problematic therapeutic relationship patterns, and negative feelings toward the therapist, the alliance improved. Interpretable actions that directly addressed weak alliances were related to good outcome, but interpretable actions that did not address alliance weakness did not improve alliance or result in good outcome.

A year later, Lansford (1986) looked at six short-term therapy cases, identifying weakening and repairs in the alliance. Independent raters were able to predict outcome by observing excerpts showing weakening and repair of the alliance even though these segments made up a small proportion of the therapy (as little as 8%). Analysis showed that segments when therapists and patients took direct action to repair weakened alliances were followed by the highest levels of patient alliance ratings and that the degree of success in addressing weaknesses was predictive of outcome. In the previously discussed study by Rhodes and colleagues (1994) of patients' recollection of misunderstandings, the investigators found that patients' willingness to assert negative feelings about being misunderstood and therapists' willingness to engage in a mutual effort to repair the rupture led to the resolution of impasses. Unilateral terminations by patients tended to take place when these processes did not occur.

There is also a growing body of evidence suggesting that the importance of dealing effectively with alliance ruptures may extend beyond allowing the treatment to continue and the technical aspects of treatment to work; it may actually be an intrinsic part of the change process. Based on a large degree on the work of Mann (1973) and Gelso and Carter (1994), these studies have examined the notion that there are identifiable stages of alliance development. According to this view, the initial stage of treatment is a period when patients become mobilized and hopeful. They then experience a phase of ambivalence when they may begin to question what therapy can provide. If this phase is successfully negotiated, the alliance is strengthened and termination can be worked through. To date, the investigations into patterns of alliance development provide some support for the idea that therapeutic dyads which go through a period of decreased alliance followed by improved alliance may do as well, and possibly even better than, dyads with steady or increasing alliance levels.

Golden and Robbins (1990) hypothesized that despite consistent therapist action during the therapy, patients would go through a period in mid-treatment of increased negative affect, attitudes, and behavior. They analyzed two successful therapy cases, finding that therapists exhibited a fair amount of warmth and friendliness and high levels of exploration consistently throughout both treatments. The patients' alliance ratings increased, dropped, and then increased again during the course of the therapy, suggesting that patients went through the phases of alliance development predicted by Mann (1973). Patton, Kivlighan, and Minton (1997) videotaped 16 patients and 6 therapists over two semesters. Analysis indicated that a quadratic high-low-high pattern of alliance development was present and related to improved outcome. While a significant linear increase across sessions was also observed, it was found to be unrelated to client outcome.

In a later study Kivloughan and Shaughnessy (2000) used cluster analysis to examine patterns of alliance development in 79 therapist-patient dyads across four counseling sessions. They found three distinct patterns of alliance development: stable alliance, linear alliance growth, and quadratic alliance growth. While average level of alliance did not predict outcome, the quadratic pattern of alliance development was associated with the greatest improvement compared to other patterns of alliance development. While the results from the studies...
on patterns of alliance development are far from conclusive, they seem to point toward the possible therapeutic benefits of alliance rupture development and repair over the course of the treatment.

It is important to distinguish between the development of the alliance at a more global level versus shifts in the alliance at a more molecular level. Although the studies of Golden and Robbins (1990); Patton, Kivlishan, and Multon (1997); and Kivlishan and Shaughnessy (2000) are relevant to the first phenomenon, Nagy, Safran, Muran, and Winston (1998) investigated patients' and therapists' perceptions of shifts in the quality of the alliance within session. In a sample of 75 short-term therapy cases consisting of three different treatment modalities, we found that patients reported the presence of alliance ruptures in 11 to 38% of the sessions, depending on the treatment modality. Therapists reported alliance ruptures in 25 to 53% of the sessions. This indicates that the perception of ruptures, while varying according to treatment modality, is a fairly common occurrence and that therapists are more likely to perceive (or at least report) ruptures than patients. Early in treatment, frequency of patient-reported ruptures was significantly negatively correlated with their ratings of alliance at the session level (that is, ratings of the quality of the alliance of the session as a whole, irrespective of whether a rupture had taken place). This was not true later in treatment and not true for therapist-reported ruptures. This suggests that for patients, once the therapeutic relationship has had a chance to develop, a momentary rupture is less likely to impact on their perceptions of the alliance at a more global level. It also suggests that therapists, even early in treatment, are less likely to allow a momentary rupture to affect their evaluation of the alliance at a more global level. Finally, we found that patient and therapist agreement about the presence of ruptures within sessions was positively related to ultimate outcome.

