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THERAPEUTIC ALLIANCE RUPTURE AS A THERAPY EVENT FOR EMPIRICAL INVESTIGATION

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Why Is the Alliance Rupture an Important Phenomenon to Investigate?

In recent years the concept of the therapeutic alliance has received a considerable amount of attention by psychotherapy researchers. Although the concept originated early in the psychoanalytic literature (Bibring, 1937; Sterba, 1934), it was Bordin's (1979) integrative conceptualization of the alliance which gave impetus to the current flurry of research interest. Bordin (1979) views the therapeutic alliance as a common change factor in all forms of psychotherapy, which consists of three interdependent components: the relational bond between the client and the therapist; the tasks of psychotherapy (i.e., the specific action in which the client is required to engage); and the goals of psychotherapy (i.e., the general outcome that is sought). According to Bordin, the quality of the therapeutic alliance is a function of the degree of agreement between therapist and client about the goals and tasks of psychotherapy. This in turn is mediated by the quality of the relational bond between therapist and client, which is affected by the degree of agreement about goals and tasks. This conceptualization of the alliance thus eliminates the rigid distinction between general relationship factors and specific technical factors and combines them within an overarching theoretical framework (Greenberg & Pinsof, 1986).

There is now a large body of empirical evidence which demonstrates that the therapeutic alliance, as rated from client, therapist, and third-party perspectives, is the best predictor of psychotherapy outcome (Alexander & Luborsky, 1986; Horvath & Greenberg, 1986; Marmor, Horowitz, Weiss, & Marziali, 1986; Suh, Strupp, & O'Malley, 1986). Given the importance of the therapeutic alliance to therapy outcome, it would seem im-

Early detection of alliance ruptures by the therapist is critical to successful therapy, and resolution or healing of alliance ruptures can be potent change events. Preliminary hypotheses regarding the processes involved in resolving them are offered and research implications are discussed.

An alliance rupture consists of an impairment or fluctuation in the quality of the alliance between the therapist and client. Alliance ruptures vary in intensity, duration and frequency, depending on the particular therapist-client dyad. In more extreme cases, the client may overly indicate negative sentiments to the therapist or even terminate therapy prematurely. At the other end of the continuum are minor fluctuations in the quality of the therapeutic alliance which may be extremely difficult for the outside observer or for even the skilled therapist to detect.

While the features of alliance ruptures vary from case to case, most therapy cases, even the more successful ones, are characterized by at least one or more ruptures in the therapeutic alliance over the course of therapy. While much of what we will have to say in the course of our discussion will ring true to the reader, our intention is to "unpack" familiar concepts such as the therapeutic alliance in a fashion which leads to more differentiated understanding and research.

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A preliminary study by Foreman & Marmor (1985), attempted to identify therapist actions capable of enhancing initially poor alliances. They examined the sessions of six clients who were rated as having poor therapeutic alliances in the early phases of treatment. At termination, three had sustained poor alliances and poor outcomes, and three had improved alliances and good outcomes. Foreman & Marmor (1985) found that in each of the improved outcome cases, the client’s problematic feelings toward the therapist were directly addressed and linked to the defenses used to ward them off (e.g., “When you begin to feel angry with me, you withdraw and fall silent”). In the unimproved alliance cases, either this link was not made, or problematic feelings toward the therapist were avoided or ignored by the therapist.

While this study provides an important starting point, it is limited by the small sample size and by the fact that the analysis is at a very general descriptive level. In order to capture the subtlety of the processes involved in healing alliance ruptures it will be necessary to investigate them in a more intensive fashion. A first step toward this type of investigation involves the examination of the relevant phenomenon from a conceptual perspective. This will set the stage for subsequent empirical analysis.

A Conceptual Framework

The growing evidence of the importance of the alliance in therapy might lead some to conclude that therapy technique is less important than the relationship aspects of therapy. However, as Bordin’s (1979) conceptualization of the alliance suggests, technical and relationship factors are interdependent aspects of the same process. The traditional distinction between technical and relationship factors assumes that treatment through psychotherapy is analogous to treatment through medication (Parloff, 1986; Strupp, 1986; Wilkins, 1985). The effect of medication, however, is theoretically distinguishable from the psychological meaning of the treatment. In contrast, the action of psychotherapeutic techniques is intrinsically linked to the interpersonal context in which they occur (Butler & Strupp, 1986; Luborsky, 1984; Safran, 1990a; 1990b). Thus as Butler & Strupp (1986) argue “The complexity and subtlety of psychotherapeutic processes cannot be reduced to a set of disembodied techniques because techniques gain their meaning, and in turn, their effectiveness from the particular interaction of individuals involved” (p. 33).

