

# Chapter 9

## Alliance, Negotiation, and Rupture Resolution

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### Introduction

More than one hundred years have passed since “the talking cure” was introduced as a treatment for psychological problems. Considerable scientific effort over the last 60 years has been spent to determine whether psychotherapy, in general, is effective, and if so, what factors underlie the mechanism of change. With the growing demand of the health care system and the public in general for accountability, there has been a continuous pressure on the mental health field to provide empirical support for the treatments we offer to our patients. This has given rise to the initiatives of the American Psychological Association and American Psychiatric Association to formulate practice guidelines and identify empirically supported interventions and treatments. The focus of these efforts has been on high-quality comparative outcome studies on techniques or brand-name therapies for single categorical disorders, while the therapeutic relationship has been ignored or addressed only vaguely [1]. However, quantitative reviews and meta-analyses of psychotherapy outcome literature consistently reveal that specific techniques account for only 5–15% of the outcome variance [1]. Moreover, technical interventions do not exist in a vacuum; they are applied in a context of patient–therapist relationship. In other words, all techniques and interventions are relational acts [2], and the therapist as a person is a central agent of change [3]. Therefore, empirical investigation of the therapeutic relationship and attempts to discover elements and factors that make this relationship effective are essential and relevant to clinical practice.

Psychotherapy research over the last several decades found the therapeutic alliance to be one of the most important elements of the therapeutic relationship. The therapeutic alliance has been consistently shown to be a robust predictor of positive outcome [4]. Building and maintaining good therapeutic alliance appears to be essential for the success of treatment. At the same time, ruptures in the alliance have been conceptualized as important change events

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and have become a subject of empirical investigation [5]. This emphasis on the importance of repairing alliance ruptures was of course anticipated by Kohut [6] among others.

The literature review that follows will discuss the existing body of literature on the therapeutic alliance, including the history of the concept, measurement of the alliance, empirical research on the relationship between the alliance and the outcome, the concept of the ruptures in the alliance, and the research on the ruptures and their resolution.

## **Overview of Psychotherapy Research**

Although scientific investigations of psychotherapy effectiveness began as early as the 1920s, increasingly empirically valid and methodologically sound psychotherapy research flourished in the second half of the 20th century. Stimulated by the controversial article of Eysenck, who after a review of 24 studies concluded that psychotherapy was not effective [7], research initially focused on the efficacy of psychotherapy. The advance of meta-analytic techniques allowed researchers to examine multiple empirical studies conducted with thousands of patients having various psychological problems treated by various therapeutic techniques. Multiple comprehensive reviews of outcome research have come to one basic conclusion: psychotherapy, in general, has been shown to be effective [8–11]. Furthermore, psychotherapies have effects beyond those of spontaneous remission and of various no-treatment controls: the average treated person is better off than 80% of untreated control subjects [11]. The effect sizes produced in psychotherapy are as large as or larger than those produced by various medical interventions (e.g., medication). Finally, according to Lambert and Bergin [11], these findings cannot be “explained away by reference to methodological weaknesses in the data reviewed or by reviewing methods” (p. 149).

Psychotherapy outcome research has also examined the effectiveness of various types of psychotherapy in treating the broad spectrum of anxiety and depressive disorders, and interpersonal problems. Numerous reviews of empirical studies comparing a wide range of psychotherapies have found no significant difference between their effectiveness [10, 11]. As Luborsky [12] once quipped, “Everyone has won and all must have prizes.” Although a small but consistent advantage for cognitive and behavioral techniques over dynamic and humanistic approaches has been found by some meta-analytic reviews of literature [13–15], it has been argued that these results can be attributed to methodological artifacts [10, 11]. Most recently, Lambert and Barley [10] examined more than 50 meta-analytic reviews of outcome research. They concluded that “while statistically significant differences can sometimes be found favoring the superiority of one treatment over another, these differences are not so large that their practical effects are noteworthy” (p. 19). It should be mentioned, however, that a few specialized techniques have shown superiority with

some specific diagnostic categories (e.g., exposure treatment with specific phobic disorders and response prevention for obsessive–compulsive disorders) [16].

The prevailing explanation of the general finding of the equivalence in outcome among highly diverse therapies is the existence of the “common” or “nonspecific” factors that are present in all forms of therapy and lead to positive change [11]. Examples of common factors include therapist’s empathy, warmth, acceptance, patient’s trust and feeling of being understood, and the therapeutic alliance. Although there is substantive evidence that common factors account for a significant amount of patient’s improvement in psychotherapy [10], the common factor model of change has been critiqued by authors who emphasize that the specific techniques cannot be separated from the interpersonal nature of a therapeutic encounter [17, 18]. According to Butler and Strupp [17], “techniques gain their meaning and, in turn, their effectiveness from the particular interaction of the individuals involved” (p. 33), and psychotherapy is the “systematic use of a human relationship for therapeutic purposes” (p. 36). Whether one adheres to the common factor model of change or to the more complex view of therapeutic process outlined by Butler and Strupp, one thing is clear: the therapeutic relationship is vital in contributing to the success of treatment.

Considerable research effort has been devoted to studying numerous variables involved in building a successful therapeutic relationship. One of the most important factors emerging from both the outcome studies and the psychotherapy process research is the therapeutic alliance.

## **Theory and Empirical Research on the Therapeutic Alliance**

This section will review the theoretical conceptualization of the therapeutic alliance (also known as working alliance, helping alliance, or simply alliance), measuring the alliance and the empirical research on the alliance.

### ***Conceptualization of the Alliance***

The concept of the alliance begins its history in the early psychoanalytic literature. It was Freud who first suggested the necessity of making patient an active “collaborator” in the analytic process [19]. Freud was primarily concerned with the transference unconscious-based aspects of the relationship between patient and analyst; however, he proposed the existence of the “unobjectionable positive transference” [20], which should not be analyzed since it provides the patient with the motivation necessary for reality-based collaboration with an analyst in order to conquer unconscious fear and rejection of exploring repressed material. Although Freud considered the resolution of transference neurosis as the main

instrument of change, he also acknowledged the role of analyst's friendliness and affection as "the vehicle of success in psychoanalysis" [21].

