Repairing Alliance Ruptures

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In this article, we review the existing empirical research on the topic of therapeutic alliance ruptures in psychotherapy. Ruptures in the therapeutic alliance are defined as episodes of tension or breakdown in the collaborative relationship between patient and therapist. Two meta-analyses were conducted. The first reviewed studies examining the relation between rupture-repair episodes and treatment outcome ($r = .24$, $z = 3.06, 95\% CI [.09, .39]$, $p = .002, k = 3, N = 148$). The second meta-analysis reviewed the research examining the impact on treatment outcome of training therapists in the use of alliance rupture intervention principles ($prepost r = .65, z = 5.56, 95\% CI [.46, .78]$, $p < .001, k = 8, N = 376$). Both meta-analyses provided promising evidence regarding the relevance of alliance rupture-repair processes to therapeutic outcome. The limitations of the research reviewed are discussed as well as practice implications for repairing the inevitable alliance ruptures in psychotherapy.

Keywords: alliance ruptures, alliance, therapy relationship, meta-analysis, treatment outcome

One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is a robust predictor of outcome across a range of different treatments and that, conversely, weakened alliances are correlated with unilateral termination by the patient (e.g., Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995). In the last two decades, there has emerged what we have characterized as a “second generation” of alliance research that attempts to clarify the factors leading to the development of the alliance as well as those processes involved in repairing ruptures in the alliance when they occur (Safran, Muran, Samstag, & Stevens, 2002).

In this article, we provide a review of this research and meta-analyses of two different types of relevant studies. The first meta-analysis examines the association between the presence of rupture-repair episodes and treatment outcome. The second examines the impact of rupture resolution training or supervision on patient outcome by assessing patient change from therapy intake to termination. We also consider the limitations of the extant research and advance clinical practices based on our research findings.

Definitions and Measures

A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2006). Although the term rupture may imply, to some, a dramatic breakdown in collaboration, ruptures vary in intensity from relatively minor tensions, which one or both of the participants may be only vaguely aware of, to major breakdowns in collaboration, understanding, or communication. Concepts that are similar or overlapping with the construct of alliance rupture include empathic failure (Kohut, 1984), therapeutic impasse, and misunderstanding event (Rhodes, Hill, Thompson, & Elliot, 1994). Alliance ruptures and repairs can be measured from patient, therapist, and observer perspectives. They can focus on rupture-repair events that take place either within a session or over the course of treatment.

Patient Self-Report of Within-Session Ruptures

One method of identifying alliance ruptures and repairs involves obtaining patient and therapist reports of shift in quality of the alliance, or perception of alliance rupture and degree of resolution within a session, using session impact questionnaires. For example, in a study comparing the efficacy of Brief Relational Therapy, Cognitive Behavioral Therapy, and short-term dynamic therapy with personality disordered patients (Muran, Safran, Samstag, & Winston 2005), patients completed postsession questionnaires (PSQ; Muran, Safran, Samstag, & Winston, 2004), which included self-report measures of the alliance (12-item Working Alliance...
ruptures using Harper’s (1989a, 1989b) unpublished coding sys-

same sessions, judges identified confrontation and withdrawal

the alliance measure, self-reports of ruptures and resolution, and

completed a brief version of PSQ after each session that included

ruptures naturally leads to common rupture-repair interventions on

about a therapeutic task or goal.

negotiate the tasks or goals of treatment may feel misunderstood or

misunderstood by the therapist.

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immediate symptom relief. An example of a disagreement about the
goal dimension would be a situation in which the patient

immediate relief from his or her panic symptoms, but the therapist

found it useful to conceptualize ruptures in the alliance as consisting

of (1) disagreements about the tasks of therapy, (2) disagreement about

the treatment goals, or (3) strains in the patient-therapist

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 dimen-

sion 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.

Understanding the typical clinical manifestations of alliance
ruptures naturally leads to common rupture-repair interventions on
-the part of the psychotherapist:

1. Repeating the therapeutic rationale. Outlining the ther-
aputic rationale at the beginning of treatment can play an impor-
tant role in developing the alliance at the outset. Reiterating the
-rationale throughout treatment can help to repair a strained alli-
-ance. For example, the therapist can help to repair an alliance
-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.

2. Changing task or goals. In this intervention, the therapist responds to ruptures resulting from disagreements about tasks or goals by modifying his behaviors in a fashion that feels meaningful to the patient. For example, a rupture ensues when a therapist attempts to challenge a patient’s dysfunctional thinking style. In response, the therapist shifts to validating his experience rather than challenging his perception. A patient is frustrated by the therapist’s attempt to explore his feelings and asks for more direct guidance. In response, the therapist shifts to providing direct advice or engaging in collaborative problem-solving with the patient.