Our Research Program Investigating Rupture Repair

Our research program, which has been primarily aimed at the study of therapeutic alliance ruptures and their resolution or repair, can be conceptualized as consisting of four recursive stages: model development, model testing, treatment development, and treatment evaluation. In the first stage, a change-process model is developed through a series of intensive analyses of single cases identified as including ruptures and resolution processes. In the second stage, the model is tested by evaluating whether the presence of the processes described in the model distinguishes rupture resolution and nonresolution events. In the third stage, treatment interventions are developed and refined in response to the findings emerging from the model development and model testing stages of the research program. In the final stage, the efficacy of treatment intervention is evaluated. This stage of the research serves simultaneously as a treatment outcome study and as a model verification study.

The stages of our research program that involve model development and verification have been greatly influenced by the task analytic paradigm for psychotherapy research, which integrates quantitative and qualitative strategies to analyze the process involved in the performance of an in-session "task" or change event (Greenberg, 1986; Rice & Greenberg, 1984; Safran, Greenberg, & Rice, 1988). An important component of our research has been the development and use of parallel forms of a questionnaire completed by both patient and therapist for every session of treatment. The post-session questionnaire (PSQ) serves the function of facilitating the identification of critical in-session processes and verifying their relationship to overall outcome. Over the course of the past decade, we have conducted several studies demonstrating the psychometric properties of our PSQ, including its sensitivity to detect ruptures and resolutions, as well as its predictive validity (Muran et al., 1995; Nagy et al., 1998; Safran & Wallner, 1991; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Winkelman, Safran, & Muran, 1998; see Muran, in press, for a review). Table 12.6 summarizes our research efforts regarding rupture resolution.