Sterba [22], building on Freud's structural model, coined the term "ego alliance" to reflect a "split in the [patient's] ego" between its observant and participant functions. This split allows the patient to use his rational, reality-based elements of the ego to ally with the therapist in order to self-observe and accomplish therapeutic tasks.

Zetzel [23], crediting the term to Bibring, distinguished between the therapeutic alliance and the transference neurosis. She argued that the patient's capacity to build the alliance depends on early developmental experiences, which result in his or her ability to form a stable trusting relationship. Zetzel insisted that if the patient lacks this ability in the beginning of treatment, the therapist needs to respond to the patient's "basic needs and anxieties" [24] and create a supportive relationship before attempting the analysis proper (i.e., interpretation of unconscious conflicts). Essentially, Zetzel was the first who conceptualized the alliance as having a direct impact on the effectiveness of therapy.

Greenson [25] continued to clarify the difference between the transference aspects of the therapeutic relationship and the real relationship between patient and therapist, including undistorted perceptions, authentic trust, and respect. Greenson distinguished between the working alliance, the ability of patient and therapist to work together on the tasks of analysis, and the therapeutic alliance, which refers to the capacity of the therapeutic dyad to form a personal bond.

The concept of the alliance allowed the practitioners of psychoanalysis to be more flexible in terms of technique and to depart from the traditional classical ideals of abstinence and neutrality [2]. However, psychoanalysts continued to believe that the core mechanism of change was insight, whereas the alliance was a necessary but not sufficient condition for change [18].

From a different theoretical perspective, Rogers [26, 27], although not using the term alliance, posited the quality of the therapeutic relationship as both necessary and sufficient condition for clinical change. He conceptualized the therapeutic relationship as a set of therapist-offered conditions, such as empathy, unconditional positive regard, and congruency. However, Rogers attributed the key responsibility for forging the therapeutic relationship to the therapist and did not address the role of the patient in this process.

During the 1970s, with the advance of the empirical investigations of the therapeutic process, the concept of the alliance ceased to be the feature of purely psychoanalytic discourse and started to become a more general construct applicable to various types of treatment. Although working from the psychodynamic perspective, Luborsky [28] provided a description of the alliance that fits therapeutic process in general. He proposed that the alliance developed in two phases. Early in treatment (i.e., Type I), the alliance involves the patient's belief that treatment would be helpful and that the therapist is providing a supportive, warm, and caring relationship. This creates condition in which the treatment can be undertaken. Later in treatment (i.e., Type II), the alliance is based on a "sense of working together in a joint struggle against what is impeding the patient"

(p. 94). Thus it involves the patient's faith in the therapeutic process itself, commitment to some of the concepts underlying the therapy (e.g., the source of the problems), and an experience of collaboration with the therapist.

In his seminal contribution, Bordin [29, 30] offered a transtheoretical reformulation of the alliance concept. Building on Greenson's concepts of the real relationship and the alliance and reflecting Rogers' ideas of facilitative conditions, he suggested that the alliance consists of three interdependent components: tasks, goals, and bond. The *tasks* refer to specific activities that patient and therapist will engage in over the course of treatment in order to facilitate the desired change. These activities will differ depending on the modality of treatment (e.g., keeping an automatic thoughts record in cognitive-behavioral therapy (CBT), "two-chairs" exercise in the Gestalt therapy, or free association in the classical psychoanalysis). The *goals* are the desired outcomes, which are the targets of the treatment. The *bond* refers to the affective quality of the patient-therapist relationship and includes feelings of mutual trust and respect, liking, and confidence. According to Bordin [30], the bond "grows out of [patient's and therapist's] experience of association in a shared activity" (p.16). All three components of the alliance influence each other in an ongoing fashion during the course of treatment. That is, the ability to agree on goals and tasks of therapy contributes to patient's feelings of being understood and respected, and the sense of the mutual trust within the therapeutic dyad. In reverse, the positive feelings (i.e., the bond) allow patient and therapist to successfully negotiate the agreement on goals and tasks.

Several authors have highlighted the significance of Bordin's conceptualization of the alliance to psychotherapy theory, research, and practice [2, 31, 32]. First, his transtheoretical conceptualization allowed the concept of alliance to spread to other than psychoanalytic therapeutic traditions. According to Wolfe and Goldfried [33], the alliance became the "quintessential integrative variable" spanning all forms of treatment modalities, including experiential [34], cognitive-behavioral [35-38], couples and family therapy [39, 40], and group therapy [41]. Second, Bordin's formulation offered an alternative to the traditional dichotomy between technical and relational factors in psychotherapy by emphasizing that these two aspects are not separate but interdependent elements of therapy. Finally, building on Bordin's model and emphasizing a relational perspective, Safran and Muran [2, 18, 42] have recently offered a reconceptualization of alliance as *negotiation*. This reconceptualization will be discussed in detail in a separate section of this paper.

### ***Measuring the Alliance***

As Horvath and Bedi [4] have pointed out, much of our knowledge about the alliance derives from the empirical studies that define the alliance by the instruments used to measure it. That is, the measures of the alliance "contribute

to the definition of the construct” (p. 39). Currently there are more than 24 different alliance measures in use by psychotherapy researchers [4]. There are several important families of instruments that are used in the majority of empirical studies specifically designed to measure the alliance [4, 43, 44].

The Penn scales were developed by Luborsky and his colleagues (HAcS [28]; HAR [45]; HAQ [46]) at the Penn Psychotherapy Project to empirically test Luborsky’s [28] psychodynamic conceptualization of the Type I and Type II helping alliances. These instruments assess two dimensions of the alliance: (1) a warm, supportive, accepting relationship and (2) patient’s experience of collaboration and participation with the therapist in working toward the goals of the treatment. Luborsky and colleagues created the Penn scales that rate the alliance from patients’, therapists’, and independent observers’ perspective.

