Alliance Ruptures, Impasses, and Enactments: A Relational Perspective

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Alliance ruptures, impasses, and transference–countertransference enactments are inevitable in therapy. A growing body of evidence suggests that repairing ruptures in the alliance is related to positive outcome (Safran, Muran, & Eubanks-Carter, 2011). Our research program has led to the development of training methods to enhance therapists' abilities to detect and work constructively with alliance ruptures and negative therapeutic process (Safran et al., 2014). This article outlines relevant theoretical underpinnings, intervention principles, and empirical findings.

Keywords: alliance ruptures, alliance-focused therapy, brief relational therapy, impasses, enactments

Moments of interpersonal tension between patient and therapist represent critical junctures for theoretical and clinical attention. Although many terms have been used to describe these moments including empathic failures, transference–countertransference enactments, and misunderstanding events, they are perhaps most commonly referred to in the psychotherapy research field as ruptures in the therapeutic alliance (Safran, Muran, & Eubanks-Carter, 2011). Whether significant disturbances or barely discernible discord, ruptures are inevitable interpersonal events and are central to our exploration of the therapeutic relationship and the process of change (Safran et al., 2011; Safran, Muran, Samstag, & Stevens, 2002). For more than two decades, our research has focused on identifying and working with ruptures—the strains, tensions, or breakdowns that, when unaddressed, may interfere with the ongoing collaboration between patient and therapist (Safran & Muran, 2000).

Our interests in consolidating, refining, and testing principles related to resolving ruptures in the therapeutic alliance are manifold. Ruptures are associated with the activation of dysfunctional interpersonal patterns and therefore offer moments of potentially productive in-session exploration (Safran & Segal, 1990). Unresolved ruptures are associated with deterioration in the alliance and may lead to poor outcome or patient dropout (Henry, Schacht, & Strupp, 1986; Safran, Muran, Samstag, & Winston, 2005). The successful resolution or collaborative negotiation of moments of tension within the treatment can foster growth and insight in both patient and therapist (Safran & Muran, 2000). Moreover, because alliance ruptures are trans-theoretical phenomena, their effective management is relevant and significant to clinicians of all orientations. Significantly, our ongoing study of ruptures has enabled us to refine training protocols that enhance therapists' abilities to

detect and work constructively with alliance ruptures and negative therapeutic process.

A Relational Approach

Conceptualizing Treatment and the Alliance

In the course of our research, we developed, manualized, and evaluated the efficacy of an alliance-focused treatment known as brief relational therapy (BRT; Muran, Safran, Samstag, & Winston, 2005; Safran & Muran, 2000). Based primarily on principles emerging from contemporary relational thinking (e.g., Aron, 1996; Mitchell, 1997; Safran, 2012) as well as our own research program, BRT strategies have been integrated into other therapeutic modalities through alliance focused training (AFT; Safran et al., 2014). Both the stand-alone treatment (BRT) and the training protocol (AFT) share the same key principles: (a) the assumption of a two-person approach in which therapist and patient are regarded as coparticipants engaging in a process of mutual influence; (b) an intensive focus on the here-and-now of the therapeutic relationship; (c) treatment conceptualized as an ongoing cycle of enactments and collaborative exploration of patients' as well as therapists' contributions to the interaction; (d) an emphasis on in-depth exploration in the context of the unfolding therapeutic interaction; (e) judicious use of therapist self-disclosure; (f) a recognition of the subjectivity of the therapist's perceptions; and (g) an assumption that the relational meaning of interventions is critical.

While psychotherapy research consistently demonstrates that the quality of the therapeutic alliance is one of the better predictors of outcome across a range of different treatments (Horvath, Del Re, Fluckiger, & Symonds, 2011), our initiative is intended to move beyond predictive findings toward clarifying the processes that lead to alliance development, as well as the interventions associated with repairing ruptures when they occur (Safran, Muran, Samstag, & Stevens, 2001). There have been a number of competing definitions of the therapeutic alliance, within the psychotherapy research community, however, Bordin's (1979) seminal reformulation of the alliance in trans-theoretical terms has been particularly influential (Safran & Muran, 2000, 2006). Bordin proposed that the alliance is a function of the extent to which the

patient and the therapist are able to maintain a strong affective relational bond as they collaborate on the tasks and goals of treatment.