Our first model of the rupture resolution process, Stage-Process Model 1, was developed from a qualitative analysis of 15 psychotherapy sessions in which alliance ruptures had appeared to reach some degree of resolution (Safran et al., 1990).
<table>
<thead>
<tr>
<th>Studies</th>
<th>Subjects</th>
<th>Selection Criteria</th>
<th>Coding Scheme</th>
<th>Method of Analysis</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage-Process Model I</td>
<td>29 cases</td>
<td>Patient &amp; therapist rated sessions by thirds on an alliance measure. Resolution</td>
<td>N/A</td>
<td>Qualitative analysis</td>
<td>Proposed model:</td>
</tr>
<tr>
<td>~ Qualitative Analysis</td>
<td>15 sessions</td>
<td>sessions indicated 20% increases by both patient &amp; therapist.</td>
<td></td>
<td></td>
<td>Attending to Rupture (1), Exploring Rupture Experience (2),</td>
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<tr>
<td>(Safran, Crocker, McMain,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Exploring Avoidance (3), Exploring Interpersonal Schema (4)</td>
</tr>
<tr>
<td>&amp; Murray, 1990)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage-Process Model I</td>
<td>5 cases</td>
<td>Patient &amp; therapist rated sessions by thirds on an alliance measure. Resolution</td>
<td>Structural</td>
<td>Frequency analysis</td>
<td>1. Higher frequency of model</td>
</tr>
<tr>
<td>~ Preliminary Test</td>
<td>7 sessions</td>
<td>sessions indicated 20% increases by both patient &amp; therapist.</td>
<td>Analysis of</td>
<td>of model stages</td>
<td>stages in resolution sessions, but 4th stage only evident in</td>
</tr>
<tr>
<td>(Safran, Muran, &amp; Samstag,</td>
<td></td>
<td></td>
<td>Social Behavior</td>
<td></td>
<td>2/4 sessions.</td>
</tr>
<tr>
<td>1994)</td>
<td>3 resolution +</td>
<td></td>
<td>(SASB),</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Experiencing</td>
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<td></td>
<td></td>
<td></td>
<td>Scales (EXP),</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Client Vocal</td>
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<td></td>
<td></td>
<td></td>
<td>Quality (CVQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage-Process Model II</td>
<td>4 cases</td>
<td>Patient &amp; therapist rated sessions by thirds on an alliance measure. Resolution</td>
<td>SASB</td>
<td>Lag 1 sequential analyses</td>
<td>Refined model:</td>
</tr>
<tr>
<td>~ Small-Scale Verification</td>
<td>8 sessions</td>
<td>sessions indicated 20% increases by both patient &amp; therapist.</td>
<td>EXP</td>
<td>of hypothesized sequences</td>
<td>attaining to rupture (1),</td>
</tr>
<tr>
<td>Study (Safran &amp; Muran,</td>
<td></td>
<td></td>
<td>CVQ</td>
<td></td>
<td>exploring rupture experience (2), exploring avoidance (3), self-</td>
</tr>
<tr>
<td>1996)</td>
<td>4 resolution +</td>
<td></td>
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<td></td>
<td>assertion (4)</td>
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<tr>
<td>Stage-Process Model II</td>
<td>3 cases</td>
<td>Patient &amp; therapist reported tension in all six sessions. Resolution sessions</td>
<td>SASB</td>
<td>Lag 1 sequential analyses</td>
<td>Significant differences between</td>
</tr>
<tr>
<td>~ Replication Study</td>
<td>6 sessions</td>
<td>required resolution ratings of ≥3 on 5-point scale by both patient &amp; therapist.</td>
<td>EXP</td>
<td>of hypothesized sequences</td>
<td>resolution and nonresolution sessions, consistent with hypotheses</td>
</tr>
<tr>
<td>(Safran &amp; Muran, 1996)</td>
<td>3 resolution +</td>
<td></td>
<td>CVQ</td>
<td></td>
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</table>

1. Significant differences consistent with hypotheses
2. Refined model: Stage-Process Model III (4th stage redefined with the CCRT method as Emergence of Wish/Need)
We selected these sessions from a pool of 29 cases based on patient and therapist post-session ratings of the therapeutic alliance. The proposed model from this exploratory analysis included four stages involving patient and therapist interactions: (1) attending to the rupture marker, (2) exploring the rupture experience, (3) exploring the avoidance, and (4) exploring the interpersonal schema (the patient's generalized representations of self and other). We then conducted a preliminary test of this model on a new sample that compared four rupture resolution and three nonresolution sessions (Safran et al., 1994). In this preliminary test, we applied various measures of psychotherapy process (such as the Structural Analysis of Social Behavior [SASB; see Benjamin, 1974], Experiencing Scales [EXP; see Klein, Mathieu-Coughlan, & Kiesler, 1986], and Client Vocal Quality [CVQ; see Rice & Kerr, 1986]) to operationalize multiple dimensions (that is, interpersonal behavior, emotional involvement, and vocal quality) of each patient and therapist position in the resolution process. The results generally indicated a higher frequency of model components in the resolution sessions than in the nonresolution sessions.

Although the results of this test provided some verification of the proposed model, it also resulted in a refinement of our rupture resolution model. First, we found it more useful to distinguish between two types of patient communications: (a) behaviors that mark a rupture—withdrawal and confrontation markers—as opposed to our original definition of seven types (Safran et al., 1990). In withdrawal markers, the patient withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process. In confrontation ruptures, the patient directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy in an attempt to control the therapist. In some instances, the marker can be characterized as a mix of confrontation and withdrawal. Second, finding that Stage 4 (exploration of the interpersonal schema) did not occur consistently, we eliminated it from our model, but included instead as the fourth stage, "self-assertion," which we observed as an elaboration of Stage 2 (exploration of the rupture experience). This refinement resulted in Stage-Process Model II.