3. Clarifying misunderstandings at a surface level. In some contexts, ruptures can be resolved at a surface level by clarifying misunderstandings. 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 their 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.

4. Exploring relational themes associated with the rupture. In some situations, the process of clarifying factors leading to a rupture can lead to an exploration of underlying 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. A patient’s feeling of being mistrusted by the therapist may reflect a narcissistic sensitivity, which becomes a major focus of the treatment.

5. Linking the alliance rupture to common patterns in a patient’s life. In some situations, resolving a rupture can involve explicitly exploring the link between the rupture that occurs in the session and some situation in the patient’s life. For example, a therapist explores similarities between the control struggles occurring in the therapeutic relationship and the patient’s parallel tendency to become involved in controls struggles with others in his or her life.

6. New relational experience. In some contexts, it can be useful for the therapist to act 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 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 a corrective contrast to the patient’s abandoning mother.

Illustration

Here we present a brief and condensed illustration of a rupture resolution process that involves exploring relational themes associated with a rupture. Liz was a 26-year-old woman who sought treatment for a history of depression and pattern of getting into romantic relationships with overly domineering and emotionally abusive men. Although the therapeutic alliance seemed reasonably good at first, and Liz seemed receptive to the treatment, over time the therapist became aware of a feeling of pressure on his part to continue to ask concrete (rather than open-ended) questions in order to keep things running smoothly. In addition, while, at one level, Liz seemed to be speaking about important issues, the therapist was beginning to wonder whether she was genuinely affectively engaged in the things she was talking about. As the therapist’s feelings intensified, he decided that rather than continuing to reflexively pick up the slack or alternatively intentionally shift to a less active role (which he speculated might lead to a power struggle or an impasse), he would begin attempting to explore what was going on between the two of them—to meta-communicate about the ongoing process.

He thus said something to the effect of, “I find myself reflexively moving toward asking you more questions, in part, I think as a way of keeping things going smoothly between us. But I’m also a bit concerned that if I continue doing this, it will get in the way of you talking about what feels most alive and important for you.” Liz responded, “I don’t know . . . what do you think?” In return, the therapist once again meta-communicated, “It feels like I’m asking you to take the lead and you’re asking me to take the lead.”

Liz explained, “I turn to you because you’re in charge here. You’re the doctor.” The therapist then asked Liz what his “being the doctor” meant meant to her. This led to an exploration of Liz’s perception of a vast power imbalance in their relationship, and also to the importance of her of knowing exactly what the therapist wanted so that she would not disappoint him. In the subsequent session, Liz spontaneously began to elaborate on a history of getting into relationships with domineering, abusive men who “take charge” in the relationship and who she tended to “submit to.” It emerged that she was accustomed to following their lead rather than expressing her own needs and desires. In response to further probes, Liz was able to talk about a need on her part to know what men want so that she would be able to provide it for them. She would then find herself submitting and feeling resentful. These two sessions began to facilitate a growing alliance between Liz and her therapist and paved the way for subsequently exploring the way in which this pattern was interfering with the development of a genuine collaborative process in the therapy as well as identifying similarities between this pattern and Liz’s habitual way of relating to romantic partners.

Meta-Analytic Review

For this research, two meta-analyses were conducted. The first set of analyses examined the association between the presence of rupture-repair episodes and treatment outcome. The second set of analyses examined the impact of rupture resolution training or supervision on patient outcome.

Search Strategy and Inclusion Criteria

To identify potential studies, we searched the reference sections of several recent reviews of the alliance rupture literature (Eubanks-Carter, Muran, Safran, & Hayes, 2010; Eubanks-Carter, Muran, & Safran, 2010; Safran et al., 2002). In addition, we conducted a computerized search of the PsycINFO database. Using the search terms alliance and outcome, and the terms alliance and
supervision and treatment outcome. In order to be included in this analysis, the alliance-focused training or supervision had to include specific focus on helping therapists to manage alliance ruptures or problems in the therapeutic relationship.