Bordin's conceptualization of the alliance is at once mutual and dynamic and, to our thinking, consonant with the relational perspective in which patient and therapist are regarded as interacting in a "relational matrix" (Mitchell, 1993) or relational pattern of self and other that shapes the way people relate to both their inner and outer worlds on an ongoing basis (Safran & Muran, 2000). Viewed in this way, the alliance, which is continually negotiated within the dyad at both conscious and unconscious levels, is always an emergent property of the therapeutic relationship. Significantly, this dynamic process between patient and therapist is an important mechanism of change in and of itself in so far as it affords patients the experience of constructively negotiating the competing needs of self and other (Safran, 1993; Safran & Muran, 2006). Such negotiation is regarded as a crucial developmental achievement as well as an ongoing interpersonal challenge that continues throughout life.

Parallels have been drawn between the affective coordination seen in mother–infant dyads and those that occur within the interpersonal therapist–patient exchange (Safran, 1993; Safran, Crocker, McMain, & Murray, 1990). As research suggests, there is a constant oscillation between periods in which mother and infant are affectively attuned and periods in which they are miscoordinated (Tronick, 1989). In healthy mother–infant dyads, moments of affective miscoordination are typically followed by repairs in the interaction. As Tronick proposes, this process of misattunement and repair serves an important developmental function. Although the dyad may not always act in concert, the baby learns to experience the mother as potentially available and to see the self as capable of negotiating relatedness even in moments of misattunement. Just as shifting states of affective miscoordination and repair are hypothesized to play a role in helping the infant to develop an adaptive relational schema, so too are negotiating alliance ruptures seen as beneficial in helping patients to explore, challenge, and change maladaptive interpersonal patterns. Through the act of collaboratively addressing strains in the alliance, the patient gradually develops more flexible and adaptive ways of negotiating interpersonal exchanges and learns that relationships are possible even where there is not always perfect accord (Safran, 1993).

Because many of the problems that people bring into treatment are related to the tension between the conflicting needs for autonomy and relatedness, negotiation between self and other becomes central to the therapeutic work. This process can have an important impact on the patient's fundamental sense of the extent to which he or she lives in a potentially negotiable world or needs to compromise his or her own sense of integrity to hold onto relationships (Mitchell, 1993). Consequently and in keeping with a relational approach, the meaning of any intervention can only be understood in the relational context in which it occurs (e.g., Aron, 1996; Mitchell, 1998). Therefore, technical factors and relational factors are always regarded as interdependent.

Ruptures and Initiation of Intervention

Alliance ruptures vary in intensity from relatively minor tensions, of which one or both of the participants may be only vaguely aware, to a major rift in collaboration, understanding, or communication (Safran et al., 1990). We understand all ruptures to be a function of both patient and therapist contributions, with the relative contribution varying from case to case. Ruptures are inevitable events and are regarded not as obstacles but as opportunities for therapeutic change. Ruptures may occur at any time in treatment: they may emerge as single events, over several sessions, or as a repeated theme across treatment. Indeed, Aron (1996) suggests that all of treatment can be regarded as one ongoing enactment.

In our research program, we have identified two broad types of alliance ruptures—*withdrawal* ruptures and *confrontation* ruptures—each with its own characteristic patterns and resolution process (Safran et al., 1990; Safran & Muran, 1996, 2000; Safran, Muran, & Samstag, 1994). In withdrawal ruptures, patients tend to deal with difficulties or misunderstandings in the therapeutic relationship by falling silent, offering minimal responses to questions, suddenly shifting topic to an unrelated matter, or becoming overly compliant to the therapist's recommendations. The resolution process may involve exploration of interpersonal fears and internalized criticisms that inhibit the expression of negative feelings, as well as providing the patient the latitude to begin to communicate their wishes and needs. By contrast, in a confrontation rupture, the patient may directly express anger, resentment, or dissatisfaction with the therapist or some aspect of the treatment, often in a blaming or demanding fashion. The resolution often involves the therapist's empathic engagement with the patient in order to facilitate the expression of disowned feelings of disappointment, hurt, vulnerability, and the need for nurturance (Safran & Muran, 1996, 2000). The therapist's capacity to understand and tolerate the patient's painful emotions during a rupture can, in turn, help patients discover that neither they nor their relationships will necessarily be destroyed by painful, aggressive feelings.

