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Alliance-Focused Training

Catherine Eubanks-Carter, J. Christopher Muran, and Jeremy D. Safran

Alliance-Focused Training

Catherine Eubanks-Carter
Yeshiva University

J. Christopher Muran
Adelphi University

Jeremy D. Safran
New School for Social Research

Alliance-focused training (AFT) aims to increase therapists' ability to recognize, tolerate, and negotiate alliance ruptures by increasing the therapeutic skills of self-awareness, affect regulation, and interpersonal sensitivity. In AFT, therapists are encouraged to draw on these skills when metacommunicating about ruptures with patients. In this article, we present the 3 main supervisory tasks of AFT: videotape analysis of rupture moments, awareness-oriented role-plays, and mindfulness training. We describe the theoretical and empirical support for each supervisory task, provide examples based on actual supervision sessions, and present feedback about the usefulness of the techniques from trainees in our program. We also note some of the challenges involved in conducting AFT and the importance of maintaining a strong supervisory alliance when using this training approach.

Keywords: alliance, alliance ruptures, supervision, training, therapist skills

Given the importance of the alliance as a predictor of outcome (Horvath, Del Re, Flückiger, & Symonds, 2011), and evidence that therapists vary in their abilities to maintain strong alliances (Baldwin, Wampold, & Imel, 2007), there is increasing interest in training and supervision approaches to enhance therapists' abilities to improve the alliance (see Safran, Muran, & Eubanks-Carter, 2011 for a review). Based on our ongoing research program on the alliance (see Muran, 2002 for a description), our group has developed an approach to training that focuses on increasing therapists' skills for negotiating problems, or ruptures, in the alliance. Our approach, alliance-focused training (AFT), has also been studied in the form of a manualized treatment called brief relational therapy (BRT).

AFT is focused on developing three interdependent therapist skills: self-awareness, affect regulation, and interpersonal sensitivity. Self-awareness is critical for recognizing that a rupture is occurring. By becoming more attuned to their own immediate experience, therapists become better able to detect strains in the alliance. The ability to detect ruptures is important: evidence from qualitative patient interviews as well as comparisons of therapist,

client, and observer ratings of ruptures show that therapists often miss ruptures, and that failure to address ruptures is linked to patient dropout (Eubanks-Carter, Muran, & Safran, 2010).

In addition to recognizing that a rupture is occurring, therapists must be able to tolerate the difficult emotions that may be involved—both their own and their patients'. The skill of affect regulation is essential for responding empathically and resisting the urge to answer patient hostility with counterhostility or to use avoidance behaviors to reduce one's own anxiety. There is preliminary evidence that therapists' abilities to regulate their emotions predict treatment outcome (Kaplowitz, Safran, & Muran, 2011).

Finally, in addition to recognizing the rupture and managing their affect, therapists need to be able to communicate with the patient about what is transpiring without exacerbating the rupture. The skill of interpersonal sensitivity refers to this ability to express accurate empathy and to address the rupture in a way that enhances the patient's awareness of his or her own experience and his or her impact on others.

We recognize that there are many ways that therapists can use these skills to address a rupture, including methods in which the rupture is not explicitly discussed or explored (see Safran & Muran, 2000). However, the focus of AFT is the resolution strategy of metacommunication (Kiesler, 1996), or communicating about the patient–therapist interaction. When teaching metacommunication, we encourage trainees to collaborate with their patients, to try to be curious together about what is happening between them. Therapists are also encouraged to take responsibility for any ways in which they have contributed to the rupture. Metacommunication may include drawing links between the patient–therapist interaction and other relationships in the patient's life in the form of transference interpretations. However, we generally recommend that trainees keep the focus of the metacommunication on the here and now, with the goal of increasing their own

and the patient's awareness of their *immediate* experience. Finally, we encourage trainees to expect that attempts to explore ruptures may lead to more ruptures. Rupture–repair is an ongoing process, and trainees need to be able to move fluidly as the nature of the interaction shifts.

