Psychotherapy
2011, Vol. 48, No. 1, 80–87

0033-3204/11/$12.00 DOI: 10.1037/a0022140

Repairing Alliance Ruptures

Jeremy D. Safran
New School for Social Research and Beth Israel Medical Center, New York, New York

J. Christopher Muran
Derner Institute, Adelphi University and Beth Israel Medical Center, New York, New York

Catherine Eubanks-Carter
Ferkauf Graduate School of Psychology, Yeshiva University and Beth Israel Medical Center, New York, New York

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

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

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

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

Definitions and Measures

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

Patient Self-Report of Within-Session Ruptures

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

Jeremy D. Safran, Psychology Department, New School For Social Research and Beth Israel Medical Center, New York, New York; J. Christopher Muran, Derner Institute, Adelphi University and Beth Israel Medical Center, New York, New York; and Catherine Eubanks-Carter, Ferkauf Graduate School of Psychology, Yeshiva University and Beth Israel Medical Center, New York, New York.

This article is adapted, by special permission of Oxford University Press, from a chapter of the same title by the same authors in J. C. Norcross (Ed.), 2011, *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press. The book project was cosponsored by the APA Division of Psychotherapy.

Correspondence concerning this article should be addressed to Jeremy D. Safran, Psychology Department, New School for Social Research, 80 Fifth Avenue, 7th floor, New York, NY 10011. E-mail: safranj@newschool.edu

Inventory [WAI]; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) as well as self-report indices measuring the occurrence of ruptures, rupture intensity, and the extent to which ruptures were resolved. Ruptures occurred frequently across the three treatments: In the first six sessions of treatment, ruptures were reported by 37% of patients and 56% of therapists (Muran et al., 2009). Ruptures were also found to be significantly related to outcome. Higher rupture intensity, as reported jointly by patients and therapists, was associated with poor outcome on measures of interpersonal functioning. Failure to resolve these ruptures was predictive of dropout. Another study (Eames & Roth, 2000) also administered the WAI items and the rupture indices from the PSQ to 30 patients receiving treatment as usual. Therapists reported ruptures more often, reporting them in 43% of sessions, while patients reported them in 19% of sessions.

Patient Fluctuations in Alliance Measures Across Sessions

Another method of identifying alliance ruptures and their repairs has been to track fluctuations in patients' alliance scores across the course of therapy. For example, Strauss and colleagues (2006) sought to identify rupture-repair episodes in a sample of 30 patients with avoidant and obsessive-compulsive personality disorders who received up to a year of cognitive therapy. They developed criteria for rupture and resolution sessions by looking for fluctuations in scores on the California Psychotherapy Alliance Scale (CALPAS; Marmar, Weiss, & Gaston, 1989) that were at least as large as the mean standard deviation of alliance scores across the sample. Of the patients with at least three alliance assessments, rupture-repair sequences occurred in 56% of the cases. For another example, Stevens, Muran, Safran, Gorman, & Winston (2007) developed criteria for identifying rupture-repair sequences from fluctuations in WAI scores in a sample of 44 patients drawn from the personality disorder cases. Ruptures were defined as decreases of at least one point on the WAI; ruptures were deemed to be resolved if the alliance score rose to within .25 points of the prerupture score in three to five sessions. Fully 50% of the cases included episodes that met these rupture-repair criteria.

Observer-Based Methods

Differences between patient and therapist perspectives of the alliance ruptures raise the concern that patients may underreport ruptures due to a lack of awareness of them or discomfort with acknowledging them. One way to address this problem is to use observer-based measures to detect ruptures and resolution processes. For example, in a study of 151 sessions from five patients in psychodynamic therapy (Sommerfeld, Orbach, Zim, & Mikulincer, 2008), the difference between patient self-report of ruptures and observer-based report was directly examined. Patients completed a brief version of PSQ after each session that included the alliance measure, self-reports of ruptures and resolution, and items tapping into the depth and smoothness of the session from the Session Evaluation Questionnaire (SEQ; Stiles, 1980). Patients reported ruptures in 42% of the sessions. Using transcripts of these same sessions, judges identified confrontation and withdrawal ruptures using Harper's (1989a, 1989b) unpublished coding system; observers identified rupture markers in 77% of sessions. There was no significant association between the observer and client perspectives.