Whether the behavior manifests as withdrawal or confrontation, once the therapist becomes aware of the rupture, he or she can begin to disembed from the relational pattern playing out within the dyad. We emphasize the need for therapists to cultivate a stance of ongoing self-awareness of their subjective reactions as a vital source of information and to remain affectively attuned to the subtle interpersonal shifts that occur in the course of treatment. Within relationships, specific interpersonal behaviors on the part of one individual can "pull for" or evoke particular responses in the other (Kiesler, 1996; Sullivan, 1956). Because of the subtlety of nonverbal cues, people are often unaware to what they are implicitly responding. In terms of the therapeutic relationship, the therapist who experiences the characteristic "tug" or "pull" of the patient must attempt to step outside of the interaction and, when appropriate, communicate with the patient about the implicit transaction taking place between them in the moment.

Metacommunication, or the process of communicating with the patient about the implicit transaction taking place in the therapeutic relationship, plays an important role in our approach (Safran, 2002; Safran & Muran, 2000). Metacommunication is an attempt to bring ongoing awareness to the emergent patient–therapist interactive process. We conceptualize metacommunication as a type of *mindfulness in action* (Safran & Muran, 2000; Safran & Reading, 2008). As much as possible, metacommunication is grounded in the therapist's immediate experience of some aspect of the therapeutic relationship (either the therapist's own feelings, or his

or her experience of some aspect of the patient's actions or affect), rather than higher level inferences. When metacommunicating the therapist is attempting to articulate his or her implicit experience or *felt sense* (Gendlin, 1998) to initiate an explicit exploration of something that is being unconsciously enacted. A fuller explanation of the specific principles associated with metacommunication will be presented later in this article.

Empirical Evidence on Rupture Resolution Training

Beginning in the mid-1980s at the Clarke Institute of Psychiatry of the University of Toronto, and continuing at Beth Israel Medical Center in New York in 1990, Safran, Muran, and colleagues undertook an intensive examination of the rupture resolution process to extend earlier research that found that close attention to alliance ruptures in the session could play an important role in successful treatment. In an initial set of studies, we used the task-analytic paradigm (Rice & Greenberg, 1984; Safran, Greenberg, & Rice, 1988) to develop and refine a preliminary-stage process model of rupture resolution (Safran et al., 1990; Safran, Muran, & Samstag, 1994). The resolution model developed in the course of this research consists of four stages: (a) therapist becomes aware of the behavior associated with the rupture; (b) therapist initiates collaborative exploration of the rupture experience; (c) therapist helps patient to overcome avoidance of addressing feelings or response to rupture; (d) exploration of the emergence of patient's underlying wish or need revealed in the course of working through the rupture event (Safran & Muran, 2000). The model is not meant to be rigidly imposed, but rather is intended to guide clinicians, helping them to recognize common patterns and strategies that may facilitate intervention. AFT draws on the resolution model research and was developed as a training method specifically designed for negotiating and resolving ruptures in the therapeutic alliance (Safran & Muran, 2000; Safran, Muran, Samstag, & Winston, 2005).

As earlier noted, AFT has been effectively incorporated into the training protocols of therapists practicing in other modalities. A study funded by the National Institute of Mental Health is under way to investigate whether integrating AFT, with its rupture-resolution focus, improves therapy process and outcome. In the study, therapists who already received training to conduct CBT and have completed one short-term case while adhering to the CBT protocol are subsequently introduced to AFT while treating a second CBT case (Safran et al., 2014).

Therapists are taught to monitor what is taking place in the therapeutic relationship on an ongoing basis by attending to their own feelings as an important source of information. In cases where patients appeared to be benefiting from the use of cognitive–behavioral interventions, therapists are encouraged to continue using these, while at the same time becoming more mindful of distinctive relational patterns or subtle ruptures that might be playing out between them and their patients in session. In other cases, where the use of cognitive interventions appeared to be problematic, therapists are encouraged to modify their approach more dramatically—in some cases actually abandoning the use of cognitive–behavioral interventions to focus more intensively on the use of relational interventions (e.g., metacommunication, therapists' exploration of their own contributions to enactments, in-depth exploration of patients' emerging feelings in the context of

the therapeutic relationship). Preliminary findings suggests that after therapists receive eight sessions of AFT while treating an ongoing cognitive therapy case, there is less evidence of negative interpersonal process (defined as patient hostility) than there is prior to receiving AFT. In recent years, a number of other research teams have also found evidence regarding the positive impact of augmenting cognitive therapy and other treatment modalities with alliance-focused treatment principles derived from our research program (e.g., Constantino et al., 2008; Crits-Christoph et al., 2006; Harmon et al., 2007; Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