In our studies at the Mount Sinai Beth Israel Brief Psychotherapy Research Program, AFT is conducted as weekly group supervision with trainees who are primarily seeing patients with Cluster C personality disorder diagnoses for 30 sessions of therapy. At the beginning of the supervision, trainees are provided with readings that introduce them to the approach, including excerpts from the book *Negotiating the Therapeutic Alliance: A Relational Guide* (Safran & Muran, 2000), which functions as our training manual. This book describes our empirically based rupture resolution model, as well as other conceptual lenses (e.g., resistance, multiple selves) that can help therapists to understand and organize their experience. AFT can also include use of process measures to help sensitize trainees to subtle changes across a therapy session (see Muran, Safran, & Eubanks-Carter, 2010; Safran & Muran, 2000; Safran, Muran, Stevens, & Rothman, 2008, for more detailed descriptions of the supervision model). This article will focus on the three tasks that are most central in AFT: videotape analysis of challenging moments in the session, awareness-oriented role-plays, and mindfulness training.

To date, research done by our group offers some support for AFT. In a randomized, controlled trial comparing a treatment condition in which trainees received this form of supervision (BRT) with cognitive behavior therapy (CBT) and a short-term dynamic treatment, all three treatments were equally effective at improving symptoms and interpersonal functioning, and BRT was more effective at retaining patients in treatment (Muran, Safran, Samstag, & Winston, 2005). Preliminary findings from an ongoing study (Muran, Gorman, Safran, Eubanks-Carter, & Winston, 2014; Safran et al., 2014) show that when therapists trained in CBT then switch to AFT following a multiple-baseline design, there is a positive impact on interpersonal process plus some evidence suggesting that this impact has implications for better outcome. There is also evidence that AFT improves therapists' abilities to reflect on their emotional involvement with their patients.

In the following sections, we will describe in more detail the three main supervisory tasks in AFT and the theoretical and empirical support for their use. We will illustrate each task with an excerpt based on actual supervision sessions we have led (trainees' names have been changed to preserve confidentiality). We will also provide some excerpts from interviews with trainees, drawn from an ongoing qualitative study (Eubanks-Carter, Silberstein, & Muran, 2014).

Videotape Analysis

A central focus of our supervision sessions is the analysis of videotapes of trainees' therapy sessions. As Haggerty and Hilsenroth (2011) noted in their review, the use of video overcomes the limitations of relying on selective memories and allows for a greater focus on nonverbal behavior. There is some evidence that the use of video in supervision benefits clients. For example, a meta-analysis by Diener, Hilsenroth, and Weinberger (2007) examined the relationship between therapist focus on patients' emotion and outcome in psychodynamic therapy. In a moderator anal-

ysis, the authors found that the use of audio- or videotaping in supervision demonstrated a moderate, though nonsignificant, effect on the relationship between therapist affect focus and patient outcome. The authors observed that the use of taping may help to maximize treatment effects.

In our use of video, we emphasize difficult moments—moments of rupture. We encourage our trainees to purposely select video segments where they felt stuck, frustrated, confused, or anxious. When watching those difficult moments in supervision, our focus is not on helping trainees to problem-solve or identify better interventions to use next time, although these tasks may be part of the discussion. Rather, the emphasis is on enhancing trainees' awareness of what they were experiencing in the moment with the patient. Our hope is that therapists will become more aware and accepting of their experience, and that this enhanced awareness and acceptance will enable them to intervene in a genuine, empathic, and flexible way.

In the following example, a trainee, Sam, shows the supervision group a segment of a session in which he raised the possibility that perhaps the patient had some disappointment about the treatment, and the patient quickly responded that she found therapy helpful. The supervisor stops the tape and asks Sam what he is experiencing as he watches it. A second trainee, Jess, then shares her experience of watching the tape.

Sam: I'm experiencing myself as being a little more defensive than I thought I was at the time.

Supervisor: Defensive in what way?

Sam: Just my facial expression. I'm very tepid about saying, "perhaps this has been unhelpful." Something about my face felt like I was—I was trying too hard to not be defensive, and it didn't come across as genuine. Whereas at the time, I felt I was being very conscientious.

Supervisor: I'm not sure I understand. In what way were you not being genuine?

Sam: I was trying to find a way of saying "perhaps you didn't find this helpful" that didn't come across as a criticism, or like I was trying to defend the work. At the time, it felt neutral, but just now when I was watching this, it felt like I was a little more defensive than I remembered.

Supervisor: So to bring up the possibility that the therapy is not helpful feels threatening?