Colli and Lingiardi (2009) have developed an observer-based method that codes transcribed sessions for both alliance ruptures and resolutions—the Collaborative Interaction Scale (CIS). A strength of the CIS is that it assesses both patients' and therapists' positive and negative contributions to the therapeutic process. The CIS has also demonstrated good interrater reliability with graduate student raters (Colli & Lingiardi, 2009). The patient rupture markers and therapist intervention items were largely derived from the Rupture Resolution Scale (Samstag, Safran, & Muran, 2004).

Given that most observer-based methods for coding ruptures and resolutions rely on the use of transcripts or the use of highly experienced clinicians as judges (e.g., Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Bennett, Parry, & Ryle, 2006), our research team has sought to develop a coding system that is accessible to graduate student raters and does not require transcription of sessions. The Rupture Resolution Rating System (3RS; Eubanks-Carter, Muran, & Safran, 2009) draws on Harper's (1989a, 1989b) manual for coding confrontation and withdrawal ruptures as well as the Rupture Resolution Scale (Samstag, Safran, & Muran, 2004). Preliminary findings from the 3RS are consistent with the evidence that alliance ruptures identified through observer-based coding systems are more frequent than those identified by patient self-report (Mitchell et al., 2010).

Clinical Examples

Following Bordin's (1979) understanding of the alliance, we find it useful to conceptualize ruptures in the alliance as consisting of (1) disagreements about the tasks of therapy, (2) disagreement about the treatment goals, or (3) strains in the patient-therapist bond. An example of a disagreement about the goal dimension would be a situation in which the patient begins treatment, seeking immediate relief from his or her panic symptoms, but the therapist believes the goal should be one of obtaining insight rather than immediate symptom relief. An example of a disagreement about the task dimension would be a situation in which the patient believes that it is important to spend time reviewing and making sense of his or her history, but the therapist has a present-focused, pragmatic orientation. An example of a strain in the bond dimension would be a situation in which the patient feels patronized or misunderstood by the therapist.

These three types of ruptures are, of course, not mutually exclusive. For example, the patient whose therapist is unwilling to negotiate the tasks or goals of treatment may feel misunderstood or disrespected. Conversely, a patient who feels mistrusting of his or her therapist will be more likely to disagree with the therapist about a therapeutic task or goal.

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

1. Repeating the therapeutic rationale. Outlining the therapeutic rationale at the beginning of treatment can play an important role in developing the alliance at the outset. Reiterating the rationale throughout treatment can help to repair a strained alliance. For example, the therapist can help to repair an alliance rupture resulting from his or her attempt to make a transference

interpretation by reiterating that exploring parallels between the therapeutic relationship and other relationships can help the patient to become aware of self-defeating patterns.

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

3. Clarifying misunderstandings at a surface level. In some contexts, ruptures can be resolved at a surface level by clarifying misunderstandings. For example, a therapist notices that her patient seems withdrawn and initiates an exploration of what is going on in the here and now of their relationship. The patient admits to feeling criticized by the therapist. The therapist responds in a nondefensive fashion and acknowledges that she can see how the patient might have felt criticized by what she said.

4. Exploring relational themes associated with the rupture. In some situations, the process of clarifying factors leading to a rupture can lead to an exploration of underlying relational themes. For example, a patient may experience the therapist's questions about her inner experience as intrusive. Exploring the meaning and nature of this experience for the patient may reveal that it is related to a more general experience on her part of feeling intruded upon by others. A patient who fails to do his homework assignments in cognitive therapy may have a particular sensitivity to feeling dominated and controlled by others. A patient's feeling of being misattuned to by the therapist may reflect a narcissistic sensitivity, which becomes a major focus of the treatment.

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

6. New relational experience. In some contexts, it can be useful for the therapist to act in a way that he or she hypothesizes will provide the patient with an important new relational experience without explicitly exploring the underlying meaning of the interaction. This intervention is particularly important when the patient has difficulty exploring the therapeutic relationship in the here-and-now. For example, a therapist decides to answer a patient's request for advice because she formulates the situation as one in which the decision to do so will provide a corrective contrast to the patient's abandoning mother.