The literature search identified four studies that met the inclusion criteria for the rupture-repair analysis. Three of these studies (Stiles et al., 2004; Stevens et al., 2007; Strauss et al., 2006) defined rupture-repair episodes based on session-to-session fluctuations in alliance scores and examined the relation between the presence of these episodes and outcome. A fourth study (Muran et al., 2009) examined ruptures and repairs that occurred within the first six sessions of treatment for patients with Cluster C and Personality Disorder NOS diagnoses, based on patient and therapist self-reports. This study reported findings regarding the relation between rupture-repair episodes and outcome, namely that higher rupture intensity was associated with poor outcome on measures of interpersonal functioning ($r = -0.35$, $p < 0.01$), and rupture repair was predictive of retention in treatment ($r = 0.29$, $p < 0.05$). However, due to the significant methodological difference of examining rupture-repairs within sessions, rather than between sessions, this study was excluded from the meta-analysis.

The literature search identified nine studies that met the inclusion criteria for the rupture resolution training analysis. However, one study (Safran et al., 2005) was excluded from the meta-analysis due to its markedly different design, which included unique selection criteria and a change in treatment conditions during the course of the study. Specifically, a subset of patients in the CBT and dynamic supervision conditions of the Muran et al. (2005) study was identified as consisting of potential patients or therapists serving as their own controls in studies that compared outcomes obtained with different patients before and after therapists received rupture resolution training or supervision. The first of these was the Vanderbilt II study conducted by Hans Strupp and colleagues (Bein et al., 2000). The second was conducted by Crits-Christoph et al. (2006). One study (Hilsenroth, DeFife, Blake, & Cromer, 2007) did not include a control group. While there was no control group in this study, Hilsenroth, Ackerman, Clemente, Strasse, & Handler (2002) did find, with the same sample, that cases treated by therapists who received structured supervision that included an alliance-focused component had significantly higher patient and therapist alliance ratings than cases seen by therapists in a supervision-as-usual condition.

In order to include all of the eligible studies, we chose to first conduct a meta-analysis of all eight studies using standardized mean-gain effect sizes comparing pretreatment to posttreatment scores. However, given that prepost comparisons typically yield very large effect sizes due to their failure to control for confounds such as the passage of time, we also conducted a meta-analysis of the standardized mean difference scores of the seven studies that included control conditions.

Methodological Considerations

Not all studies reported effect sizes, and those that did varied as to the effect size statistic used as well as the data on which it was based (e.g., termination vs. follow-up data, all outcome measures, or a subset of outcome measures). In order to achieve greater methodological consistency, effect sizes were recalculated for all studies. First, standardized mean differences (or, in the case of prepost effect sizes, standardized mean gains) were calculated based on means and standard deviations or $F$ ratios provided in the articles or directly from the authors. The standardized mean scores were then converted into $r$ effect sizes. When studies reported more than one outcome measure or findings for more than one subgroup, effect sizes were calculated for each outcome measure or each subgroup and then averaged to form one effect size per study. The meta-analyses were conducted using random effects models, with each effect size weighted by the inverse of its variance. Comprehensive Meta-Analysis, Version 2.0 (Borenstein, Hedges, Higgins, & Rothstein, 2005) was used for all analyses.

Results

Table 1 presents the correlations between the presence of rupture-repair episodes and treatment outcome in three studies including a total of 148 patients. The aggregated correlation was $r = 0.24$, $z = 3.06$, 95% CI [.09, .39], $p = .002$, a medium size effect that indicates that the presence of rupture-repair episodes was positively related to good outcome.

Our second meta-analyses examined the impact of rupture resolution training or supervision on patient outcome in eight published studies including a total of 376 patients. Both prepost and group-contrast effect sizes were calculated; the results are presented in Table 2. The mean weighted prepost $r$ for the rupture resolution training studies was $r = 0.56$, 95% CI [.46, .78], $p < .001$. Given the particularly large effect sizes produced by two studies (Bambling et al., 2006; Castonguay et al., 2004), the
results were recalculated excluding these studies (leaving six studies with 252 patients), yielding an effect size of .52, $z = 6.94$, 95% CI [.40, .63], $p < .001$. These results provide evidence that rupture resolution training/supervision led to significant patient improvement; however, with a prepost design, we cannot determine whether this improvement was greater than what patients would experience with treatment from therapists who were not trained in rupture resolution.

A meta-analysis of the between-groups effect sizes for the seven studies with control conditions (a total of 343 patients) yielded a mean weighted effect size of .15, $z = 2.66$, 95% CI [.04, .26], $p = .01$. When one outlier study was removed (Castonguay et al., 2004), leaving six studies with 321 patients, the mean weighted effect size was reduced to .11, $z = 2.24$, 95% CI [.01, .21], $p = .03$. These results indicate that rupture resolution training/supervision leads to small but statistically significant patient improvements relative to treatment by therapists who did not receive training.