Training and Clinical Applications

Metacommunication

As noted earlier, metacommunication encompasses a series of principles for negotiating ruptures in the therapeutic alliance and constructively working through transference–countertransference enactments. Attempting to address a rupture often involves therapist self-disclosure, but it can also involve sharing observations, asking questions, or speculating about the patient's experience. The objective is to initiate an explicit exploration of something that is being unconsciously enacted. Below are some basic principles of metacommunication (for a more detailed description of these principles, see Safran & Muran, 2000):

1. Explore with skillful tentativeness and emphasize one's own subjectivity. Therapists should communicate observations in a tentative and exploratory fashion. The message at both explicit and implicit levels should be one of inviting patients to engage in a collaborative attempt to understand what is taking place. For example, if a patient's response to a therapist's question is muted or there are signs of anxiety or tension (e.g., a heavy sigh, sudden change of posture), the therapist might metacommunicate in the following way: "I noticed that you sighed and then abruptly changed the topic just now and I wonder if my question about your wife caused you discomfort, or, perhaps some anger. I realize I may be off the mark, but I wonder if this at all relates to what you may be feeling right now."

2. Do not assume a parallel with other relationships. A therapist should be wary of prematurely attempting to establish a link between the configuration that is being enacted in the therapeutic relationship and other relationships in the patient's life. In addition to being inconsistent with a two-person psychology, interpretations of this type can be experienced by patients as blaming. Instead, the focus should be on exploring patients' internal experience and actions in a nuanced fashion, as they emerge in the moment.

3. Accept responsibility. Ground all formulations in awareness of one's own feelings and accept responsibility for one's own contributions in an open and nondefensive manner. Because each participant is contributing to the interaction in ways of which they are unaware, it is

essential to continually attempt to clarify the nature of the contribution. This process can help patients become more aware of feelings that they have but are unable to articulate clearly, in part because they fear the therapist's response. For example, if the therapist becomes aware of sounding critical or blaming, the therapist might say: "I'm aware that I may have sounded harsh or impatient just now. I wonder if that was your experience as well." Such an acknowledgment on the part of the therapist has the potential of freeing patients to express feelings of hurt or resentment; validating their experience of the interaction; and teaching them that they can trust their judgment. Increasing patients' confidence in their judgment may also help to decrease their need for defensiveness, in turn facilitating their exploration and acknowledgment of their own contribution to the interaction.

4. Start where you are. Metacommunication should be based on the therapist's feelings and intuitions that emerge in the moment. What was true in one session may not be true in the next, and what was true at the beginning of a session may not be true later in that same session. For example, the therapist may provide specific feedback related their immediate experience of the patient: "Right now, I sense that you seem very wary of me." Or, "As you're speaking, I'm aware of feeling excluded by you now, like you're pushing me away. Do you have any sense of that?" Such metacommunications may facilitate the here-and-now exploration of thoughts or feelings that the patient regards are unacceptable or frightening.

5. Focus on the concrete and specific. Whenever possible, questions, observations, and comments should focus on concrete instances in the moment rather than on generalizations. This promotes experiential awareness rather than abstract, intellectualized speculation. For example, "I am experiencing you as pulling away from me right now. Do you have any awareness of doing this?" When providing therapeutic feedback, rather than saying, "You tend to speak in a very abstract way," the therapist can say, "What you're saying right now seems kind of abstract to me." This type of concreteness and specificity helps patients to cultivate greater self-awareness.

6. Evaluate and explore patients' responses to interventions. Therapists should monitor the quality of patients' responsiveness to interventions on an ongoing basis. If an intervention leads to a decrease in relatedness then the therapist needs to explore the patient's experience of the intervention. Close attention to responses to interventions may alert the therapist to the patient's entrenched and disabling interpersonal patterns. It may also lead to a progressive refinement in therapists' understanding of their own contribution to the interaction.

7. Clarify or reflect on the relational meaning of the therapist's intervention for both the patient and therapist. It is important to always bear in mind that the impact of any intervention is always mediated by its relational meaning.