Sam: I wouldn't say threatening. I was happy that she said that because it was the first time she's articulated something like that, where she's been able to verbalize her ambivalence. But I do remember feeling a twinge.

Supervisor: It's perfectly natural to feel a twinge, and it's good that you're able to notice and acknowledge that.

Jess: As I was thinking about how I would feel if I were in your position, I felt defensive. The patient was so quick to say that therapy was helpful. It was very quick for someone who usually takes a long time to express herself. That brought up defensive feelings in me.

Sam: Yes. When the patient and I first started talking about the question of whether therapy has been helpful for her, I pursed my lips a little bit. But then when she said that it was helpful, I relaxed visually. I didn't realize that I did that at the time, but I can see it now watching the tape.

Observing his own nonverbal behavior helped Sam become more aware of the defensiveness he experienced—and unwittingly

displayed—in his interaction with his patient. The supervisor encouraged Sam to explore these feelings in a nonjudgmental way. Participation by fellow trainees who could validate Sam's experience also helped to create an atmosphere in which Sam felt safe to be open and curious, rather than defending against his defensiveness.

Creating a safe space for trainees to show videos of rupture moments can be challenging. As one trainee noted: "I never completely forgot that there was a camera in that room . . . and always knowing that I was going to be showing tape would make the session sort of a little more stressful." Another trainee observed: "If you're feeling uncomfortable you can sort of hide a little bit in supervision, and not necessarily show your tape if you had a really tough session, and you're not quite sure how you feel about it yet."

Other trainees acknowledged the evaluative pressure but also reported that the use of videotape actually helped them to be more accepting and less self-critical. As one trainee noted: "It's really raw to watch yourself on video, and in a way, you know, there are times when you feel like you're being critiqued, but there are times when it really brings to light maybe some dynamics you weren't aware of in the room . . . . It helped me to pay attention more to my own experience in the room instead of trying to be, you know, this perfect therapist." Similarly, another trainee noted how the participation of the other supervisees validated her own experience: "Hearing other people's reactions to [the patient's behavior in session] I think probably, maybe, freed me up a little bit more . . . hearing other people's reactions to it made me feel more accepting of my own reaction to it."

Awareness-Oriented Role-Plays

The second key feature of AFT is the use of awareness-oriented role-plays. Trainees may take turns playing the roles of patient and therapist, or one trainee may be asked to switch back and forth between patient and therapist roles. These awareness exercises are similar to the experiential techniques of two-chair and empty chair, and share their goal of focusing attention on the participant's experience to increase awareness of implicit feelings, to express unmet needs, and to gain greater understanding and acceptance of self and other. Research has found that the use of the two-chair technique is effective in helping patients resolve intrapersonal conflicts (Clarke & Greenberg, 1986). Emotion-focused therapy, which uses empty-chair as a primary technique, has been found to be an effective treatment for depression, interpersonal problems, and trauma, and is effective in promoting empathy (Greenberg & Watson, 2006).

In our use of role-plays in AFT, trainees do gain the opportunity to experiment with intervening in different ways, similar to the way in which role-plays may be used to practice interventions in other forms of supervision such as CBT. However, the primary focus of role-plays in AFT is to help trainees explore their own feelings and internal conflicts as they emerge. Supervisors intervene at critical points to encourage trainees to focus on and articulate their experience. The supervisor may encourage the trainee to verbalize his or her feelings and intuitions in the role-play as part of a metacommunication process. The supervisor may also encourage exploration of the therapist's fears or frustrations that are contributing to the rupture, as in the following example.

The trainee, Sarah, showed a video segment of a recent session and shared her growing frustration with her patient. The supervisor suggested a role-play with Sarah playing her patient, and another trainee, Anna, playing the therapist.

Sarah: OK, I'll start the way she did in the segment I just showed you. [as patient]: What session is this, is this Session 21?

Anna [as therapist]: Yes, this is session 21, so we have 9 left.

Sarah [as patient]: (*Loud, sharp laugh.*)

Anna [as therapist]: Do you have some thoughts or feelings about that?

Sarah [as patient]: No, no, I just was trying to keep track. It's not enough.

Anna [as therapist]: It's not enough? Do you feel disappointed?