The Vanderbilt scales (VPPS [47, 48]; VTAS [49]) were developed by Strupp and his colleagues to measure the process dimensions of the Vanderbilt I project. The original 80-item Vanderbilt Psychotherapy Process Scale (VPPS) was an observer-rated measure of the therapist–patient relationship and the psychotherapy process. It was later refined to contain 44 items that specifically measure the alliance (Vanderbilt Therapeutic Alliance Scale). The alliance components in these measures include Patient’s Participation, Patient’s Exploration, Patient Motivation, Patient’s Acceptance of Responsibilities, Therapist’s Warmth and Friendliness, and Negative Collaboration.

The California–Toronto scales include the instruments developed over time by researchers from the University of Toronto and the Langley Porter Psychiatric Institute in San Francisco. The Therapeutic Alliance Rating Scale (TARS) [50, 51] was guided by the psychodynamic conceptualization of the alliance and combined items from other scales (the VPPS, the VTAS, and the HAcS). It focuses mostly on the affective dimensions of the alliance and measures its four components: Patient’s Positive Contribution, Patient’s Negative Contribution, Therapist’s Positive Contribution, and Therapist’s Negative Contribution. The most recent meta-analysis of the studies on the alliance and outcome [43] found that the TARS did not significantly correlate with the outcome. The authors advise against using this measure for future studies interested in the association between the alliance and the outcome. The California researchers revised the TARS based on factor-analytic studies and created the California Therapeutic Alliance Rating Scale (CALTARS) [52]. A subsequent revision resulted in creating the California Psychotherapy Alliance Scales (CALPAS) [53]. The current CALPAS assess four aspects of the alliance as conceptualized by Gaston [54], which are as follows: (1) the Patient Working Capacity scale reflects patient’s ego strength and his or her capacity to work purposefully in therapy, (2) the working alliance is assessed by the Patient Commitment scale, (3) the therapist’s contribution to the alliance is measured by the Therapist Understanding and Involvement scale, and (4) the Working Strategy Consensus scale reflects the collaborative agreement between the patient and the therapist on the treatment goals and tasks. The CALPAS offers versions that are rated by patients, therapists, and independent observers.

The Working Alliance Inventory (WAI) [55] was developed to measure Bordin's [29] transtheoretical model of the alliance as consisting of three components: the bond, the agreement on goals, and the agreement on tasks. To allow measurement of the alliance from different perspectives, Horvath and colleagues developed patient, therapist, and independent observer-rated versions of the WAI. A shortened 12-item version of the WAI was also developed [56]. Subsequent studies [56] suggested that the WAI appears to be measuring one general alliance factor, as well as the three specific alliance factors of task, goal, and bond. However, there is also evidence that patients make relatively little distinction between the task and the goal dimensions of the scale [57], while therapist are able to make more distinctions among these dimensions [58].

Several studies that compared different alliance measures (the CALPAS, the Penn, the VTAS, and the WAI) reported that all instruments demonstrated high internal consistency and good interrater reliability [59, 60]. The recent meta-analysis of the alliance literature [43] reported the overall average reliability of the alliance scales based on various estimation methods to be 0.79 ( $n = 93$ ,  $SD = 0.16$ ). When interrater reliability was used, the average reliability was 0.77 ( $n = 33$ ,  $SD = 0.15$ ), whereas when Cronbach's  $\alpha$  was reported, the average alliance scale reliability was 0.87 ( $n = 44$ ,  $SD = 0.10$ ). Horvath and Bedi [4] summarized the existing findings regarding the overlap between different instruments and reported medium to high (ranging from 0.34 to 0.87) intercorrelations between various measures of the alliance. Horvath and Bedi [4] also report that factor-analytic examination of the most popular measures indicates three underlying factors present, to varying degrees, in all measures: "personal bonds, energetic involvement in treatment (collaborative work), and collaboration/agreement on the direction (goal) and substance (tasks) of treatment." However, it does not appear that each scale measures the identical construct. Although each instrument reflects the core dimensions, they also assess some features of the relationship that other measures do not.

### *The Empirical Research on the Alliance*

Numerous studies examining the relationship between the strength of the alliance and the outcome of treatment have been conducted over the past 20 years. These studies use different instruments to measure the alliance and outcome, address various psychiatric disorders (e.g., depression, personality disorders, and substance abuse), and various treatment modalities (e.g., psychodynamic, behavioral, and cognitive). The advance of the meta-analytical methods allows us to integrate the vast empirical evidence and to identify patterns in the literature. Several meta-analytic reviews of the alliance literature [4, 43, 61] have provided evidence linking the quality of the alliance to the treatment outcome. Horvath and Symonds [61] found an overall effect size of 0.26 between the alliance and the outcome based on 24 studies. Martin and



colleagues [43] reviewed 79 studies and reported a slightly smaller effect size of 0.22. Most recently, Horvath and Bedi [4] located 10 additional studies published after Martin and colleagues conducted their review and presented their results based on 89 studies. Across all these studies, the average relation between the alliance and the outcome was 0.21, and the median effect size was 0.25 [4]. Although, as Horvath and Bedi pointed out, the magnitude of this relation may not appear very impressive, “the impact of the alliance across studies is far in excess of the outcome variance that can be accounted for by techniques.” [4, pg. 61] In other words, the quality of the patient–therapist relationship is more important than the treatment modality.

Although the earlier analyses of the alliance studies suggested that the client-rated alliance was a better predictor of the outcome than the therapist-rated alliance, and that the therapists’ ratings showed poor correlations with the patients’ [61], some more recent studies indicate that therapists’ assessment of the alliance becomes a better predictor of outcome later in therapy [58]. Some researchers found that ratings of the alliance from the independent observer perspective have significant correlations with outcome, while both patient and therapist ratings were not as predictive [60]. Horvath and Bedi [4] reported that patient- and observer-rated alliance have a similar relation to outcome (regardless of the source of outcome ratings), while therapist-rated alliance and outcome are somewhat less related. Horvath and Bedi [4], along with other researchers [59, 62, 63], pointed out that each rater’s view of the alliance reflects a qualitatively different aspect of it and provides unique information about the therapeutic relationship. It is, therefore, important to continue studying the alliance from all perspectives.