The same intervention can be experienced as facilitative or hindering, depending on the patient's unique history as well as the therapist's state of mind at the time he or she intervenes. For example, a patient whose mother was overly intrusive may experience any attempt made by the therapist to explore her experience as intrusive. A therapist who is feeling frustrated with his patient, may make an interpretation that is accurate at one level, but is nevertheless experienced by the patient as critical.

8. Establish a sense of collaboration and we-ness. Patients often feel alone during a rupture. It can be helpful for therapists to frame the impasse as a shared dilemma that patient and therapist will explore collaboratively; acknowledge that "we are stuck together." For instance a therapist might say, "It feels like the two of us are playing chess." Or, "It feels like we're both being very tentative right now." Or, "It feels like I'm constantly intruding, and you're trying to politely keep me out. What do you make of that?" In this way, instead of being yet one more in an endless succession of figures who do not understand the patient, the therapist can become an ally who joins the patient in his or her struggle.

9. Judiciously disclose and explore your own experience. Therapists' feelings of being stuck or paralyzed often reflect their difficulty in acknowledging and articulating to themselves what they are currently experiencing. The process of articulating one's feelings to patients can free the therapist to intervene more effectively. Another valuable intervention that is related to self-disclosure is inviting patients to suggest ways in which the therapist may be contributing to the interaction, or to speculate about what the therapist is experiencing internally. For example, a therapist might ask, "I wonder if you have any thoughts about what may be going on for me right now?" This invitation can help to clarify the patient's experience of the therapist and may lead to further elaboration of the patient's interpersonal schemas. It can also provide new insight into the therapist's contributions to the impasse.

10. Expect resolution attempts to lead to more ruptures, and expect to revisit ruptures. Even the most thoughtfully and sensitively delivered metacommunication can exacerbate a rupture or lead to a new one. In addition, therapists often find that the same impasse is revisited many times. Therapists should try to appreciate the ways in which each occurrence is unique, and respond in the immediacy of the moment.

Tracking Emerging Relational Processes

A final point important to emphasize is that it is important not to confuse the technique of metacommunication with the essence of the skill of resolving alliance ruptures. Although metacommunication can be a useful and powerful tool, it is not unusual for some patients to find any attempts to explore what is going on in the therapeutic relationship as intrusive or irrelevant to their problems. Moreover, even for those patients who do experience the explicit exploration of the therapeutic relationship as useful, a

relentless effort on the therapist's part to explore the here-and-now can be experienced by the patient as invasive or persecuting. During training, the process of experimenting with metacommunication in role playing can help therapists to develop these skills, but it is important for therapists not to become overly reliant on the use of metacommunication when they are actually working with patients. From our perspective, the most important skill for therapists to hone and the essence of the approach involves developing the capacity to internally track what is emerging in the therapeutic relationship on a moment-by-moment basis, to be able to reflect on what may be playing out in the treatment.

Case Illustration[1]

The following case illustrates how an ongoing enactment between patient and therapist is collaboratively explored across the course of treatment. Ruth contracted to receive 30 sessions of BRT as part of an ongoing psychotherapy research program. She was an attractive, young-looking 52-year-old woman who years earlier divorced a man who she described as controlling, emotionally abusive, and generally unable or unwilling to be responsive to her emotional needs. At the beginning of treatment, she admitted that as she grew older she desperately wanted to be in a "real relationship" but felt hopeless about the possibility.

Although the therapist initially felt empathy for her, a pattern rapidly developed in which Ruth told long and detailed stories in an unemotional and droning fashion that left the therapist feeling distant and unengaged. He found that she seldom paused to welcome his input or reflections and often found himself biding time until the sessions ended. In an attempt to understand what was being enacted between them, the therapist began to metacommunicate about his emotional disengagement. Ruth was able to articulate an underlying fear of abandonment that led her to defend against vulnerable feelings by controlling her style of presentation. Although the therapist felt encouraged by her openness to exploring what was going on between them, he had an intuition that something did not feel quite right—perhaps an element of compliance in her response or a vague sense of himself beginning to play the sadistic role in a sadomasochistic enactment.

During Session 16, after listening to an extended and rather difficult to follow monologue about a conflict Ruth was having with her neighbors over the custody of a stray dog, the therapist finally interrupted and metacommunicated with her by saying:

T: I find myself poised to start talking with you about it . . . but sort of waiting for an opening.

R: Oh . . . Okay . . .

T: I also find myself wondering a little bit about the extent to which you're really wanting or inviting my input.