Sarah [as patient]: (*Loud, sharp laugh again, dramatically rolls her eyes. The group laughs.*)

Anna: (*laughing*) Wow, you really don't like your patient, do you?

Sarah: I just get so frustrated with her avoidance maneuvers. I feel like she could do more than she does. I feel very critical of her. Does anyone else have that kind of reaction to her?

Supervisor: I think there's another question behind that question—is it OK that I feel this way?

Sarah: (*Nods.*)

Supervisor: And that is completely OK. What's important is that is how you are feeling. So let's stick with that for a moment. Let's try the role-play again, but this time you play yourself and Anna will play the patient. And this time, tell her how you really feel. Don't worry about phrasing it nicely or how you would really talk to a patient. Just tell her how you feel.

Anna [as patient]: What session is this? How many do we have left?

Sarah [as therapist]: This is 21. We only have 9 more. Do you have some thoughts about that?

Anna [as patient]: No, no thoughts, just curious.

Sarah [as therapist]: OK. But I wonder, maybe you do have some thoughts. Maybe we should talk about that.

Supervisor: Don't hold back. You are being careful and cautious and talking like a therapist. Just tell her directly how you feel. Don't censor yourself.

Sarah: OK. [as therapist]: I'm frustrated. I'm frustrated with you. I feel like you never work with me. You never let me in. (*Turns to face the group.*) This is really hard.

Supervisor: What's happening for you right now?

Sarah: I feel judged by her. She's been disappointed with me since we started. You know, the first time I went to meet her in the waiting room, she seemed disappointed to learn that I was her therapist. But I can't tell her that I feel judged by her—that will just sound like more criticism.

Supervisor: You're both caught in this right now, feeling critical, and feeling criticized. It's a shared dilemma.

Sarah: Yeah, that's true. That's something I could say to her.

Similar to the use of video, awareness-oriented role plays can contribute to performance anxiety in trainees. In the trainee interviews, some trainees admitted that they avoided volunteering for role-plays due to anxiety. Most trainees, however, while acknowledging their anxiety, described the role plays as being the most helpful part of supervision. As one trainee stated: "I love role plays. They're nerve-wracking to do but I learn a lot from them . . . The reason why I like the role plays is because it's like a dual track

of learning at once. It's like speed learning . . . I typically get more insight into what the patient might be experiencing as I'm trying to be in their position. That helps me to get them more. And also tracking [the therapist's] responses helps me to understand better what I might do in that situation, and also what a patient might feel in relation to some of the responses that I might make."

Another trainee noted the importance of feeling supported when doing a role-play: "It was just real hard being a therapist in that moment because I could feel myself kind of reliving a lot of the uncomfortable, anxiety-like feelings I would experience when I would be in the room with [my patient] . . .. It was difficult because other people were watching me, and the supervisor, and you knew you were being critiqued in some ways. But it was also relieving, knowing you were doing it in a safe environment, and that it was with the notion of receiving some feedback and some help with, you know, what they were seeing that maybe I could utilize at the time, so I didn't feel so alone in the process."

An important component of role-plays is the way in which they actively involve other members of the supervision group and can help to foster an alliance among the group members. As one trainee observed: "When you are watching a case unfold and you are not in it, I think you really can kind of reflect on an experience the therapist is having in a less judgmental way, and just kind of start to verbalize it. I found it really helpful when we inhabited each other's spaces, as therapists, and tried to speak about what we might be feeling."

Mindfulness Training

The third key feature of AFT is mindfulness training. Mindfulness is commonly defined as the ability to attend to one's experience in the present moment with an attitude of nonjudgmental acceptance (Aronson, 2004). Mindfulness has become an important component of a number of psychotherapy treatments, including acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), dialectical behavior therapy (Linehan, 1993), and mindfulness-based cognitive behavioral therapy (Segal, Williams, & Teasdale, 2002). Therapists practicing these treatments are encouraged to develop their own mindfulness skills (Wilson & Dufrene, 2008). In their review, Davis and Hayes (2011) report on findings that provide some evidence (albeit based primarily on trainee self-report) that mindfulness training for trainees leads to increased empathy toward clients and greater attention to therapy process; increased self-compassion, self-awareness, and self-efficacy; and decreased stress and anxiety.