The impact of the therapist’s behavior on the client must ultimately be understood in terms of the client’s perception of that behavior, and this perception is ultimately determined by the client’s unique learning history. The same therapeutic intervention may thus be interpreted very differently by two different clients. While one client may construe it in a fashion which promotes the therapeutic alliance, another may construe it in a manner which impedes it. For this reason, it seems vital to have an understanding of the factors shaping a client’s perception of the meaning of therapeutic interventions.

A number of theorists suggest that a client’s perception of the meaning of other people’s actions is organized by core cognitive structures or schemata (Arntz, 1988; Guidano & Liotti, 1983; Horowitz, 1988; Mahoney, 1982; Meichenbaum & Gilmore, 1984; Safran, Vallis, Segal & Shaw, 1986). These core cognitive structures can be thought of as generalized expectations about self—other interactions or interpersonal schemata that are based on past experiences (Safran, 1990a; Safran, Segal, Hill & Whiffen, 1990). When these core cognitive structures are dysfunctional they activate maladaptive cognitive—interpersonal cycles in which the client’s expectations lead to behavior on his or her part which elicits predictable interpersonal consequences that confirm their dysfunctional expectations (Carson, 1969; 1982; Kiesler, 1982; 1986; Luborsky, 1984; Safran, 1984a; 1984b; 1990a; 1990b; Safran & Segal, 1990; Strupp & Binder, 1984; Wachtel, 1977). For example, one individual anticipates others will abandon him, and thus behaves in a clinging, dependent fashion that ultimately alienates people and confirms his expectations. Another person anticipates that others will be critical of her and thus acts in an excessively self-justifying fashion that irritates people and ultimately elicits the type of criticism that she expects.

When the therapist acts in a fashion which is consistent with the client’s dysfunctional interpersonal schema, he or she perpetuates an existing dysfunctional cognitive—interpersonal cycle. For example, the therapist who responds to the client’s hostility with counterhostility may confirm his belief that the world is a hostile place that should be met with hostility. Conversely, if the therapist is able to refrain from participating in the client’s cognitive—interpersonal cycle, the client encounters
an important experiential challenge to his dysfunctional beliefs.

An important related concept has been articulated by Weiss, Sampson & the Mount Zion Psychotherapy Research Group (1987), who maintain that people's problems result from pathogenic beliefs about interpersonal relationships that have developed as a result of interactions with significant others. They theorize that the process of disconfirming the client's pathogenic beliefs is a central mechanism of change in psychotherapy, and that clients unconsciously submit their therapists to transference tests in an attempt to disconfirm their pathogenic beliefs. In an extensive series of studies they have demonstrated both that pathogenic beliefs can be measured reliably, and that the disconfirmation of pathogenic beliefs is related to both the immediate (i.e. in-session) and ultimate outcome (Weiss et al., 1987).

The above theory and research suggest that therapist interventions that disconfirm the client's dysfunctional beliefs about self—other interactions will be construed in a fashion which permits collaboration on the task and goal components of the alliance. Conversely, interventions which confirm the client's dysfunctional beliefs perpetuate a maladaptive cognitive—interpersonal cycle and make collaboration on a particular task or toward a particular goal difficult.

For example, the client who anticipates that others will attempt to dominate him or her will have difficulty establishing a therapeutic alliance with a domineering therapist. The client who anticipates that others will be emotionally unavailable will have difficulty establishing an adequate therapeutic alliance with a withdrawn therapist. For this reason particular types of therapy are at risk for particular types of alliance ruptures (Safran & Segal, 1990). Cognitive therapy, for example, with its active techniques for challenging cognitions, is at risk for alliance ruptures in which the client feels criticized or invalidated. Forms of psychodynamic therapy in which the therapist plays a less active role are at risk for ruptures in which the client feels that the therapist is emotionally unavailable to him or her. Thus, as Bordin (1979) suggests, different clients will find it easier to meet the alliance demands of different forms of psychotherapy, depending on the particular demands of the relevant therapeutic tasks.