R: I really do.

T: You do?

R: Well . . . I want it to whatever extent you feel comfortable getting involved.

T: Yeah?

R: I mean . . . I guess . . . that's why there's a hesitancy . . . I guess there's an assumption on my part . . . that you don't want to be involved . . . that you're throwing it back to me.

T: So it sounds like you're reluctant to directly ask me for my help, because you assume I won't respond.

R: Yeah.

The therapist's metacommunication to Ruth about her impact on him (i.e., his feelings of uncertainty about whether she wanted his input) seemed to facilitate Ruth's capacity to express her desire for help more directly. In subsequent sessions, rather than withdraw or behave in a compliant manner, Ruth began to acknowledge her dissatisfaction and directly expressed what she felt she was not getting from the therapist in treatment. With the therapist's encouragement, she was eventually able to tell him that she needed more emotional engagement from him and that she did not want to try to be a more interesting person in order to keep his interest. Witnessing the emergence of these feelings led to a subtle, but irrevocable, shift in the therapist's perception of her.

The experience of challenging the therapist and seeing that the relationship was able to survive enabled Ruth subsequently to bring her sense of despair and underlying vulnerable and dependent feelings into the relationship. As they entered the final phase of the 30-session treatment, they explored how difficult it was for Ruth to acknowledging her deep desire to be nurtured and cared for.

T: In the back of my mind I'm thinking that we only have six or seven more sessions, and so I'm wondering about this whole issue of opening up and being abandoned in this context.

R: Well, it does make me sort of scared when I start thinking about the ending. And I guess that's true of me in general. I guess I'm reluctant to really involve myself deeply in relationships . . . but the desire is still there.

T: Uh-huh . . . I have a sense of a real yearning inside of you. [Ruth begins to cry and then stops herself.] What's happening for you?

R: Well, it starts to hurt, and then I think, intellectually, "It's so inappropriate for me to be upset about therapy ending."

T: It doesn't seem inappropriate to me. We've worked together for a while now and really started to develop a relationship, and my sense is that you're beginning to open up and trust. And we're ending soon . . . and that's got to be painful.

Ruth was able to express her anger toward him and she spontaneously drew a parallel between the asymmetry of their investment in the relationship and a general tendency for the men she felt deeply about to not reciprocate the depth of her feelings. The therapist by acknowledging and validating her feelings enabled her to put her yearning to be cared for by him into words. Ruth began Session 28 by talking about her difficulty trusting that men are interested in her or care about her.

T: It sounds as though normally there's a real lack of faith that relationships will work out.

R: Yeah [appears touched by this comment]. That really captures something important. Normally I tend to devalue relationships when I don't get much active reassurance from people. And I guess there's a risk of my doing that to some extent with our relationship, because you're not proposing that we extend our meetings.

T: What I'm thinking is that you really need and deserve somebody to be there for you on an ongoing basis, and I'm wondering if you can still find anything of value in our relationship

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[1] This case was first described in Safran and Muran (2000). The name, age, and other identifying details of the patient have been changed. Transcribed material from the sessions is presented verbatim.

despite the fact that I'm not going to be there for you in the future in the way you deserve.

Ruth begins to cry and expresses a sense of sadness as she considers that her lack of faith in people and fear of abandonment have been obstacles to intimacy. She describes how she tends to experiences feelings of connection or closeness as potentially suffocating.

T: Can you say anymore about this feeling of suffocation?

R: I guess it's something about the welling up of all these emotions. There's some part of me that always wants to push it down. I don't know what would happen if I didn't. I don't know if it's about being exposed or being out of control. I don't know. But I want to contain it. It's bigger than the both of us [laughing, then pause]. I don't know what love really is. I think I have it with my daughter . . . but even that . . . it's not direct. The direct expression of feelings is very hard.

T: Uh-huh. I was wondering when you said, "It's bigger than the both of us." I know you were laughing, but it sounded interesting.

R: Well, when you ask what am I afraid of . . . I'm afraid that feelings . . . they're consuming . . . I think I've been in an environment where feelings were so measured . . . It's almost like a family image that comes to me . . . where things aren't stopped, where they're not repressed . . . where they're bountiful. I think my natural exuberance as a child was prohibited. But it's just that letting things tumble out of you in an unrestrained way and letting yourself be doesn't mean that horrible things are going to tumble out.