In AFT, the goal of mindfulness training is to help therapists refine their capacity to observe their inner experience as well as their contributions to the interaction with the patient. Our hope is that mindfulness training will enhance trainees' abilities to attend to the here and now with an attitude of curiosity and nonjudgmental acceptance. In other words, mindfulness training will help therapists to decenter, to observe their thoughts and feelings as temporary mental events rather than unalterable truths (Safran & Segal, 1990). Taking this observing stance helps therapists to disembed from a rupture—to step out of a vicious cycle of patient hostility and therapist counterhostility, or of patient withdrawal and therapist pursuit, for example. Therapists are then better able to metacommunicate about the rupture in a noncritical,

nondefensive fashion. We conceptualize metacommunication as a form of "mindfulness in action" (Safran & Muran, 2000).

We encourage trainees to develop their own daily mindfulness practices. We also incorporate mindfulness training into the supervision sessions. We may start a supervision session with an exercise such as the following:

Supervisor: Get comfortable in your chair, and you can close your eyes or just lower your gaze. Focus your attention on your breath. Pay attention to each inhale and exhale. Now start to count each breath. Whenever you notice your mind wandering, just note this, no judgment, no criticism, just note that your attention has wandered, and then gently refocus your attention on your breath and start counting again, beginning again at one.

In the interviews, one trainee noted that mindfulness training was particularly helpful during a hectic internship year: "It really did help me during this difficult year to, kind of ground me at certain points, and when I wasn't really able to get into it, then to be mindful about what was going on that made it hard, and why I felt distracted as well." However, a number of interviewees expressed some disappointment with mindfulness training. Concerns were raised that it was not sufficiently integrated with the rest of AFT. As one trainee observed: "We started off doing a lot of meditation, and I guess I was expecting that to kind of tie in more, and I don't think that it did. I just feel like maybe it could have, in terms of the actual moment-to-moment clinical material." Another trainee observed how challenging it is to require mindfulness training: "I really like mindfulness meditation quite a bit, and I do it on my own, and I know it's a component of the treatment, and I think it's a good one. I think it's kind of the sort of thing that's hard to enforce upon a group. Everybody's got to maybe figure it out on their own."

Discussion

Our alliance-focused training approach aims to increase therapists' ability to recognize, tolerate, and negotiate alliance ruptures by enhancing their self-awareness, affect regulation, and interpersonal sensitivity. Through the use of videotape analysis of rupture moments, awareness-oriented role-plays, and mindfulness training, we encourage trainees to develop an open, accepting, nonjudgmental curiosity about their own experience and the experience of their patients, and to begin to articulate their experience via metacommunication.

Our research program has produced evidence that suggests that AFT helps trainees to treat challenging patients effectively. Additional research is needed to tie particular supervisory actions to client outcomes. Interviews with trainees suggest that they find role-plays and the use of video anxiety-producing but helpful. Their feedback also suggests that we need to explore different ways to integrate mindfulness into AFT. One possibility is to develop a brief mindfulness exercise that therapists could engage in prior to seeing a patient. There is evidence that practicing mindfulness right before a session may be beneficial. Dunn, Callahan, Swift, and Ivanovic (2013) randomly assigned therapists to either complete a 5-min acceptance and commitment therapy centering exercise right before a session, or engage in common presession routines such as checking email. When therapists engaged in the centering exercise, they rated themselves as being more

present in the subsequent session, and their patients rated the sessions as being more effective.

While we support our trainees' efforts to attend to their alliances with their patients, we as supervisors must also build and maintain an alliance with our trainees. A strong supervisory alliance is essential in order for trainees to feel safe sharing difficult therapy experiences. We endeavor to be aware of and explore any ruptures that emerge in the supervision. However, from the trainee interviews, it is clear that we supervisors, just like therapists, can miss ruptures. Some trainees reported that they experienced moments of feeling criticized or misunderstood by their AFT supervisors, but that they did not share these feelings and the supervisors appeared unaware of the ruptures. A future challenge for us will be to continue to explore this phenomenon and see if there are additional tasks that we should employ to increase our sensitivity to ruptures with trainees. In our work with patients, we have found that ruptures present difficulties but also opportunities for growth—our hope and expectation is that additional exploration of ruptures in supervision will also prove challenging but fruitful.

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