Since alliance ruptures are likely to occur at junctures where the therapist's actions confirm a client's dysfunctional interpersonal schemata, they are ideal points for phenomenological exploration. The existence of an alliance rupture provides the therapist with a unique opportunity to explore expectations, beliefs, emotions, and appraisal processes which play a central role in the client's dysfunctional cognitive—interpersonal cycle (Safran & Segal, 1990). For example, a therapist becomes aware that a client responds to intervention by withdrawing in a sullen fashion. By exploring the client's experience at this point, she discovers that the client feels patronized, but has been reluctant to say anything for fear that the therapist will be angry. Further exploration reveals that this theme cuts across a variety of interpersonal situations.

The successful resolution of an alliance rupture can be a powerful means of disconfirming the client's dysfunctional interpersonal schema. While failure to adequately resolve an alliance rupture is likely to lead to poor outcome in psychotherapy, the successful resolution of an alliance rupture can be one of the more potent means of inducing change. In the above illustration, for example, metacommunication about the alliance rupture can potentially help the client to clarify whether she really has been patronized and to challenge her belief that it is too risky to discuss this experience with others.

The current perspective suggests that empathic failures take place when the therapist fails to adequately understand the nature of the client's dysfunctional beliefs about self—other interactions and thus inadvertently confirms them. The resulting alliance rupture, however, provides an important opportunity. First, it allows the therapist to refine his or her understanding of the problematic cognitive structure, by activating it and bringing the relevant construal processes to the surface. Second, once the relevant cognitive structure has been activated the possibility of a corrective interpersonal experience emerges.

A converging perspective is offered by Kohut (1984), who pinpoints the client's negative response to the therapist's empathic failure as a critical juncture for intervention. According to him, the therapist's ability to deal empathically with the client's response to these inevitable lapses in empathy plays a vital role in activating the change process in psychoanalysis. While the focus on the therapist's empathic failure is a central emphasis in self-psychology, the current perspective attempts to cast the event within a more general theoretical framework.
An illuminating developmental perspective on the significance of alliance ruptures in therapy can be found in the research on affective miscoordination and repair (Tronick, 1989). In healthy mother–infant dyads the interaction frequently moves back and forth between periods in which the affective communication is coordinated and periods when it breaks down. When the infant’s affective experience (e.g., sadness) is misinterpreted by the mother, the infant reacts with a secondary affect (e.g., anger). In healthy mother–infant dyads the mother responds to the secondary affect empathically, and the affective communication becomes coordinated once again.

In dysfunctional mother–infant dyads the mother fails to become attuned to the secondary affective response as well as to the initial affective response. A state of affective miscoordination between mother and infant thus continues. Tironik & Cohn (1989) hypothesize that in healthy mother–infant dyads the continuous oscillation between affective miscoordination and interactive repair helps the infant to develop expectations that disruptions in the relationship are remediable and that negative affective experience will be transformed into positive affective experience. They thus develop a representation of themselves as interpersonally effective and of the caretaker as trustworthy. They are thus able to maintain interpersonal engagement in the face of stress.

Infants in dysfunctional dyads are not able to develop this type of adaptive representation of self in interaction with others, and thus have difficulties maintaining interpersonal engagement in less-than-optimal situations. Moreover, because of consistent misattunement by the caretaker to both the primary and the secondary affect, they may have problems in learning to process and express both types of affective experience.

Safran & Segal (1990) hypothesize that developmental experiences of this type can have implications for alliance ruptures which emerge in therapy. For example, a client who has consistently had the emotion of sadness misattuned to as a child may have difficulty expressing that emotion when appropriate in therapy, and may respond in anger when the therapist fails to become attuned to the underlying sadness. There will thus be a rupture in the therapeutic alliance. If the therapist is able to adequately empathize with the anger, the alliance will be strengthened and the client may, over time, be better able to access and express both the anger and the underlying sadness that was misattuned to. It is then critical to empathize with the underlying sadness as well. In this fashion she may gradually be able to develop a new representation of herself as capable of maintaining interpersonal contact in the face of disruption and of others as being emotionally available.

**Alliance Rupture Markers**

The alliance rupture is a potentially fruitful domain for empirical investigation. As a recurring, circumscribed and operationalizable occurrence in therapy, the resolution of an alliance rupture qualifies as the type of change event amenable to investigation through the new “events paradigm” in psychotherapy research (Elliot, 1984; Rice & Greenberg, 1984; Safran, Greenberg & Rice, 1988).

In a preliminary effort to map out the domain of the alliance rupture for empirical investigation we selected a number of therapy segments in which ruptures had been identified for intensive observation. These segments were selected from psychotherapy sessions of clients being treated for depression or anxiety disorders with an integrated cognitive–interpersonal approach (Safran, 1984a; 1984b; 1990a; 1990b; Safran & Segal, 1990). Using postsession questionnaires we selected a number of sessions in which both therapists and clients had identified problems in the therapeutic alliance. By listening repeatedly to audiotapes of these sessions, we attempted to identify consistent themes.