T: But it sounds as if the fear is that it's all consuming and that you don't really know where it's going to lead, in a way.

R: Yes.

T: And maybe that's what you mean when you say, "It's bigger than the both of us."

R: Yes.

T: Because there's a kind of uncharted territory in a way.

R: Yeah.

T: For me as well. I feel a sense of contact with you right now . . . a sense of connection and intimacy, and there's a sense that the feelings are not something I have control of.

R: Yeah. I think that's it. You've got to keep the reins on. But the idea of it is such a wonderful image for me.

T: Well I was struck by your words before, "A family image." "Bountiful." There's a real sense of richness there."

The final two sessions were devoted to summing up and consolidation. By the end of treatment, Ruth's feeling was that the seed of a new way of being in relationships was beginning to grow in her. She was able to acknowledge her sadness about separating from the therapist and her anxiety about the future, as well as a growing optimism and belief that things could be different in her life and in intimate relationships.

Clinical Discussion

There will inevitably be both subtle and not-so-subtle levels at which we, as therapists, fail to accept our patients. Only by becoming aware of and acknowledging the ways in which we are not being fully accepting can we become more so. This process involves an ongoing internal examination of our contributions to the shifting dynamic and an active engagement in ongoing dialogue with the patient, in which the therapist judiciously shares

aspects of his or her subjective experience in an attempt to facilitate an exploration of what is being enacted in the relationship.

The therapist's process of metacommunicating about his difficulty staying engaged with Ruth helped him to make explicit that which was already implicit—that is, his difficulty being there for her in a present and attuned fashion on a consistent basis. By acknowledging to himself and Ruth an aspect of his experience that made it difficult for him to be more accepting, a process was initiated that ultimately allowed him to become more present and emotionally available. There were times within their sessions when the therapist felt strongly chastised, pressured, and momentarily at a loss as to how to respond to Ruth's pressure. At the same time, Ruth's ability to express her need for more emotional engagement helped the therapist to empathize more fully with Ruth's experience of not feeling accepted and validated by him.

By encouraging Ruth to tell him about the impact of his metacommunication on her, and by being receptive to her feedback, the therapist was able to develop an affective appreciation of her dilemma, in part, as a result of his increased experiential appreciation of the way he had become a perpetrator in a victim–abuser cycle. Rather than acquiesce or comply, Ruth's experience of challenging the therapist and seeing that their relationship was able to survive this challenge enabled Ruth subsequently to bring her feelings of despair, as well as her vulnerability and dependency, more fully into the relationship.

A pivotal moment in treatment arrived as Ruth and her therapist collaboratively explored the "uncharted territory" within their relationship, an experience of expansiveness that was at once "bountiful" and frightening: "It's bigger than the both of us." One way of understanding the experience that Ruth is describing here is that the process of working through the alliance rupture, expressing her wishes and needs to the therapist, and collaboratively negotiating a new type of relatedness with the therapist afforded her intimations of a fuller and more "bountiful" sense of a relational encounter. This type of encounter is referred to by Benjamin (2004) as a cocreated intersubjective space in which both partners surrender to a process, rather than actively trying to shape it.

Conclusion

Relational psychoanalysis situates relations with others at the center of psychic life and places the patient–therapist relationship at the center of treatment. Therapy—regardless of the modality—inevitably takes place within the context of the unique relationship between patient and therapist. Keeping a focus on the strategies for maintaining the alliance has been the paramount aim of both our research and training initiatives. When things are running smoothly, the therapist, of course, spends less time explicitly addressing the therapeutic relationship. At such times, other therapeutic tasks (which depend on the therapist's orientation) may come to the fore. However, the underlying principle of attempting to understand what is being enacted relationally between therapist and patient on an ongoing basis remains essential, even when not always explicitly addressed.

Ruptures in the therapeutic alliance take place more commonly than many therapists realize. Our research indicates that it is rare to have more than a session or two without some minor strain in the alliance. Moreover, therapists often fail to detect the ruptures experienced by their patients (Safran & Muran, 2000). Given that a growing body of evidence suggests that repairing ruptures in the

alliance is related to positive outcome, therapist of all orientations would be well-served to turn their attention to rupture events when they occur (Safran et al., 2011). Although every strain may not warrant an intervention, a therapist's awareness of ongoing fluctuations in the quality of relatedness can present valuable opportunities for exploration that may initiate an important shift in the treatment and mobilize the process of change.

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