One of the issues that has been discussed over the years in alliance literature is the possible role of a “halo effect,” which is the exaggerated relations between the alliance and the outcome due to the fact that both the alliance and the outcome are rated by the same participants. Horvath and Bedi [4] concurred with the conclusions of others [43, 61] in finding no difference between the effect sizes based on the “same-source” alliance and outcome ratings and the effect sizes based on studies with different sources of the alliance and outcome assessment.

The relationship between alliance ratings at different points in treatment and the final outcome has been investigated by many researchers. Horvath and Symonds [61] found that the early and late alliance measures predict outcome better than the alliance assessments obtained in the middle phase of treatment or the alliance averaged across treatment. According to Horvath and Bedi [4], subsequent investigations confirmed this trend. There is substantial empirical evidence that establishing a strong alliance early in therapy is paramount to the success of treatment and that the alliance measured between the third and fifth sessions is a consistent predictor of final therapy outcome [4]. Moreover, the strength of the alliance after the first session has been shown to be a good predictor of dropout from treatment [64, 65]. These findings also speak against the suggestion that the relation between alliance and outcome is merely an artifact and a by-product of treatment gains [32].



Several researchers attempted to investigate the development of the alliance over the course of treatment. Gelso and Carter [66] suggested that the alliance in successful treatment follows a curvilinear trajectory: initially established strong alliance deteriorates during the middle phase of treatment due to therapist's increasing challenge to patient's dysfunctional relational schemas and improves again toward the end of treatment. The empirical evidence in support of this hypothesis is mixed. Some studies found that the alliance remains stable across the time [67, 68], while others found evidence for the linear growth [58]. Kivlighan and Shaughnessy [69] examined the development of the alliance across four sessions of counseling and discovered three patterns of alliance development: stable alliance, linear alliance growth, and quadratic alliance growth. A pattern of quadratic alliance development was associated with greater improvement on outcome measures when compared to other patterns of alliance development. Tracey and Ray [70] also found that this quadratic trend differentiated good from poor outcome cases, with the good ones showing the high–low–high trajectory. Although not finding the support for the cyclical model of alliance development for patients and therapists on a group level, Bachelor and Salame [67] indicated that individual therapists' and patients' perceptions of various aspects of the alliance showed variation over one time period or another. They concluded that "single assessments of many facets of the participants' perceptions of the relationship cannot be assumed to be representative of their perceptions throughout the course of therapy" (p. 49). The evidence for the dynamic, labile nature of the alliance comes from the longitudinal case studies of more or less successful therapies [71, 72]. These studies found high–low–high pattern of alliance development in good outcome cases and suggested that the course of the alliance in a successful therapy is characterized by a series of ruptures and repairs.

Stiles and his colleagues [73] examined the patterns of alliance development in 79 patients who underwent short-term CBT or psychodynamic–interpersonal treatment for depression. They found that patients whose pattern of alliance development was characterized by episodes of sharp declines in the strength of the alliance followed by a quick return to previous or higher levels (i.e., rupture–repair sequences) made larger gains in treatment compared to other patients. Similarly, in their study of 30 patients who were treated with cognitive therapy for personality disorders, Strauss and his colleagues [74] discovered that most of the patients who reported rupture–repair episodes also reported symptom reductions of 50% or more on all outcome measures.

## **Ruptures in Therapeutic Alliance and their Resolution**

Although the concept of ruptures in therapeutic alliance (also called strains, breaches, tears in the alliance) is relatively new, working through impasses or difficulties in therapeutic relationship has long been considered pivotal in the

process of therapeutic change [2, 75]. In psychoanalytic theory, working through patient's resistance, which was initially seen as an impediment to the analytic process, eventually was conceptualized as the core mechanism of change by the ego psychological school [2, 30]. According to Kohut [6], empathic failures on the part of a therapist are not only inevitable in the course of the therapeutic process but are, in fact, ascribed a central role in the process of change. Therapist's ability to attend to empathic failures by validation of patient's subjective experience and affective attunement results in patients internalizing these "therapist's self-object functions" and patient's capacity to tolerate disappointments and develop a cohesive sense of self. Alexander and French [76] suggested that change takes place through the corrective emotional experience, which the therapist provides by behaving differently from the patient's parents in a conflict situation and thus disconfirming patient's expectations and beliefs about interpersonal relations. A similar concept was proposed and empirically tested by Weiss, Sampson and their colleagues from the Mount Zion Psychotherapy Research Group [77], who theorized that people's problems result from the pathogenic beliefs about interpersonal relationships. These pathogenic beliefs (e.g., that anger will lead to retaliation or that dependence will lead to abandonment) originated as a result of interactions with significant others in the past. According to Weiss and colleagues [77], the process of disconfirming the patient's pathogenic beliefs constitutes a central mechanism of change, and patients unconsciously submit therapist to "transference tests" in order to disconfirm these beliefs. Their empirical studies showed that the disconfirmation of pathogenic beliefs is related to both immediate (i.e., in session) and ultimate outcome [77].

The concept of the alliance rupture overlaps to a certain degree with constructs such as resistance, empathic failure, and transference test [2, 78, 79]. However, the concept of the alliance rupture "has a certain heuristic value because of its link to current psychotherapy research and because of its trans-theoretical status" [78]. It is understood to be a function of both patient and therapist contributions – a conceptualization that further distinguishes it from constructs such as resistance, which tend to emphasize the patient's contribution. Alliance ruptures are conceptualized as a type of therapeutic enactment, i.e., periods of unconscious mutual influence between patient and therapist [18, 80]. Enrico Jones [81] calls these unconscious enactments "repetitive interaction structures," and he and his colleagues have devoted considerable attention to investigating them empirically.