Our next step was to conduct a verification study of this revised model, in which we compared matched resolution and nonresolution sessions from four different cases (8 sessions in total). We followed this analysis with a replication study involving matched resolution and nonresolution sessions from another three cases (six sessions in total). In both studies, we operationalized the various stages of the model using a coding scheme that included the SASB, EXP, and CVQ. We then conducted a series of lag one sequential analyses to confirm the hypothesized sequences and demonstrate a difference between resolution and nonresolution sessions. In sum, the results indicated support for the hypothesized sequences of the model and demonstrated differences between resolution and nonresolution sessions, particularly with regard to the "exploring avoidance" pathway and the pathway from "exploring the rupture" to "self-assertion." These processes were more evident in resolution sessions.

Further qualitative analysis of the seven new rupture resolution sessions led to further revision of the model in the form of Stage-Process Model III (see figure 12.1). Probably the most noteworthy revision concerned the definition of the fourth stage. We found the Core Conflictual Relationship Theme (CCRT; see Luborsky, 1984) method to understanding transference dynamics (Safran & Muran, 1996) and the distinction between primary and secondary emotions (Greenberg & Safran, 1987) to be especially helpful in refining our understanding of the patient state that emerges upon the resolution of a rupture. Specifically, we observed that the fourth stage of the resolution process invariably involves the expression of the patient's underlying wish/need or the primary emotion associated with that wish/need—and so came to define this stage as the Emergence of the Wish/Need. This can sometimes take the form of expressing negative feelings, but it can also take other forms (the assertion of a desire for more help, direction, or nurturance, or the expression of an underlying vulnerability). Further, we observed that the type of rupture marker (withdrawal versus confrontation) is associated with some important differences in the res-
Figure 12.1. Stage-Process Model III of Rupture Resolution

The rupture resolution process, especially in the transition from Stage 2 (exploration of the rupture experience) to Stage 4 (emergence of the wish/need), involves moving through increasingly clearer articulations of discontent to self-assertion, in which the need for agency is realized and validated by the therapist (Stage 4). The progression in the resolution of confrontation ruptures consists of moving through feelings of anger, to feelings of disappointment and hurt over having been failed by the therapist, to contacting vulnerability and the wish to be nurtured and taken care of (Stage 4). Typical avoidant operations that emerge, regardless of rupture type, concern anxieties and self-doubts resulting from the fear of being too aggressive or too vulnerable. These concerns are associated with the expectation of retaliation or rejection by the therapist (Stage 3).

Our study of the rupture resolution process has enabled us to develop and manualize a treatment model that includes interventions that we have found facilitative of the resolution process (see Muran & Safran, in press; Safran, 2002a, 2000b; Safran & Muran, 2000a). The model has been manualized as a short-term treatment in order to facilitate clinical trial research, but it is not intrinsically a short-term model. This approach (referred to as Brief Relational Therapy, or BRT) synthesizes principles derived from our research program with principles derived from relational psychoanalysis (see Mitchell & Aron, 1999), humanistic/experiential psychotherapy (see Greenberg, Watson, & Lietaer, 1998), and contemporary theories on cognition and emotion (see Greenberg & Safran, 1987; Safran & Greenberg, 1991).