Below, seven different themes are featured because of their recurrent emergence in the sample of alliance ruptures studied. It is not our intention to imply that this list is exhaustive or that the rupture types are mutually exclusive. Each theme, however, can potentially be thought of as what Rice & Greenberg (1984) have referred to as a process *marker*, i.e., a distinctive type of client verballization and/or behavior indicating the presence of a distinctive underlying psychological process, and a potential readiness for a particular type of intervention. Although the current list of rupture markers is framed in terms of client indicators, it should be borne in mind that all ruptures in the therapeutic alliance are conceptualized as involving both client and therapist. The precise contribution of each will vary, depending on the particular rupture.

1. **Overt expression of negative sentiments.** A commonly observed sign of a disruption in the
therapeutic alliance is a client’s expression of negative sentiments toward the therapist. For example, the client directly attacks the therapist’s competence or accuses him or her of being cold or heartless.

2. Indirect communication of negative sentiments or hostility. While some clients communicate negative sentiments directly, these feelings are often communicated indirectly through sarcasm, nonverbal behavior or passive-aggressive behavior. For example, one client became withdrawn and subtly derisive when she perceived the therapist as moving from an intimate discussion of concrete events and feelings to a more abstract and impersonal level. When this behavioral pattern was explored, she acknowledged that she felt as though the therapist was playing the “psychologist” in a “cliched manner” at these points in the session, and thus she didn’t feel comfortable revealing herself to him.

One frequently observed example of an indirect expression of negative sentiments involves the client’s allusion to negative sentiments or concerns about the therapeutic relationship through a thematically linked discussion of out-of-session events, or an allusion to the transference (Gill & Hoffman, 1982). For example, one client, who in an earlier session felt rejected by his female therapist and dissatisfied by her evasive responses to his questions, initiated the session by discussing feelings of frustration and humiliation associated with a recent interaction with another woman who he felt had rejected and humiliated him. Only after sensitive and emphatic exploration by the therapist was he able to acknowledge similar feelings toward her.

3. Disagreement about the goals or tasks of therapy. Another commonly observed marker involves the client questioning or rejecting the goals or tasks of therapy. This observation is consistent with Bordin’s (1979) suggestion that the strength of the therapeutic alliance is mediated by the degree of agreement between therapist and client about goals and tasks. While in some cases there may be fundamental incompatibilities between the goals and tasks of a particular therapeutic approach and the client’s worldview, in other cases this disagreement may be the surface manifestation of other underlying themes. For example, one client consistently asked the therapist to provide her with strategies and advice of a more concrete and tangible nature. This client had a core belief that others were never available to provide the kind of nurturance that she needed. The development of this belief had been influenced by her relationship with an alcoholic and emotionally unavailable father. Due to her desire for nurturance she consistently pulled for support and advice from others. At the same time, however, she resisted others giving her directions because she perceived them as dominating her.

During her sessions, she repeatedly urged the therapist to provide her with tangible techniques and specific advice. However, when he did comply by becoming more directive, she became resentful and angry. In this instance the disagreement about the tasks of therapy reflected an underlying cognitive interpersonal cycle which was problematic for the client.

4. Compliance. Client compliance with the therapist is also a common marker of problems in the therapeutic alliance. In this type of situation, rather than risk threatening the relationship with the therapist, the client acquiesces. In one case, for example, the client who initially indicated a reluctance to try a particular exercise, eventually responded to the therapist’s coaxing and agreed to comply with the task. The therapist, however, detecting a begrudging quality in her voice, began to explore the experience associated with the act of compliance for her. This led to an exploration of some central beliefs, related to the need to submerge her own needs in order to avoid rejection, and to an eventual improvement in the alliance. Another common indicator of compliance involves a hasty agreement with the therapist, with no further elaboration.

5. Avoidance maneuvers. Clients also engage in avoidance maneuvers to reduce the anxiety associated with a rupture in the alliance. The client may, for example, protect himself from a sense of threat by becoming unresponsive to the therapist’s interventions or by skipping from topic to topic in a fashion which prevents the therapist from exploring issues in depth. In some situations the client may become unclear or confused by a therapist’s interventions, or may completely ignore a therapist’s remarks. Other more extreme reactions include the client arriving late, cancelling the appointment, or failing to attend a session.