An alliance rupture is broadly defined as a strain or breakdown in the collaborative process between patient and therapist, a deterioration in the quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset [5, 75, 78, 80, 82, 83]. Alliance ruptures vary in intensity and duration from minor tension, which can go unnoticed even by a skilled therapist to major problems in communication that, if unresolved, can lead to premature termination or

negative outcome [5, 83]. Ruptures can occur during different phases of treatment and with various frequencies.

Bordin [30] awarded central importance to the dynamics of strains in the alliance during the process of therapeutic change. Safran and his colleagues have discussed at length, from both theoretical and empirical perspectives, the importance of investigating alliance ruptures [2, 5, 78, 82–84]. They suggested that alliance ruptures inevitably occur in the course of treatment and can provide a valuable opportunity for therapeutic change. Safran [82] outlined three factors that make alliance ruptures “important therapeutic junctures.” First, negative patient–therapist interactions in which therapists respond to patients’ hostile communications with similar hostile communications have been shown to result in poor outcome and treatment failure [85]. Second, ruptures provide the therapist with an opportunity to explore patients’ expectations and beliefs that constitute their core dysfunctional interpersonal schema, since they often emerge when therapist unwittingly participates in maladaptive interpersonal cycles. Finally, the exploration and resolution of the ruptures can provide the patient with a corrective emotional experience and can modify their dysfunctional interpersonal schemas.

Ruptures in therapeutic alliance have only recently become a subject of rigorous empirical investigation. Safran and colleagues [5] reviewed the existing research related to the alliance ruptures and outlined several emerging trends. First, it appears that patients often avoid revealing their negative feelings about therapists and therapy process [86–88] while even experienced therapists are unable to detect problems in the relationship with patients [87, 88]. Two studies conducted retrospective analyses of therapeutic impasses from patients’ [89] and therapists’ [90] perspectives. The first study showed that when misunderstandings occurred in a context of poor therapeutic relationship and patients were not able to assert their negative feelings about being misunderstood, they eventually quit therapy. Moreover, when the misunderstanding occurred in a context of good relationship, patients were willing to openly confront their therapists about their negative feelings, and patients and therapists engaged in a mutual repair process over some period of time, the misunderstandings were resolved, which led to an enhanced relationship with the therapist and to patient’s growth. The second study conducted a qualitative analysis of therapists’ recollection of ruptures that led to unilateral termination. The study showed that patients did not reveal their dissatisfaction until they prematurely terminated, and therapists reported that they were not aware of any problems in the relationship until patients quit therapy.

Second, even when therapists become aware of ruptures in the alliance, they find it difficult to address them in a way leading to their repair and improvement in the alliance. In fact, they may unwittingly contribute to further deterioration of the relationship and to poor outcome of treatment. Several studies [91–94] found that in poor outcome cases, therapists, confronted with ruptures in the alliance, attempted to address them by increasing adherence to the treatment model in a rigid and unconstructive fashion (i.e., challenging distorted cognitions

in the CBT modality or transference interpretations in psychodynamic therapy). Critchfield and colleagues [31] used the Structural Analysis of Social Behavior, a well-established measure of interpersonal process, to examine the differences in the nature of therapeutic relationship between cases with good outcome, declining outcome (high level of functioning at termination but a low level at 12-month follow-up), and poor outcome (low level of functioning at both termination and follow-up) in CBT for generalized anxiety disorder. They found that patients in the declining and poor outcome groups showed higher level of control toward therapists. Therapists in the poor outcome group responded to this behavior with the increased attempts to control the session, thus engaging in a power struggle and a vicious cycle of negative interpersonal process, as opposed to therapists in the declining outcome group who granted patients more interpersonal distance. These findings are similar to those of the Vanderbilt studies, which also used the SASB to measure the interpersonal process [95, 96]. Strupp and colleagues found that the interpersonal process associated with poor outcome was characterized by negative complementarity (interpersonally disaffiliative communications) and higher evidence of therapists' hostile control. Therapists in the Vanderbilt II study who underwent extensive training in a manualized form of psychodynamic treatment specifically focused on patient-therapist relationship and managing maladaptive interpersonal patterns, however, showed more negative disaffiliative process and became more authoritarian and defensive, despite exhibiting good adherence to the model. In fact, as mentioned before, it appears that, faced with the difficulties in therapeutic relationship, therapists increased rigid adherence to the model, which negatively affected the alliance and the outcome.

Several small-sample qualitative studies attempted to investigate factors that contribute to the resolution of the alliance ruptures. Foreman and Marmar [97] selected six patients who initially displayed poor alliance out of a sample of 52 patients undergoing short-term dynamic psychotherapy of bereavement. Of these patients, three had improved alliance over the course of treatment and had good outcome, while the other three did not improve alliance and had poor outcome. The researchers found that the alliance improved when therapists directly addressed patient's defenses, guilt and expectation of punishment, patient's negative feelings toward the therapist, and linked the problematic feeling in relation to therapist with patient's defenses. When therapists' interventions failed to directly address problems in the relationship, the alliance did not improve.

Lansford [98] specifically studied weakening and repairs in the alliance by looking at six cases in short-term psychotherapy. Independent raters assessed the effectiveness in repairing weakened alliance by observing segments of sessions and were able to predict outcome based on the degree of successful resolution of ruptures. She also found that when patients initiated addressing problems in the relationship and worked with therapists to repair weakened alliance, it resulted in the highest patients' alliance ratings. Lansford emphasized the role of addressing strains in the alliance during the process of change

by stating that “if weakenings [in the alliance] were successfully repaired and resolved, then one could say that the person had been able. . .to change what was most painful or difficult in his or her life” (p. 366).

Safran, Muran, and colleagues [2, 5, 78, 83, 99] have conducted a series of studies investigating the roles of alliance rupture and resolution in treatment process and outcome. Guided initially by the task-analytic paradigm for the psychotherapy research [100, 101], we have developed and refined a model of the rupture resolution process. Following task analysis procedures, we have employed a combination of qualitative and quantitative methods, and oscillated back and forth between theory building and empirical analysis to progressively refine this model [102].