### Moderators and Mediators

The meta-analysis examining the relation between rupture-repair and outcome included only three studies, which precludes most moderator analyses. Furthermore, across these three studies, mean weighted effect sizes were not significantly heterogeneous, $Q(2) = .99$, $p = .61$.

For the analysis of prepost effect sizes of rupture resolution training, mean weighted effect sizes across the studies were significantly heterogeneous, $Q(7) = 203.85$, $p < .001$. Potential moderators that might explain this variability were examined.

To examine whether effect sizes varied as a function of patient diagnosis, studies were divided into two groups: a group of studies focused on patients with Axis I disorders (depression and anxiety) and a group of studies that targeted patients with Axis II disorders or interpersonal problems. We observed that these groupings also reflected treatment length; studies targeting Axis I disorders provided between 8 and 20 sessions of treatment, while studies targeting Axis II disorders or interpersonal problems provided 25 or more sessions. With the exception of one 16-session dynamic treatment targeting major depression (Cris-Cristoph et al., 2005), these groupings also reflected the theoretical orientation of the treatments administered by the therapists receiving rupture resolution training: the briefer, Axis I treatments were cognitive-behavioral, while the longer treatments targeting personality and interpersonal problems were dynamic and/or relational. Mean weighted effect sizes were computed for each of these groups, and they differed significantly, $Q(1) = 10.96$, $p = .001$, with briefer, predominantly cognitive-behavioral treatments that targeted Axis I disorders showing more patient improvement from intake to termination ($r = .76, z = 6.62, p < .001$) than longer dynamic and relational treatments that targeted Axis II disorders or interpersonal problems ($r = .40, z = 5.34, p < .001$). The smallest prepost effect size found was for the Vanderbilt II study. In some respects, this is not surprising given the fact that authors found that therapists’ skills did, in some respects, deteriorate after training, and that a majority of the therapists had not achieved basic competence in Time-Limited Dynamic Psychotherapy (Bein et al., 2000).

In contrast to the prepost effect sizes, the between groups effect sizes comparing rupture resolution supervision/training to a control condition were not significantly heterogeneous, $Q(6) = 7.65$, $p = .27$. However, to facilitate comparison with the prepost meta-analysis, we examined potential moderators by dividing the studies into the two groups compared in the moderator analysis above. The briefer, predominantly CBT treatments targeting Axis I disorders again yielded a higher mean weighted effect size ($r = .22, z = 3.18, p = .001$) than the longer dynamic and relational treatments targeting Axis II disorders ($r = .04, z = .57, p = .57$); however, the difference between the two groups failed to reach statistical significance, $Q(1) = 3.14, p = .08$.

### Limitations of the Research

There are a number of limitations to the studies included in our meta-analyses. At this point in time, there are a limited number of relevant studies. A number of the studies are correlational in nature. The studies included were heterogeneous with respect to design, treatment modality tested, treatment length, and client population. Some of the outcome studies included were not randomized clinical trials. Finally, the majority of the outcome studies included evaluated the efficacy of alliance-focused treatments (or treatments enhanced with alliance-focused interventions) but did not directly test the hypothesis that training in the implementation of an alliance-focused treatment improved therapists’ ability to work with challenging patients. Finally, none of the studies included in the meta-analyses investigated the processes through which alliance ruptures are resolved. The task- analytic research programs investigating these processes
Table 2