6. Self-esteem-enhancing operations. Client behavior during the process of a rupture is sometimes characterized by self-justifying or self-aggrandizing communications. A client may attempt to justify or defend himself or herself as a means of regaining a deflated sense of self-worth. For example, one client in our sample tended to provide
extended explanations as to how she had become the way she was, when the alliance appeared strained.

Other examples of self-esteem—enhancing operations include clients’ attempts to boost their self-esteem by presenting positive images of themselves to their therapist. For example, one client tended to boast about his previous accomplishments when it appeared that he felt criticized by the therapist. Another client discussed the nature of his problem using highly theoretical terms, in what appeared to be an attempt to impress the therapist.

Clients may support their floundering self-esteem by attacking or deprecating the therapist. The client may belittle the therapist with overt remarks or by devaluing the therapist covertly, through sarcasm. Both avoidance maneuvers and self-esteem—enhancing operations can be considered to be reflections of what Sullivan (1953) termed security operations, i.e., operations that function to reduce or avoid anxiety resulting from a deflation of the individual’s self-esteem. From an interpersonal perspective it is hypothesized that self-esteem is associated with a subjective sense of interpersonal relatedness and that an impairment in the therapeutic relationship will thus be associated with an increase in anxiety (Safran, 1990a, 1990b; Safran & Segal, 1990).

7. Nonresponsiveness to intervention. A final alliance rupture marker can be designated as nonresponsiveness to intervention. This marker is characterized by a sequence of events in which the client fails to respond positively or make use of a particular therapeutic intervention. For example, the therapist offers an interpretation which is rejected by the client or attempts to challenge a cognitive distortion without success. Failed interventions of this type often (but not always) reflect preexisting problems in the alliance. Alternatively, a poorly timed or unempathic intervention can disrupt an alliance which has been satisfactory. In either case, further exploration can potentially lead to a better understanding of the client’s interpersonal schema. It should be emphasized that the fact that a failed intervention can lead to a better understanding of the client’s interpersonal schema does not mean that the client is responsible rather than the therapist. An alliance rupture is always an interactional phenomenon.

The above list provides a preliminary description of seven potential alliance rupture markers. Further investigation will be required to establish whether they can be reliably identified. Moreover, it will be important to clarify whether the underlying processes are sufficiently distinct to justify retaining the entire list or whether one or more marker subtypes should be collapsed.

Resolving Alliance Ruptures: General Principles

Resolving alliance ruptures involves a process of therapeutic metacommunication, i.e., talking about what is currently transpiring in the therapeutic relationship. Therapeutic metacommunication is, of course, a central intervention in any interpersonal approach to therapy and is not restricted for use in the context of an alliance rupture. It is precisely in the context of an alliance rupture, however, that metacommunication becomes most critical. In this section we will emphasize those aspects of the metacommunication process that are hypothesized to be most important in the process of resolving an alliance rupture. Five general principles will be discussed. Our discussion of this issue has been influenced by a number of different sources. Most directly influential, however, has been Kiesler’s (1982; 1986; 1988) operationalization of the principles of therapeutic metacommunication.

1. Attending to ruptures in the alliance. This step is critical since the process of resolution cannot begin until the rupture has been noted. Since clients are, however, often reluctant to communicate negative sentiments directly, this first step can be problematic. For this reason a perceptual readiness for the presence of alliance ruptures should be cultivated. The systematic identification of alliance rupture markers will hopefully facilitate this process.

2. Awareness of one’s own feelings. This is a critical step for a number of reasons. First, the therapist’s feelings provide a useful barometer regarding the quality of the relationship in a moment-by-moment fashion. If the client is feeling sufficiently safe to allow the therapist access to his inner world, the therapist should have a subjective feeling of true empathy with him (Safran & Segal, 1990). The absence of this experience may indicate the presence of an alliance rupture. Second, the therapist’s feelings provide important information that can be employed in the process of metacommunication (Kiesler, 1982; 1986; 1988). Third, the accurate identification of one’s own feelings is an important part of the process of accepting responsibility. Unless the therapist
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is able to accurately identify her own feelings, her actions will be biased by factors outside of awareness. For example, a therapist who is angry at his or her client, but not aware of that anger may nevertheless communicate it in subtle ways. Thus, an intervention, which at one level is intended to help the client, may in fact be delivered in a punitive fashion.

