# REPAIRING ALLIANCE RUPTURES

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*Increasingly, research on the therapeutic alliance has shifted its focus to clarifying the factors contributing to alliance development, including the processes involved in resolving alliance ruptures. This article provides a brief review of the empirical literature on ruptures in the alliance and their resolution or repair. In sum, the research is promising, indicating the relevance of ruptures and resolution to psychotherapy outcome. However, much of the research thus far consists of small samples or qualitative studies. In many respects, such research should be considered in the early stages of development. Provisional practice implications are presented, suggesting that therapists be more attentive to ruptures, explore patient negative feelings about therapy, and respond to those feelings in an open and nondefensive fashion.*

Much of the original research on the therapeutic alliance focused on providing empirical evidence for what had long been established clinical wisdom, that is, 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. 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 negotiation of ruptures in the alliance is at the heart of the change process (Safran & Muran, 2000a). In this article, we review the recent research in this second generation of alliance research and spell out what we consider the emerging practice guidelines.

### Review of Empirical Evidence

In this section, we first review the research most relevant to the topic of alliance rupture and repair, then summarize our own research program on this topic, and conclude with an evaluation of the empirical evidence.

One of the most consistent findings coming out of the research of the therapeutic alliance is that a strong or improving therapeutic alliance contributes to a positive treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 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 (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tyron & 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 is a task that often proves difficult for even experienced therapists. Patients are not always able or willing to reveal when they are uncomfortable or disagree with

their therapists. Rennie (1994), using a qualitative research methodology, discovered that patients' deference to their therapists played a significant role in therapeutic interactions. 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 and found 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) asked therapists and therapists-in-training to recall misunderstanding 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 towards the therapist, patients who felt uncomfortable addressing misunderstanding events were able to conceal them from their therapists, and 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 able to guess when patients had hidden negative feelings only 45% of the time. Furthermore, 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.

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 et al. (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 (e.g., Fuller & Hill, 1985; Martin, Martin, Meyer, & Slemon, 1986; Martin, Martin, & Slemon, 1987). There is empirical evidence 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, Raue, 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.

Similarly, 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 suggested that increased concentration of transference interpretations may have been an attempt to repair a weakened alliance. In a later study, Piper et al. (1999) examined a sample of dropouts and conducted a qualitative analysis of the last session prior to drop out. They found that the sessions typically started with patients expressing dissatisfaction or disappointment with treatment, and therapists responding with transference interpretations. As the patients continued

to withdraw or express resistance, therapists often continued to focus on transference issues. The 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 his colleagues (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 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).

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 towards the therapist, problematic therapeutic relationship patterns, and negative feelings towards the therapist, the alliance improved. Interpretive actions which directly addressed weak alliances were related to good outcome, but interpretive action that did not address alliance weakness did not improve alliance or result in good outcome.

A year later, Lansford (1986) looked at several short-term therapy cases, identifying weakening and repairs in the alliance, and found that segments when therapists and patients took direct action to repair weakened alliances were followed by the highest levels of patient alliance ratings, and the degree of success in addressing weaknesses was predictive of outcome. Likewise, the Rhodes et al. (1994) study 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. These studies have examined the notion that there are identifiable stages of alliance development. To date, the investigations into patterns of alliance development provide some support for the idea that therapeutic dyads that 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 & Robbins, 1990; Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997).

It is important to distinguish between this type of research, which investigates the development of the alliance at a more global level versus research investigating shifts in the alliance at a more molecular level. In an example of the latter, Nagy, Safran, Muran, and Winston (1998) investigated patients' and therapists' perceptions of shifts in the quality of the alliance within session. In a large sample of 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 (i.e., 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 than patients to generalize from a momen-

tary rupture to their evaluation of the alliance at a more global level.

## Our Research Program to Studying Alliance 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 (see Muran, in press; Safran & Muran, 1996 for reviews). Using task analysis procedures (Greenberg, 1986), we have developed and refined a model of the rupture repair process.

In the first stage of the research program a change-process model was developed through a series of intensive analyses of single cases identified as including ruptures and resolution processes. In the second stage, the model was tested by evaluating whether the presence of the processes described in the model distinguishes rupture resolution and nonresolution events. Over the years, we have conducted a series of small-scale studies toward the development of stage-process models (Safran & Muran, 1996; Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Samstag, 1994). The result of these qualitative and quantitative analyses is a process model consisting of four stages (that involve both patient and therapist components: (a) attending to the rupture marker, (b) exploring the rupture experience, (c) exploring the avoidance, and (d) emergence of wish/need. We have found it useful to distinguish between two types of patient communications or behaviors that mark a rupture — withdrawal and confrontation markers. 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. We have observed that the type of rupture marker is associated with differences in the resolution process. For example, the common progression in the resolution of withdrawal ruptures consists of moving through increasingly clearer articulations of discontent to self-assertion, in which the need for patient agency is recognized and validated by the therapist. 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. 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, associated with the expectation of retaliation or rejection by the therapist.

In the third stage of our research program, treatment interventions are developed and refined in response to the findings emerging from the model-development and model-testing stages. 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. 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, 2002b; Safran & Muran, 2000b). 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. The model, Brief Relational Therapy (BRT) also synthesizes principles derived from relational psychoanalysis, humanistic and experiential psychotherapy, and contemporary theories on cognition and emotion.

In a treatment study of 128 personality-disordered patients presenting with comorbid symptomatology, we compared BRT to two traditional short-term psychotherapies: one psychodynamic, the other cognitive-behavioral. In a series of analyses, (a) we found equivalent efficacy among the three models for those who completed treatment (based on traditional statistical tests of between-group differences on multiples measures of change; (b) we found both BRT and the cognitive-behavioral model to be superior to the psychodynamic treatment with regard to clinical significance; and (c) we found a significant difference in drop-out rates, with BRT superior to the cognitive-behavioral and psychodynamic models. In another effort to evaluate the efficacy of BRT, we conducted a small-scale study funded by National Institute of Mental Health. In brief, the study (a) identified patients with whom therapists had difficulty establishing an alliance and who were at risk for treatment failure and then (b) involved a randomized treatment trial comparing the three treatments with these patients. The

results have provided preliminary evidence favoring BRT.

*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 or qualitative studies. Some of the studies lack ecological validity in that they use graduate student therapists administering analogue treatments (e.g., four sessions). Moreover, there are a limited number of relevant studies available. At this 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-sample and qualitative research, and there is clearly a need to complement the available research with larger samples and more traditional hypothesis-testing approaches.

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 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. Notwithstanding the evidence suggesting that patients' expressions of their negative feelings toward their therapists is an important component of the resolution process, there is also some evidence to suggest that cases in which therapists are aware of their patients' 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 patients' negative communications.

6. There is also some empirical evidence to suggest that it is extremely 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.

7. 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 (i.e., 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 feel-

ings about the therapy to the therapist, should they emerge, or to assert their perspective on what has transpired when it differs from the therapist's perspective.

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

4. There is some evidence to suggest that the process of exploring the patient's 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.

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