In a treatment study of 128 personality disordered patients presenting with comorbid symptomatology (Muran & Safran, 2002), we compared BRT to two traditional short-term psychotherapies: one psychodynamic, the other cognitive-behavioral (see table 12.7). In one set of analyses involving traditional statistical tests of between-group differences on multiple measures of change, the results indicated equivalent efficacy among the three models for those who completed treatment, although there was a nearly significant ($p < 0.10$), medium-effect that suggested a difference, at termination, in favor of BRT and the cognitive-behavioral model. In a second set of analyses, we tried to examine clinical significance and found both BRT and the cognitive-behavioral model to be significantly superior to the psychodynamic
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Table 12.7. Rupture Resolution: Treatment Evaluation Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Subjects</th>
<th>Design</th>
<th>Results</th>
</tr>
</thead>
</table>
| Muran & Safran (2002) | 128 patients  
Personality disordered patients with comorbid symptomatology randomly assigned | **Comparative Treatment Study:** Relational treatment model  
(BRT) (based on process research) versus two traditional short-term models  
(one psychodynamic, the other cognitive-behavioral) | 1. All three treatments are equally effective for patients who completed, based on traditional statistical analyses  
2. BRT cognitive-behavioral models are superior for those who completed, based on clinical significance  
3. BRT is superior based on dropout rates |
| Safran & Muran (2002) | 59 patients randomly assigned  
18 patients determined to be at risk for treatment failure (based on in-session performance variable) and offered random reassignment | **Comparative Treatment Study:** Comparison of same three treatments: relational treatment as experimental condition, other two as control condition | 1. Of the 18 cases, only 10 elected to be reassigned.  
2. Of the five cases reassigned to experimental condition, three completed with good outcome, one moved out of state, and one dropped out.  
3. Of the five reassigned to the control condition, all dropped out. |

Finally, in a third take on efficacy, we examined dropout rates and found a significant difference, with BRT (20%) superior to the cognitive-behavioral (37%) and psychodynamic (46%) models.

In another effort to evaluate the efficacy of our integrated treatment model, we have been conducting a small-scale clinical trial funded by the National Institute of Mental Health (NIMH) that employs a methodology designed to overcome an important obstacle to finding differences in treatment efficacy and to be maximally sensitive to any real treatment effects that occur (Safran & Muran, 2002). The assumption guiding our proposed research strategy is that a major obstacle to finding treatment differences is a lack of contextual specificity (Beutler, 1991; Greenberg, 1986). To the extent that patients can be grouped together on the basis of a variable that in theory is particularly relevant to a specific intervention, the possibility of finding treatment differences should be increased. Following this line of reasoning, we hypothesized that selecting patients for treatment specifically on the basis of difficulties they are having in establishing a therapeutic alliance with their therapists should increase the possibility that an intervention designed specifically to resolve problems or ruptures in the alliance would have more impact than one which is not. This type of patient selection strategy goes beyond the more traditional factorial design of clustering patients on the basis of a static characteristic (such as diagnostic category) by selecting on the basis of a relevant in-session performance variable (ability or failure to establish an adequate therapeutic alliance). This should increase the power of the design by reducing the slippage resulting from selecting on the basis of the type of trait variable, which has been shown to have limited predictive validity.

The NIMH study has consisted of two phases (see table 12.7). In the first phase, patients are randomly assigned to either the psychodynamic or cognitive-behavioral treatment model. The patients are tracked early in treatment; and on the basis of a number of empirically derived criteria
from patient and therapist perspectives, a subgroup is identified with whom therapists are having difficulty establishing an alliance and who are at risk for treatment failure or dropout. These patients are then offered the option of transferring to another treatment condition. Those who choose to be transferred are randomly reassigned to BRT or the control for their previous treatment, that is, the psychodynamic therapy if they are coming from the cognitive-behavioral therapy, or the cognitive-behavioral therapy if they are coming from the psychodynamic therapy. In the second phase of the study, they undergo another treatment. Of the 59 patients admitted thus far into this study, 18 (31%) met criteria for risk of treatment failure and were offered the opportunity to be randomly reassigned to the experimental condition or one of the two control conditions. Ten agreed to the offer, and eight chose to remain in the treatment they were receiving (seven of whom eventually dropped out). Of the five assigned to BRT, three completed treatment with indication of good outcome, one moved out of state after completing midphase (with good outcome), and one dropped out. Of the five assigned to the control conditions, all dropped out.