The preliminary model of the rupture resolution was based on psychodynamic and interpersonal theory [99] and included several stages. First, the patient reenacts with the therapist his or her characteristic maladaptive interpersonal pattern (e.g., anticipating abandonment, patient withdraws). The therapist unwittingly responds in a complementary fashion, thus contributing to the dysfunctional interpersonal cycle (e.g., reacting to patient’s withdrawal, the therapist becomes bored, unresponsive, or frustrated). In the next stages, the therapist becomes aware of his role in the enactment and begins disembedding from the negative process by metacommunicating to the patient about the current interaction. He or she explores the patient’s experience of it in the “here and now” and accepts responsibility for his or her own contribution to the interaction.

This model was refined through a series of small-scale, intensive, qualitative and quantitative studies. The studies involved identifying sessions with ruptures and rupture resolution, exploratory and qualitative analyses of these sessions using various measures of psychotherapy process in order to operationalize different dimensions of the model components, and testing the hypothesized resolution model on different samples (for more detailed discussion of the model development see [78]). The resulting general model of rupture resolution includes four stages of interactions between patient and therapist: (1) attending to the rupture marker, (2) exploring the rupture experience, (3) exploring the avoidance, and (4) emergence of wish or need. Rupture events were categorized into two major types: confrontation ruptures and withdrawal ruptures [99]. A confrontation rupture is characterized by an aggressive and accusatory statement of resentment or dissatisfaction in regard to the therapist or some aspect of the therapy process. A withdrawal rupture is characterized by patient disengaging from the therapist, some aspect of the therapy process or from his or her own internal experience. The resolution process for confrontation and withdrawal ruptures follows different exploratory pathways (stages 2, 3, and 4). The typical progression in the resolution of confrontation ruptures involves moving through feelings of anger to feelings of disappointment and hurt over having been failed by the therapist to contacting underlying vulnerability and the wish to be nurtured. The avoidant operations in this case typically involve fear of being too vulnerable associated with the expectation of rejection by therapist.

The progression in the resolution of withdrawal ruptures involves moving through increasingly clearer articulations of discontent to self-assertion and becoming aware of the wish for agency. The avoidance that emerges usually concerns the fear of one's aggression and the expectation of retaliation by the therapist.

As mentioned above, small quantitative studies were conducted to test the resolution model (see [78]). The results of these studies provided evidence consistent with the presence of the hypothesized components of the model in resolution sessions and demonstrated statistically significant differences between resolution and nonresolution sessions [77]. The clear limitation of these studies is a small number of cases on which the findings are based. Currently, a study that will attempt to verify the model on a large number of cases is in progress.

In the course of the development of the model of rupture resolution described above, Safran and his colleagues [5, 99] created a self-report measure for identifying ruptures in the alliance and rupture resolution events and establishing their relationship to overall outcome. The postsession questionnaire (PSQ) is completed by both patient and therapist after each psychotherapy session. It includes direct questions about the presence of a rupture in the alliance ("Did you experience any problem or tension in your relationship with your therapist/patient during the session?") and their resolution ("To what degree do you feel this problem was resolved by the end of the session?" [rated on a five-point scale]), as well as the Rupture Resolution Questionnaire (RRQ) specifically designed to identify the presence of experiences hypothesized to be associated with the rupture resolution process (RRQ; Safran JD, Muran JC, Winkelman E. Rupture Resolution Questionnaire. In: Unpublished measure. New York, 1996). This measure will be discussed in more detail below. Several studies (see [99] for a review) demonstrated the psychometric properties of the PSQ, including its ability to detect ruptures and rupture resolution, as well as its predictive validity. In a study of 128 cases [103], patient- and therapist-reported resolution (as measured by a direct query) was found to be positively related to depth of in-session exploration and therapeutic alliance, as rated by patient and therapist. Early session patient and therapist reports of rupture resolution negatively predicted patient dropout. These findings were based on medium to large effects ( $r = .22-.48$ ).

The proposed model of the rupture resolution was further investigated through a series of studies that examined the efficacy of brief relational therapy (BRT) [2], a short-term treatment that integrates principles emerging from rupture resolution research with principles of relational Psychoanalysis. A treatment study of 128 personality-disordered patients compared the BRT, short-term psychodynamic treatment of a more traditional nature, and CBT [103]. Although all three treatments were equally effective for patients who completed treatment, the BRT was significantly more superior to the other two modalities based on the dropout rates. Another study attempted to evaluate the efficacy of the BRT



with patients who have difficulties in establishing a therapeutic alliance and are at risk for premature termination [104]. Sixty patients were randomly assigned to either the psychodynamic treatment or CBT model. Patients were monitored early in treatment to identify those who were having difficulties in establishing an alliance with their therapists and were at risk for dropout. These patients were offered to be reassigned to a therapist from another treatment condition: either to BRT or to the control for their previous treatment (i.e., patients who were treated in the CBT modality were transferred to the traditional psychodynamic treatment, whereas patients from the traditional psychodynamic treatment were switched to the CBT). Of the 60 patients in the study, 18 met criteria for a switch and were offered an opportunity to be reassigned. Ten patients agreed to be transferred to another treatment modality. Of the five patients assigned to the BRT, three completed treatment with good outcome, one had to leave the city due to a job change after completing midphase (with good outcome), and one dropped out. Of the five patients transferred to the control conditions, all five dropped out. Although the sample size in this study was small, it provided preliminary evidence of the superiority of BRT, a treatment which employs interventions specifically geared to rupture resolution for patients who have difficulties in establishing and maintaining the therapeutic alliance and are, therefore, at risk for poor outcome and dropout.

### **Clinical Illustration of the Resolution Process in Confrontation Ruptures**

Cindy was a participant in the above-discussed study evaluating the efficacy of the BRT with patients who have difficulties in establishing therapeutic alliance and are at risk for premature termination [104]. She was a 38-year-old divorced woman who was attempting to make it in a career as an actress. She sought short-term therapy to work on what she termed her lack of self-confidence, as well as a tendency toward procrastination and a lack of perseverance. Cindy described the relationships in her life as generally “shaky,” and herself as a “negative and angry person.” She also reported having difficulty in separating from her family. Cindy reported having been in longer-term therapy on three previous occasions, but was uncertain about whether or not these experiences had been beneficial.