Illustration

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

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

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

Meta-Analytic Review

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

Search Strategy and Inclusion Criteria

To identify potential studies, we searched the reference sections of several recent reviews of the alliance rupture literature (Eubanks-Carter, Muran, Safran, & Hayes, 2010; Eubanks-Carter, Muran, & Safran, 2010; Safran et al., 2002). In addition, we conducted a computerized search of the PsycINFO database. Using the search terms *alliance* and *outcome*, and the terms *alliance* and

rupture, a list of 578 journal articles was generated on April 15, 2010. These articles were inspected for studies meeting the following inclusion criteria: (a) the study was published in English in a peer-reviewed journal, and (b) it included a quantifiable measure of outcome at the beginning and termination of treatment.

To be included in the meta-analysis of rupture-repair episodes, a study also had to use quantitative criteria to identify patients who experienced discrete ruptures and rupture repairs or resolutions over the course of treatment. In order to be included in the meta-analysis of rupture resolution training and supervision, a study also had to constitute an investigation of therapist training or supervision focused on improving therapists' abilities to build and/or maintain good alliances with their adult patients in individual, in-person psychotherapy. Many psychotherapy treatments include attention to the alliance; in order to be included in this analysis, the alliance-focused training or supervision had to include a *specific* focus on helping therapists to manage alliance ruptures or problems in the therapeutic relationship.

The literature search identified four studies that met the inclusion criteria for the rupture-repair analysis. Three of these studies (Stiles et al., 2004; Stevens et al., 2007; Strauss et al., 2006) defined rupture-repair episodes based on session-to-session fluctuations in alliance scores and examined the relation between the presence of these episodes and outcome. A fourth study (Muran et al., 2009) examined ruptures and repairs that occurred within the first six sessions of treatment for patients with Cluster C and Personality Disorder NOS diagnoses, based on patient and therapist self-reports. This study reported findings regarding the relation between rupture-repair episodes and outcome, namely that higher rupture intensity was associated with poor outcome on measures of interpersonal functioning ($r = -.35$, $p < .01$), and rupture repair was predictive of retention in treatment ($r = .29$, $p < .05$). However, due to the significant methodological difference of examining rupture-repairs within sessions, rather than between sessions, this study was excluded from the meta-analysis.

The literature search identified nine studies that met the inclusion criteria for the rupture resolution training analysis. However, one study (Safran et al., 2005) was excluded from the meta-analysis due to its markedly different design, which included unique selection criteria and a change in treatment conditions during the course of the study. Specifically, a subset of patients in the CBT and dynamic supervision conditions of the Muran et al. (2005) study was identified as consisting of potential treatment failures, based on patient and therapist postsession questionnaire ratings, and these patients were given the opportunity to switch midtreatment to one of the other treatment conditions. Those who agreed to switch were randomly assigned to either rupture-resolution supervision condition or the other standard treatment condition (CBT or dynamic therapy). This study found that patients who switched to the rupture resolution condition were significantly more likely to remain in treatment than those who switched to another treatment condition.

The remaining eight studies in the rupture resolution training analysis all presented intake and termination data for therapists who received some form of rupture resolution training and/or supervision. Seven of the eight studies also included a control condition; however these control groups varied considerably. They included a wait list control (Castonguay et al., 2004), an unsupervised active treatment (Bambling et al., 2006), supervised active treatments (Constantino et al., 2008; Muran et al., 2005; Newman et al., 2008), and therapists serving as their own controls in studies that compared outcomes obtained with different patients before and after therapists received rupture resolution training or supervision. The first of these was the Vanderbilt II study conducted by Hans Strupp and colleagues (Bein et al., 2000). The second was conducted by Crits-Christoph et al. (2006). One study (Hilsenroth, DeFife, Blake, & Cromer, 2007) did not include a control group. While there was no control group in this study, Hilsenroth, Ackerman, Clemence, Strassle, & Handler (2002) did find, with the same sample, that cases treated by therapists who received structured supervision that included an alliance-focused component had significantly higher patient and therapist alliance ratings than cases seen by therapists in a supervision-as-usual condition.