3. Accepting responsibility. The preliminary model suggests that one of the more important components in resolving an alliance rupture consists of the therapist acknowledging his or her role in the interaction (Kiesler, 1988). Gill (1982) has spoken particularly clearly about the importance of the analyst being able to acknowledge their role in the transaction as part of the transference interpretation. The reason that this is so important is that often when there is a rupture in the therapeutic alliance, the client and the therapist become locked into interactional positions in which they are both trying to validate themselves.

Consider the following example. A therapist and client are involved in a struggle over what their topic of focus will be. In an attempt to meta-communicate with the client about what is going on, the therapist says: "I feel like you are trying to control the interaction." The client who is involved in the current struggle in order to maintain his own self-esteem perceives this comment as blaming, and experiences an even greater need to control the interaction in order to maintain self-esteem. If the therapist includes himself in the description of the interaction and acknowledges his own role, it is easier for the client to view the process of exploration as a collaborative activity. The situation begins to shift from one in which there is a sense of "me against you" to one in which there is a sense of "we-ness." By speaking about the rupture as "our problem," rather than "your problem" a sense of connectedness begins to develop.

A more effective response in the above example would be for the therapist to state: "I feel like I'm involved in a struggle with you and I'm not sure what's going on. Does this connect with your experience in any way?" With this response, the client no longer feels blamed or invalidated to the same extent and is thus freed up to begin trying to discover in collaboration with the therapist exactly what is going on in the situation. Thus, an important transition takes place when the therapist shifts from a stance of blaming the client for what is going on in the interaction to accepting responsibility for his or her own role in the interaction.

In some situations, even when the therapist acknowledges his or her own role in the interaction and then comments on the client's role, the client may still continue to feel criticized or blamed and thus may have difficulty letting go of her self-protective stance. In these instances it can be important for the therapist to stop short of commenting on the client's contribution to the interaction. Simply accepting responsibility for his or her part of the interaction may help free the client up to begin to explore his or her role in the interaction.

Another reason that it is important for therapists to begin intervening by acknowledging their role in the interaction is that often clients in situations of this type feel particularly threatened because they are not quite sure where reality lies. Their own responses to the situation may seem irrational or disproportionate to them and they may thus have an even greater need to defend their position. They may thus have difficulty truly acknowledging their own feelings either to themselves or to the therapist. This can make it particularly difficult for the client to begin to understand his or her role in the interaction. If, however, the therapist is able to honestly clarify his or her own role in the interaction, the client may begin to understand the context of their own reactions and thus begin to feel somewhat more comfortable in accepting his own feelings and reactions. This makes it easier for the client to begin exploring his or her contribution to the interaction.

For example, a therapist who perceived that her client was angry with her reacted in a defensive fashion. When she asked the client whether she was angry, she denied such feelings. However, when the therapist became aware that she had been critical of her client and acknowledged this, the client's own responses became more understandable to her, and she found it easier to acknowledge her feelings of anger at the therapist. The therapist's acceptance of responsibility for her contribution to the interaction in this situation thus made it easier for the client to begin the process of self-exploration which eventually led to the resolution of the alliance rupture.

4. Empathizing with the client's experience. In addition to acknowledging his or her contributions to the interaction, it can be useful for the therapist to convey an empathic understanding of the client's experience to him/her. In the above situation, for example, it might have been useful for the therapist to indicate that if she were the client, she imagined she would be feeling angry. If the therapist is able to accurately empathize
with the client's experience during an alliance rupture and convey this understanding, the client may feel understood and find it easier to begin exploring what is going on in the interaction. In addition to feeling understood, an accurate empathic response in this situation may help the client to acknowledge feelings that he or she is not fully aware of.

Attempts at therapeutic metacommunication can be fruitless unless they are grounded in an accurate empathic understanding of the nature of the patient's struggle. There is often an observable "shift point" in the interaction when the therapist finally develops and is able to communicate a true empathic understanding. For example, one therapist who felt distanced by his patient's intellectualized attempts to talk about the therapeutic relationship communicated this feedback in various forms, without a positive therapeutic impact. When, however, he was able to truly empathize with the patient's intense and painful experience of struggling in vain to improve this and other relationships, the patient's stance changed from one of self-protection to self-disclosure and exploration.

Although conveying an empathic understanding of the client's experience to them often facilitates the process of resolution, in some instances it can also impede the process of resolution. Our observation has been that this tends to happen when the client appears to feel patronized by the therapist's empathic response—as if the therapist's empathic response implies to them that the problem is the client's rather than a shared problem.