The sessions described below were ones in which Cindy had reported that there had been a problem or tension in her relationship with therapist. The sessions selected were those that had achieved the highest ratings on the resolution question (“To what extent was [this problem] resolved by the end of the session?” rated on a five-point scale), from Cindy in each of the treatment conditions (CBT and BRT). The two senior authors (JDS and JCM) examined videotapes of these sessions and combined their observations



to develop consensually based narratives describing the most salient features of each session.

***Before Reassignment (cognitive–behavior therapy, Session 5; Resolution rating: 3)***

Cindy is an angry, critical, single woman in her mid-thirties, with a dramatic manner. The therapist (a woman of approximately the same age) is 5 minutes late for the session and Cindy is upset that the therapist is “rattled about being late,” because it indicates to her that “you get rattled like I do.” The therapist denies being rattled and then attempts to explore Cindy’s concerns about her in greater detail. Cindy admits to not having confidence in the therapist or the treatment. Throughout the session, the therapist has somewhat of an edge to her and Cindy seems to be alternately angry and cowed. She admits to attending a weight control clinic at the same time she is in treatment, and the therapist speculates that Cindy may be trying to undermine her treatment. When asked what her motivation for this might be, Cindy compliantly speculates that maybe she does not want to beat her father. The therapist says, “Don’t speculate...what would happen if you took the next step?” Cindy responds, “I feel badly talking about this. I feel I’m making you angry at me. I feel like I’m being difficult.” The therapist asks Cindy to think about how she might be able to test their relationship or experiment to see if there is some way that she can become more trusting about the therapy. “Why don’t you experiment with putting aside your doubts? What would that be like for you?” Cindy suggests that she could try, but she appears compliant and subdued. The therapist suggests that it is important for them to actually start working and to adopt a problem-solving attitude. When asked what she is experiencing, Cindy replies that she is feeling reprimanded and that she feels like she is being difficult. Consistent with study protocol, Cindy was offered a transfer to a different treatment and therapist.

***After Reassignment (Brief Relational Therapy, Session 6; Resolution rating: 3)***

Cindy begins the session with an angry, demanding tirade, “I don’t feel this is helping me. There is nothing worthwhile about this.” The therapist (a man of approximately the same age) responds, “I guess I’m feeling a little stuck. I understand there hasn’t been the kind of progress you want... and I guess... watching the tapes, I’m aware that I’ve also been acting a little defensive... I guess feeling that you’re questioning my competency. And it may be affecting my work a little.” Cindy responds, “That’s your problem. The bottom line is that I’m stuck. And I resent your implying that it’s my fault.” The therapist

replies, "Well, we need to come up with a way of working together that's more profitable for you." Cindy responds: "That makes me feel there's no plan here. I feel we're directionless. You don't work with dreams. I want to feel you can handle me." The therapist attempts to empathize, "you're really feeling angry about not getting what you want here." This leads to a shift in Cindy's focus. She tells the therapist about a community meeting she participated in between sessions, during which she felt angry, powerless, humiliated and "like a child."

The therapist attempts to explore her feelings, and she vacillates between anger and tears in a somewhat histrionic style. She lists a litany of slights she has experienced in her life and then returns the focus to therapeutic relationship by asking the therapist what he meant earlier when he said he "felt stuck." The therapist replies, "I want to apologize if it felt I was blaming you. I'm just trying to understand what's going on here." Cindy responds, "I think I'm being cooperative." The therapist says, "Did you hear me saying that you're not?" Cindy, "I guess I feel like I get the message that it's not okay to be angry." The therapist acknowledges that he may, at times, communicate this but takes responsibility for his contribution: "When you get angry at me it gets to me sometimes. It's not that you shouldn't get angry...but I let it get to me sometimes."

Cindy softens and suggests that she may in part be "dumping" on him because it feels like a "safe place." "I can act powerful here, but I can't in real life." She becomes tearful, lapses into hysterical crying, and then abruptly stops. The therapist says, "I feel like you're kind of asking me for help, and I'd like to take care of you. I'm just not sure how right now." At first Cindy denies asking for help, but later in the session she spontaneously suggests that maybe she's being overly dramatic, but that she really does want his help and sympathy. This request has an authentic flavor to it (clinical example reprinted with permission from Safran JD, Muran JC, Samstag L, Winston A. Evaluating an alliance focused treatment for potential treatment failures. *Psychotherapy* 2005;42: 512-531).

This session clearly contains some of the same themes as the session with the previous therapist: Cindy's anger at the therapist, her questions about the therapist's competence, and her concerns about being blamed for being uncooperative and for being angry. In contrast, however, the therapist responds less defensively. He acknowledges responsibility for his own feelings and his contributions to the interaction and attempts to explore the interaction between them. He attempts to empathize with her anger at him and the unmet needs underlying her anger. Cindy gradually moves from an angry, demanding, blaming stance to one in which she accepts some responsibility for her displaced anger and begins to acknowledge her more vulnerable feelings. This transition on the patient's part, from demanding and blaming to acknowledgement of underlying vulnerability, is characteristic of the resolution process in confrontation ruptures.

## Reconceptualizing the Alliance

Building on Bordin's [29, 30] transtheoretical tripartite model of alliance, contemporary relational psychoanalytic thinking [105, 106], and their empirical research on alliance ruptures and their resolution, Safran and Muran [2, 5, 18] have proposed a reconceptualization of the alliance as an "ongoing process of intersubjective negotiation, that is, the negotiation of the respective needs of two independent subjects." As discussed above, three dimensions of the alliance outlined by Bordin (bond, tasks, and goals) are interdependent and influence each other in an ongoing fashion. When disagreements about therapeutic tasks and goals arise, a strong preexisting bond between patient and therapist allows them to constructively negotiate the problem. Moreover, successful resolution of the rupture through negotiation between different perspectives enhances patient's feelings of trust and provides patient with an experience of authentic relatedness [84]. Furthermore, in the process of a constructive negotiation with a therapist, patient develops a capacity to negotiate the needs of the self versus the needs of the others, which, according to Safran and Muran [5], constitutes an "ongoing challenge of human existence" [5, p. 236].