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

Methodological Considerations

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

Results

Table 1 presents the correlations between the presence of rupture-repair episodes and treatment outcome in three studies including a total of 148 patients. The aggregated correlation was .24, $z = 3.06$, 95% CI [.09, .39], $p = .002$, a medium size effect that indicates that the presence of rupture-repair episodes was positively related to good outcome.

Our second meta-analyses examined the impact of rupture resolution training or supervision on patient outcome in eight published studies including a total of 376 patients. Both prepost and group-contrast effect sizes were calculated; the results are presented in Table 2. The mean weighted prepost r for the rupture resolution training studies was .65, $z = 5.56$, 95% CI [.46, .78.], $p < .001$. Given the particularly large effect sizes produced by two studies (Bambling et al., 2006; Castonguay et al., 2004), the

Table 1
Correlation Between Rupture-Repair and Outcome

Study	Treatment	Patient diagnostic criteria	*N*	Outcome measure	*r*	95% CI LL	95% CI UL	*z* value	*p* value
Stiles et al. (2004)	CBT and PI	Depression	79	BDI, GSI, IIP, SAS, Self-esteem	.19	−.04	.39	1.64	.10
Stevens et al. (2007)	BRT, CBT, and STDP	Cluster C or PDNOS	44	GAS, GSI, IIP, TC, WISPI	.26	−.03	.50	1.77	.08
Strauss et al. (2006)	CT for PDs	AVPD and OCPD	25	BDI, SCID II, WISPI	.39	.03	.66	2.12	.03

Note. CBT = Cognitive Behavior Therapy; PI = Psychodynamic-Interpersonal; BRT = Brief Relational Therapy; STDP= Short-Term Dynamic Psychotherapy; CT= Cognitive Therapy; PDNOS= personality disorder, not otherwise specified; AVPD = avoidant personality disorder; OCPD= obsessive-compulsive personality disorder.

results were recalculated excluding these studies (leaving six studies with 252 patients), yielding an effect size of .52, $z = 6.94$, 95% CI [.40, .63], $p < .001$. These results provide evidence that rupture resolution training/supervision led to significant patient improvement; however, with a prepost design, we cannot determine whether this improvement was greater than what patients would experience with treatment from therapists who were not trained in rupture resolution.

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

Moderators and Mediators

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

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

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

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

Limitations of the Research

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

Table 2
Rupture Resolution Training/Supervision Effect Sizes

Study	Treatment	Patient diagnostic criteria	Outcome measure	Prepost *r*	95% CI	*z* value	Control group	Between-groups *r*	95% CI	*z* value
Bambling et al. (2006)	PST with process-focused supervision (N = 34)	Major depression	BDI	.89	[.84, .92]	15.62**	PST with no supervision (N = 38)	.18	[.02, .33]	2.13*
Bambling et al. (2006)	PST with skills-focused supervision (N = 31)	Major depression	BDI	.85	[.79, .89]	13.56**				
Bein et al. (2000)	TLDP (N = 32)	Interpersonal problems	GAS, GSI, IDI, MCMI	.30	[.20, .39]	5.82**	Pre-training (n = 32)	.09	[−.16, .32]	.70
Castonguay et al. (2004)	ICT (N = 11)	Major depression	BDI, GAF, HAM-D	.86	[.77, .91]	9.94**	Wait list (n = 10)	.54	[.21, .76]	3.02**
Constantino et al. (2008)	ICT (N = 11)	Major depression	BDI, BSI	.66	[.51, .78]	6.64**	CT (n = 11)	.19	[−.22, .54]	.92
Crits-Christoph et al. (2006)	Alliance-fostering therapy (N = 14)	Major depression	BDI, HAM-D, QOLI	.57	[.43, .69]	6.72**	Pre-training (n = 14)	.15	[−.23, .49]	.76
Hilsenroth et al. (2007)	STPP (N = 33)	Major depression and BPD	MDE criteria, BSI, GARF	.51	[.44, .58]	11.51**	N/A			
Muran et al. (2005)	BRT (N = 33)	Cluster C PD or PD NOS	GAS, GSI, IIP, TC, WISPI	.38	[.27, .48]	6.41**	CBT (n = 29) and STDP (n = 22)	.02	[−.16, .20]	.19
Newman et al. (2008)	CBT with I/EP (N = 18)	GAD	Assessor severity, daily diary, HAM-A, PSWQ, RRAQ, STAI-T	.69	[.59, .77]	9.86**	CBT with SL (n = 3)	.14	[−.27, .51]	.65

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

are, at this point, limited in number and at an early stage of development (see Safran, Muran, & Eubanks-Carter, 2011, for a review). The most well-established research program in this area (Safran and colleagues) has some verification or hypothesis testing data supporting the model, but even these findings are based on small samples and have not been replicated in multiple samples or by independent investigators.