Rupture Resolution Training/Supervision Effect Sizes

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Patient diagnostic criteria</th>
<th>Outcome measure</th>
<th>Prepost  $r$</th>
<th>95% CI</th>
<th>$z$ value</th>
<th>Control group</th>
<th>Between-groups $r$</th>
<th>95% CI</th>
<th>$z$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bambling et al. (2006)</td>
<td>PST with process-focused supervision (N = 34)</td>
<td>Major depression</td>
<td>BDI</td>
<td>.89</td>
<td>[.84, .92]</td>
<td>15.62**</td>
<td>PST with no supervision (N = 38)</td>
<td>.18</td>
<td>[.02, .33]</td>
<td>2.13*</td>
</tr>
<tr>
<td>Bambling et al. (2006)</td>
<td>PST with skills-focused supervision (N = 31)</td>
<td>Major depression</td>
<td>BDI</td>
<td>.85</td>
<td>[.79, .89]</td>
<td>13.56**</td>
<td>Pre-training (n = 32)</td>
<td>.09</td>
<td>[-.16, .32]</td>
<td>.70</td>
</tr>
<tr>
<td>Bein et al. (2000)</td>
<td>TLDP (N = 32)</td>
<td>Interpersonal problems</td>
<td>GAS, GSI, IDI, MCM</td>
<td>.30</td>
<td>[.20, .39]</td>
<td>5.82**</td>
<td>Wait list (n = 10)</td>
<td>.54</td>
<td>[.21, .76]</td>
<td>3.02**</td>
</tr>
<tr>
<td>Castonguay et al. (2004)</td>
<td>ICT (N = 11)</td>
<td>Major depression</td>
<td>BDI, GAF, HAM-D</td>
<td>.86</td>
<td>[.77, .91]</td>
<td>9.94**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constantino et al. (2008)</td>
<td>ICT (N = 11)</td>
<td>Major depression</td>
<td>BDI, BSI, BDI, HAM-D, QOLI</td>
<td>.66</td>
<td>[.51, .78]</td>
<td>6.64**</td>
<td>CT (n = 11)</td>
<td>.19</td>
<td>[-.22, .54]</td>
<td>.92</td>
</tr>
<tr>
<td>Criis-Christoph et al. (2006)</td>
<td>Alliance-fostering therapy (N = 14)</td>
<td>Major depression</td>
<td>BDI, BDI, HAM-D, QOLI</td>
<td>.57</td>
<td>[.43, .69]</td>
<td>6.72**</td>
<td>Pre-training (n = 14)</td>
<td>.15</td>
<td>[-.23, .49]</td>
<td>.76</td>
</tr>
<tr>
<td>Hilsenroth et al. (2007)</td>
<td>STPP (N = 33)</td>
<td>Major depression</td>
<td>MDE criteria, BSI, GARF</td>
<td>.51</td>
<td>[.44, .58]</td>
<td>11.51**</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muran et al. (2005)</td>
<td>BRT (N = 33)</td>
<td>Major depression and BPD</td>
<td>Cluster C PD or PD NOS</td>
<td>.38</td>
<td>[.27, .48]</td>
<td>6.41**</td>
<td>CBT (n = 29) and STDP (n = 22)</td>
<td>.02</td>
<td>[-.16, .20]</td>
<td>.19</td>
</tr>
</tbody>
</table>

Note. CI = confidence interval; BDI = Beck Depression Inventory; GSI = SCL-90 Global Severity Index; IIP = Inventory of Interpersonal Problems; SAS = Social Adjustment Scale; GAS = Global Assessment Scale; TC = Target Complaints; SCID II = Structured Clinical Interview for DSM Disorders; WIPSI = Wisconsin Personality Disorders Inventory.
Therapeutic Practices

We have reviewed the growing body of evidence indicating that repairing ruptures in the therapeutic alliance is related to positive outcome. On the basis of these reviews, we describe research-supported therapeutic practices:

- Practitioners should be aware that patients often have negative feelings about the psychotherapy or the therapeutic relationship that 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 relationship and to take the initiative in exploring what is transpiring in the relationship when they suspect that a rupture has occurred.
- It is probably helpful for patients to express negative feelings about the therapy to the therapist should they emerge or to assert their perspective on what is going on when it differs from the therapist’s.
- 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 as opposed to blaming the patient for misunderstanding or distorting.
- It also proves important for therapists to empathize with their patients’ experience and to validate them for broaching a potentially divisive topic in a session.
- In some forms of treatment, the primary intervention may consist of the therapist changing the tasks or goals of treatment without necessarily explicitly addressing the rupture with the patient.
- In other forms of treatment, resolving alliance ruptures may involve more in-depth exploration of what is transpiring between the therapist and patient as well as in-depth exploration of the patient’s experience.
- There is also preliminary evidence to suggest that, in some approaches, it may prove useful for the therapist to explicitly establish a link between the rupture event and characteristic interpersonal patterns in the patient’s life. This evidence should, however, be cautiously interpreted in light to the growing body of evidence indicating that frequent transference interpretations linking what is taking place in the therapeutic relationship to other relationships in the patient’s life can exert negative effects (e.g., Henry, Strupp, Schacht, & Gaston, 1994; Crits-Christoph & Gibbons, & Connolly, 2002). The quality (as opposed to the quantity) of the interpretation and the relational meaning of the interpretation in the context of the emergent therapeutic relationship appear to make the difference between a positive and negative effect on the patient.

References


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