Safran and his colleagues [5, 18] emphasize that negotiation of therapeutic tasks and goals is a ubiquitous phenomenon in psychotherapy occurring both explicitly and implicitly (out of conscious awareness of participants). However, when there is a rupture in the alliance, the process of negotiation itself becomes the most salient feature of the change-producing therapeutic process. Safran and colleagues [5] also point out that this process should not be aimed at superficial agreement and compliance but rather reflect a "genuine confrontation between individuals with conflicting views, needs, or agendas" (p. 236).

As described above, Winkelman, Safran, and Muran (Safran JD, Muran JC, Winkelman E. Rupture Resolution Questionnaire. In: Unpublished measure. New York, 1996) developed a self-report measure, the RRQ, to identify the presence of experiences hypothesized to be associated with the process of rupture resolution. The RRQ can be conceptualized as a measure of alliance as negotiation. Unlike most measures of the alliance described in the previous section, which focus on the agreement between patient and therapist, the RRQ focuses on experiences associated and resulting from the constructive negotiation of conflict between them. Initially, 68 items believed to reflect the patient's experience of constructive negotiation of the therapeutic relationship were generated by a team of psychotherapy researchers. These items were subjected to a content validation procedure involving relevancy ratings first by 10 senior clinicians and then by 60 graduate students in clinical psychology or recently graduated clinicians. Based on the results of the reliability and item analyses, 18 items were retained to construct the RRQ. Patients were asked to fill out the RRQ whenever they had indicated that they experienced a problem or tension in their relationship with their therapists during the session. The items of the RRQ are reprinted below:

Please rate the extent to which each of the following statements reflects your experience during this session

Not at all	Somewhat			Definitely	
1. I felt a closer connection with my therapist	1	2	3	4	5
2. I discovered feelings toward my therapist that I had not been fully aware of	1	2	3	4	5
3. My therapist and I were able to work through a conflict and connect in a stronger way	1	2	3	4	5
4. I saw how I was contributing to the difficulties my therapist and I were having	1	2	3	4	5
5. I acted in a way that felt more authentic or genuine for me	1	2	3	4	5
6. I recognized and accepted my therapist's limitations	1	2	3	4	5
7. I felt freer to make mistakes with my therapist	1	2	3	4	5
8. I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist	1	2	3	4	5
9. I saw that I can expose risky feelings and not be rejected/criticized by my therapist	1	2	3	4	5
10. I began to get the sense that I don't have to protect my therapist	1	2	3	4	5
11. I felt more comfortable with expressing vulnerability or anger toward my therapist	1	2	3	4	5
12. I told my therapist something I had been hesitant to say	1	2	3	4	5
13. I felt able to disagree with my therapist	1	2	3	4	5
14. I began to accept a part of myself which I had not fully acknowledged before	1	2	3	4	5
15. I said something to my therapist which I had felt for a while and it left me with a sense of relief	1	2	3	4	5
16. I saw that I was doing something to distance myself from my therapist or push him/her away	1	2	3	4	5
17. I felt more trusting of my therapist	1	2	3	4	5
18. I was afraid something I said would upset or hurt my therapist but I found out that it did not	1	2	3	4	5

The studies of the psychometric properties of the instrument [107, 108] found the RRQ to be a soundly reliable instrument with an adequate internal consistency (Cronbach's  $\alpha = 0.87$ ). Concurrent validity was established by examining the relationship between the RRQ and various measures of psychotherapy process. The RRQ was shown to be positively related to patient and therapist ratings of session helpfulness, depth of therapeutic exploration, and strength of the therapeutic alliance as measured by the WAI. Predictive validity was examined by analyzing the relationships between the RRQ and patient- and therapist-rated measures of the global outcome of treatment. The RRQ was found to be a significant predictor of the improvement in the patient's overall level of functioning (as rated by therapist), a significant predictor of the decrease in severity of patient's interpersonal problems (as rated by therapist), and a significant predictor of the decrease in the severity of symptoms (as rated by patient). The correlation coefficients were in the medium range (0.28–0.41).

In addition, the RRQ was found to make a unique and significant contribution above and beyond the WAI to predict the improvement in interpersonal functioning as rated by therapist. Overall, these results suggest that this measure is a potentially useful instrument for future research on psychotherapy process and outcome.

## Summary and Conclusions

More than 60 years of empirical research on psychotherapy outcome and process strongly supports the following findings: (1) psychotherapy in general is effective; (2) different types of psychotherapy are equally effective in producing therapeutic change; (3) measures of therapeutic relationship correlate more highly with outcome than do specialized therapy techniques; and (4) the quality of the therapeutic alliance appears to be the most robust predictor of the outcome.

The concept of the therapeutic alliance has been refined over the years, with multiple instruments designed to measure it, thereby contributing to the definition of the construct. The recent reconceptualization of the alliance as an ongoing negotiation requires further empirical investigation. The alliance appears to be dynamic, and fluctuations in the alliance (i.e., ruptures and resolutions) appear to be important change-related events in the therapy process. The empirical research on alliance ruptures and resolution is promising. However, the number of studies investigating this issue is limited; most of the studies are qualitative and based on small sample sizes. Nevertheless, the preliminary evidence suggests that the process of recognizing and addressing ruptures in the therapeutic alliance may play an important role in preventing patient dropout and in facilitating good outcome. There is also evidence that even experienced clinicians experience difficulties in recognizing and resolving ruptures in the alliance. Continued research on the mechanism of rupture resolution will clearly have implications for practice, potentially providing clinicians with guidelines on how to effectively deal with problems in the alliance.

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