Therapeutic Practices

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

◆ Practitioners should be aware that patients often have negative feelings about the psychotherapy or the therapeutic relationship that they are reluctant to broach for fear of the therapist's reactions. It is thus important for therapists to be attuned to subtle indications of ruptures in the relationship and to take the initiative in exploring what is transpiring in the relationship when they suspect that a rupture has occurred.

◆ It is probably helpful for patients to express negative feelings about the therapy to the therapist should they emerge or to assert their perspective on what is going on when it differs from the therapist's.

◆ When this takes place, it is important for therapists to attempt to respond in an open or nondefensive fashion, and to accept responsibility for their contribution to the interaction as opposed to blaming the patient for misunderstanding or distorting.

◆ It also proves important for therapists to empathize with their patients' experience and to validate them for broaching a potentially divisive topic in a session.

◆ In some forms of treatment, the primary intervention may consist of the therapist changing the tasks or goals of treatment without necessarily explicitly addressing the rupture with the patient.

◆ In other forms of treatment, resolving alliance ruptures may involve more in-depth exploration of what is transpiring between the therapist and patient as well as in-depth exploration of the patient's experience.

◆ There is also preliminary evidence to suggest that, in some approaches, it may prove useful for the therapist to explicitly establish a link between the rupture event and characteristic interpersonal patterns in the patient's life. This evidence should, however, be cautiously interpreted in light to the growing body of evidence indicating that frequent transference interpretations linking what is taking place in the therapeutic relationship to other relationships in the patient's life can exert negative effects (e.g., Henry, Strupp, Schacht, & Gaston, 1994; Crits-Christoph & Gibbons, & Connolly, 2002). The quality (as opposed to the quantity) of the interpretation and the relational meaning of the interpretation in the context of the emergent therapeutic relationship appear to make the difference between a positive and negative effect on the patient.

References

Aspland, H., Llewelyn, S., Hardy, G. E., Barkham, M., & Stiles, W. (2008). Alliance ruptures and rupture resolution in cognitive-behavior therapy: A preliminary task analysis. *Psychotherapy Research, 18,* 699–710.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16,* 317–331.

Bein, E., Anderson, T., Strupp, H., Henry, W. P., Schacht, T. E., Binder, J., & Butler, S. (2000). The effects of training in Time-Limited Dynamic Psychotherapy: Changes in therapeutic outcome. *Psychotherapy Research, 10,* 119–132.

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy: Theory, Research, and Practice, 79,* 395–418.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Borenstein, M., Hedges, L. V., Higgins, J. P. T., & Rothstein, H. R. (2005). Comprehensive Meta-analysis (Version 2) [Computer software]. Englewood, NJ: Biostat.

Castonguay, L. G., Schut, A. J., Aikins, D., Constantino, M. J., Lawrenceau, J. P., Bologh, L., & Burns D. D. (2004). Repairing alliance ruptures in cognitive therapy: A preliminary investigation of an integrative therapy for depression. *Journal of Psychotherapy Integration, 14,* 4–20.

Colli, A. L., & Lingiardi, V. (2009). The Collaborative Interactions Scale: A new transcript-based method for the assessment of the therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research, 19,* 718–734.

Constantino, M. J., Marnell, M. E., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., & Arnow, B. A. (2008). Integrative cognitive therapy for depression: A randomized pilot comparison. *Psychotherapy: Theory, Research, Practice, Training, 45,* 122–134.

Crits-Christoph, P., Gibbons, P., & Connolly, M. B. (2002). Relational interpretations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 285–300). New York: Oxford University Press.