Evaluation of the Empirical Evidence

Although research on alliance rupture and repair is promising, in many respects it is in its early stages. Much of it consists of small sample and/or qualitative studies. Some of the studies lack ecological validity in that they use graduate student therapists to administer analogue treatments (for example, four sessions). Moreover, the number of relevant studies available is limited. At this point in time, our impression is that the following conclusions can be drawn:

1. Given the fact that the quality of the therapeutic alliance is one of the most robust predictors of treatment outcome, it can be inferred that the process of repairing alliance ruptures is an important one. Direct evidence in support of this proposition exists but is limited. This absence of evidence is a function, however, of the limited number of studies available addressing this proposition and should not be confused with the presence of negative findings.

2. There is preliminary evidence available supporting the role that specific processes (e.g., patient expression of negative feelings, therapists’ nondefensive behavior) play in resolving ruptures in the therapeutic alliance. Some of this evidence demonstrates the relationship between specific resolution processes within a session and improvements of the alliance within that session. Other evidence demonstrates the relationship between these processes and both improved alliances and outcome over the course of treatment. This evidence is based primarily on small samples and qualitative research, and there is clearly a need to complement the available research with larger samples and more traditional hypothesis testing approaches. Nevertheless, the consistency of the research findings regarding the relevant rupture repair processes, combined with the consistent evidence of the importance of the therapeutic alliance, provides sufficient grounds for proposing provisional guidelines for therapeutic practice.

3. There is preliminary evidence indicating that for some patients a “tear-and-repair” pattern of alliance development over the course of treatment is associated with positive outcome. There is also evidence to suggest that both average level of alliance over the course of treatment and a linear increase in quality of alliance over the course of treatment both predict outcome. This suggests that while the process of developing and repairing alliance ruptures over the course of time is not necessarily an essential aspect of the treatment process for all patients, it may play an important role in the treatment process for some patients. It may, in fact, be the case that different types of alliance development are important for different types of patients. It may also be the case that different patterns of alliance development are associated with different types of change processes and different types of outcome.

4. There is evidence to suggest that poor outcome cases are distinguished by a pattern of patient-therapist complementarity (vicious cycles) in which therapists respond to patients’ hostile communications with hostile communications of their own.

5. There is preliminary evidence indicating that ruptures in the alliance occur fairly frequently and that frequency of ruptures (or willingness to report them) is influenced by factors
such as treatment modality and the observer’s (that is, the therapist’s or patient’s) perspective.

**THERAPEUTIC PRACTICES**

In this section, we summarize provisional practice implications of the foregoing research, bearing in mind the limitations of the research discussed previously.

1. Therapists should be aware that patients often have negative feelings about the therapy or the therapeutic relationship which they are reluctant to broach for fear of the therapist’s reactions. It is thus important for therapists to be attuned to subtle indications of ruptures in the alliance and to take the initiative in exploring what is transpiring in the therapeutic relationship when they suspect that a rupture has occurred.

2. It appears to be important for patients to have the experience of expressing negative feelings about the therapy to the therapist should such feelings emerge, or to assert their perspective on what is going on when it differs from the therapist’s.

3. When this takes place, it is important for therapists to attempt to respond in an open or nondefensive fashion, and to accept responsibility for their contribution to the interaction.

4. There is some evidence to suggest that the process of exploring patient fears and expectations that make it difficult for them to assert their negative feelings about the treatment may contribute to the process of resolving the alliance rupture.

5. Notwithstanding the evidence suggesting that patients’ expression of their negative feelings toward their therapists is an important component of the resolution process, there is also evidence to suggest that cases in which therapists are aware of their patient’s negative feelings toward them are more likely to result in poor outcome. This may reflect the possibility that therapists in such cases are responding in a hostile or defensive fashion to their patient’s negative communications.

6. There is some empirical evidence to suggest that it is difficult to train therapists to deal in a constructive fashion with vicious cycles of this type. This suggests that it is important to place greater emphasis on clarifying the factors mediating the acquisition of the relevant skills by therapists.

**REFERENCES**