5. Maintaining the stance of the participant/observer. Once the therapist has begun the process of metacommunication, it is vital for him or her to maintain the stance of the participant/observer, to use Sullivan's (1953) term. A common error observed is for therapists to become hooked into a dysfunctional interpersonal cycle at a new level once the process of metacommunication has begun. For example, in one case the client tended to be rather closed and reluctant to share his inner experience with the therapist. The more the therapist attempted to explore the client's experience the more closed the client became. Moreover, in response to the therapist's attempts to metacommunicate about the process, the client continued to be closed. After the failure of this metacommunication the therapist appeared to intensify his efforts to get the client to open up, and this appeared to intensify the client's withdrawal. In this situation the process of metacommunication was a recapitulation of the already existing dysfunctional interpersonal cycle at a new level. It thus appears to be important for the therapist to avoid the pitfall of maintaining the status quo of the current interactional dynamic, through his or her metacommunication.

A Preliminary Model

The next phase in the research process involves moving beyond the articulation of the general therapeutic principles outlined in the previous section toward a finer-grained empirical examination of the therapist—client interactional patterns through which alliance ruptures are best resolved. Following Rice & Greenberg's (1984) task analysis approach to psychotherapy research it is important to generate a preliminary model that can guide the intensive observation of the actual change process. This model should be refined continuously in response to new information as it is compared with the phenomenon of interest (Greenberg, 1986; Safran, Greenberg & Rice, 1988).

First, the model is used informally to facilitate an evaluation of the degree of fit between the model and the actual change process observed. Once a certain degree of refinement of the model has taken place, however, it can be used to generate specific hypotheses that are empirically testable—about the nature of the interaction between client and therapist when the alliance rupture is resolved.

The preliminary model to be articulated here has been developed through a combination of intensive observation of successfully resolved alliance ruptures in our sample and through available psychotherapy theory. Our impression is that this particular model is most applicable to ruptures that are marked by a pattern of avoidance of direct confrontation on the client's part (e.g., indirect communication of negative sentiments, compliance, avoidance maneuvers). The model, which consists of an eight-stage sequence of client—therapist interactions, is diagrammed in Fig. 1.

Stage 1—Avoidance of Confrontation Marker. This stage is marked by an apparent avoidance of confrontation on the client's part. The client may indicate negative sentiments indirectly (e.g., through sarcasm, or through an allusion to the transference). Alternatively, he or she may comply or defer to the therapist. When this happens there is often a somewhat begrudging quality, suggesting that the response is compliance rather than true agreement. Alternatively, the client may appear to agree with the therapist too hastily or readily,
without taking the time to integrate things or elaborate on his or her own perspective.

Stage 2—Therapist Empathizes with Negative Feelings and Establishes a Focus on the Here and Now. In this stage it is important for the therapist to empathize with any negative feelings the client is expressing. When the client is expressing negative feelings indirectly (e.g., through sarcasm) it is helpful for the therapist to use self-disclosure in order to convey the impact of the client’s behavior at a personal level (e.g., “I feel criticized”). If the client is speaking about negative feelings in general terms and the therapist has reason to suspect that these feelings are relevant to the current transaction, it is important for the therapist to explore the relevance of these feelings to the present interaction. This exploration should be conducted in a noncontrolling fashion, which respects any decision on the client’s part not to discuss negative feelings toward the therapist in the present context. This is particularly important with clients who tend to be compliant, since to push for an exploration of something the client is not ready to explore will invite more compliance.

Stage 3—The Client Engages in Assertive Behavior, Alternating with Deference or Dependency. In this stage the client begins to express his or her concern about the therapeutic relationship more directly. This assertive expression, however, is mixed with compliance or dependency. For example, the client begins to express negative feelings toward the therapist, but then withdraws or softens the statement (e.g., “I guess I’m feeling somewhat dissatisfied . . . I don’t know . . . maybe I’m expecting too much”).

Stage 4—Therapist Explores the Client’s Fears of Expressing Negative Sentiments Directly. In this stage the therapist questions the client regarding expectations or beliefs that would make it difficult to express negative feelings directly. For example: “What would be the risk of telling me about your dissatisfaction?” “What is your concern about disagreeing with me?”

Stage 5—Client Accesses Fears of Expressing Negative Sentiments and Self-Assertion. In response to the therapist’s probing, the client begins to explore attitudes, beliefs, and expectations that prohibit self-assertion or the direct expression of negative sentiments. It is important for the client to explore these fears and beliefs in an experientially real way, rather than in an intellectualized fashion. A common deflection from productive therapeutic process here involves denying or invalidating one’s own fears (e.g., “Well, I guess there’s not really any risk. You’re not going to throw me out of therapy”). This type of self-invalidation appears to prevent the client from gaining a perspective on the way in which his or her own fears and beliefs block self-assertion.