Crits-Christoph, P., Gibbons, M. B., Crits-Christoph, K., Narducci, J., Schramberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research, 16,* 268–281.

Eames, V., & Roth, A. (2000). Patient attachment orientation and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10,* 421–434.

Eubanks-Carter, C., Muran, J. C., Safran, J. D., & Hayes, J. A. (2010). Interpersonal interventions for maintaining an alliance. In L. M. H. S. Strack (Ed.), *Handbook of interpersonal psychology: Theory, research, assessment and therapeutic interventions* (pp. 684–702). Hoboken, NJ: Wiley.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2009). Rupture resolution rating system (3RS): Manual. New York: Beth Israel Medical Center.

Harper, H. (1989a). *Coding Guide I: Identification of confrontation challenges in exploratory therapy.* Sheffield, England: University of Sheffield.

Harper, H. (1989b). *Coding Guide II: Identification of withdrawal challenges in exploratory therapy.* Sheffield, England: University of Sheffield.

Henry, W., Strupp, H., Schacht., T., & Gaston, L. (1994). Psychodynamic approaches. In A. E. G. Bergin, S. L. (Ed.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 467–508). New York: John Wiley & Sons, Inc.

Hilsenroth, M., Ackerman, S., Clemence, A., Strassle, C., & Handler, L. (2002). Effects of structured clinical training on patient and therapist perspectives of alliance early in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 39,* 309–323.

Hilsenroth, M., DeFife, J., Blake, M., & Cromer, T. (2007). The effects of borderline pathology on short-term psychodynamic psychotherapy for depression. *Psychotherapy Research, 17,* 175–188.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work.* New York, NY: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Consulting and Clinical Psychology, 36,* 223–233.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment, 1,* 46–52.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Counseling and Clinical Psychology, 68,* 438–450.

Mitchell, A., Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). *Version II of the 3RS, a new observer-based system for rating confrontation and withdrawal rupture markers and rupture resolution strategies.* Paper presented at the Society for Psychotherapy Research.

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 46,* 233–248.

Muran J. C., Safran J. D., Samstag, L. W., & Winston, A. (2004). *Patient and therapist postsession questionnaires, Version 2004.* New York: Beth Israel Medical Center.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 42,* 532–545.

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. S. (2008). An open trial of integrative therapy for generalized anxiety disorder. *Psychotherapy: Theory, Research, Practice, Training, 45,* 137–147.

Rhodes, R., Hill, C., Thompson, B., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Counseling Psychology, 41,* 473–483.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy, 43,* 286–291.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work.* New York, NY: Oxford University.

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis *Psychotherapy: Theory, Research, Practice, Training. Special Issue: The Interplay of Techniques and the Therapeutic Relationship in Psychotherapy, 42,* 512–531.

Samstag, L. W., Batchelder, S., Muran, J. C., Safran, J. D., & Winston, A. (1998). Predicting treatment failure from in-session interpersonal variables. *Journal of Psychotherapy Practice and Research, 5,* 126–143.

Samstag, L. W., Mura, J. C., & Safran, J. D. (2004). Defining and identifying alliance ruptures. In D. Charman (Ed.), *Core concepts in brief dynamic psychotherapy* (pp. 187–214). Hillsdale, NJ: Erlbaum.

Sommerfeld, E., Orbach, I., Zim, S., & Mikulincer, M. (2008). An in-session exploration of ruptures in working alliance and their associations with clients' core conflictual relationship themes, alliance-related discourse, and clients' postsession evaluation. *Psychotherapy Research, 18,* 377–388.

Stevens, C. L., Muran, J. C., Safran, J. D., Gorman, B. S., & Winston, A. (2007). Levels and patterns of the therapeutic alliance in brief psychotherapy. *American Journal of Psychotherapy, 61,* 109–129.

Stiles, W. B. (1980). Measurement of the impact of psychotherapy sessions. *Journal of Consulting and Clinical Psychology, 48,* 176–185.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., & Agnew-Davies, R. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology, 51,* 81–92.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., . . . Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74,* 337–345.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 207–210.

Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research, 5,* 189–198.

Received August 19, 2010
Revision received September 9, 2010
Accepted September 10, 2010 ■