Stage 6—Therapist Empathizes with Client’s Fears. By empathizing and accepting the client’s fears, the therapist facilitates the process of self-exploration. Also, it appears that there is something
about the therapist being empathic with this process rather than dismissing the client’s fears, which provides the client with experiential evidence that it is safe to reveal vulnerability to the therapist, thus strengthening the therapeutic alliance.

**Stage 7—Client Expresses Negative Sentiments in Direct Self-Assertive Fashion.** At this point the client expresses a negative feeling in a direct fashion, without lapsing into compliance or dependency. This stage is often marked by an energetic and lively quality in the client’s voice, which has not been there before. It is important to note that the negative sentiments expressed are not always angry or hostile in nature. The client may, for example, talk with the therapist about feelings of hurt or vulnerability that he or she has been afraid to discuss previously (e.g., “When you gave me that feedback before it really hurt.”) Both angry and vulnerable sentiments in this context are considered a form of self-assertion, since they involve an honest communication of the client’s feelings that is not possible when the client is deferring or complying in order to protect the relationship with the therapist.

**Stage 8—Therapist Validates Client’s Experience and Acknowledges His or Her Own Role in Interaction.** It is crucial that the therapist respond to the client’s self-assertion in a validating and nondefensive manner. In situations where the client has accurately identified a therapist behavior which contributed to the rupture, it is vital for the therapist to acknowledge his or her contribution. For example, the client indicates that he or she felt criticized by the therapist’s statement, and the therapist acknowledges he was feeling critical at the time that he said it.

**Future Directions**

The current preliminary model lends itself well to investigation and empirical refinement with the type of task analysis approach advocated by Rice & Greenberg (1984) or the type of stage process design employed by Cashdan (1973), McCullough (1984a; 1984b) and Hudgins & Kiesler (1987). Given the importance of this type of change event to psychotherapy process, we would encourage researchers in this direction. It will be important to clarify which features of this preliminary model generalize across different rupture markers and which features are unique to ruptures that involve an avoidance of confrontation on the client’s part.

There are also a number of definitional and conceptual issues that will need to be clarified. How intense must the strain in the alliance be before it is considered a rupture? Should the term be reserved for fairly serious disruptions in the therapeutic alliance which become the focus of therapeutic metacommunication or should it be applied to the momentary and subtle fluctuations in the quality of therapist–client contact as well? Is it important to distinguish between situations in which a rupture takes place in the context of an already established alliance and those in which an adequate working alliance has never been established? Should a distinction be made between situations in which an apparent rupture is a sign of therapeutic progress (e.g., the client has begun to feel safe enough in the relationship to express his anger), and those in which the rupture indicates a reversal of therapeutic progress (e.g., the rupture results from a clear therapeutic error). These are complex definitional and conceptual issues, the resolution of which will depend partially on the individual investigator’s theoretical assumptions, and partially on the stance which is likely to be most theoretically and empirically generative.

**Implications for Training**

Finally, we would like to comment on the implications of this type of research for the training of psychotherapists. Over the course of observing psychotherapy sessions with an eye toward clarifying our understanding of the nature and structure of alliance ruptures and the processes leading to their resolution, we have found that we have become more sensitized to the occurrence of alliance ruptures and better able to detect them in situations where they may have previously eluded observation. This has been particularly useful in the training of clinical interns on our research team. The research process has sharpened their perceptual abilities.

Commenting on his failure to locate even a “single instance in which a difficult client’s hostility and negativism were successfully confronted or resolved,” Strupp (1980) noted that a major deterrent to the formation of a good working alliance was “the therapist’s personal reaction” (pp. 953-954). This observation was found to be applicable to our own sample of alliance ruptures where therapists often avoided or “sealed over” rifts in the alliance without addressing the rupture, despite having a general understanding of the importance of this type of exploration.
Directly addressing alliance ruptures with a client can be an uncomfortable and threatening experience for the therapist—one that activates concerns around competency as a therapist. Because ruptures may entail failures in empathy and therapist errors, there is a natural tendency to avoid addressing them with clients, and to respond defensively, especially among relatively inexperienced therapists. Focusing on the alliance rupture as a potential change event, however, and studying the processes involved in resolution, reframes the meaning of the phenomenon and fosters an enthusiasm for detecting and addressing alliance ruptures.

References


