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The development of the therapeutic Alliance: Rupture Processes and the Role of the Therapist´s Experience

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THE DEVELOPMENT OF THE THERAPEUTIC ALIANCE: RUPTURE PROCESSES AND THE ROLE OF THE THERAPIST´S EXPERIENCE

ABSTRACT

Ruptures in the Therapeutic Alliance are the main theme of this dissertation, organizing all the studies that compose it. According to Safran and Muran (2000) ruptures may be defined *"as tension or breakdown in the collaborative relationship between the therapist and patient"*. Ruptures may occur when the therapist participates in maladaptive interpersonal cycles similar to those that occur in the patient's other relationships (Safran & Segal, 1990), thus they may contribute to understand the processes that maintain the client´s generalized representations of self-other interactions.

The concept of alliance ruptures that we adopted in this work, proposed by Safran and Muran, was strongly influenced by the Interpersonal Approach to Psychotherapy (Benjamim, 1990; Mitchell, 1993), according to which almost all human behaviors have an interpersonal meaning. As we argue in the first paper of this thesis, within this perspective, the individual´s internal models about the self and the world are structured from the interpersonal experiences he or she lives across life. The alliance is seen as the result of a process of mutual regulation between the therapist and the client, that is influenced by both therapist´s and client´s factors, suggesting that therapist´s variables must also be taken into account in the research of alliance processes.

Several empirical studies that were reviewed in the first paper had indicated that alliance ruptures can promote therapeutic change when efficiently addressed (e.g., Stiles et al., 2004; Strauss et al., 2006), or to premature termination or treatment failure when unresolved (e.g., Tryon & Kane, 1995; Muran, 2002). We were able to replicate this finding in our second study, in which we evaluated the development of the therapeutic alliance in a sample of 47 therapeutic dyads, using longitudinal statistical models. We found that in dropout cases, there was an increase of rupture markers in the period immediately before the patient abandoned therapy. Additionally we found that only in dropout cases the confrontation scores, which measure a subtype of rupture marker, presented a weekly increase.

Following these findings, in the third study, we wanted to look at the negative impact of unresolved ruptures, at a more microscopic level of analysis, by analyzing the interpersonal transactions that occur in cases with unresolved rupture markers. This was done through the intensive analysis of a dropout case in which several ruptures markers

have been identified. Considering the crucial importance of therapist´s factors to therapeutic interaction we also wanted to explore the therapist´s contribution to these unresolved episodes. We found that the number of therapist´s intervention attempts was about four times less than the number of expected interventions according to the Rupture Resolution Model (Safran & Muran, 2000), which may partly contribute to the validation of this resolution model. Interestingly the therapist´s inability to adequately address the ruptures seemed to be more related to training and supervision factors and to the therapist´s internal processes during the rupture events, than to personal variables such as her attachment organization and interpersonal schemas.

This led us to the last study in which we explored the therapists´ and clients´ experience of unresolved alliance ruptures. By interviewing both participants about the same rupture events, we were able to compare their experience regarding important dimensions such as the causes of the event, its resolution and impact. We found that rupture events seemed to involve the previous occurrence of other rupture events and its emergence was associated with the client not being yet prepared to adhere to the therapist´s challenge for novelty. In terms of internal processes during the event, the experience of confusion or ambivalence was frequent for both the therapist and the client, suggesting that ruptures probably activate some kind of surprise or difficulty assimilating the new experience brought on by the episode. Confrontation events seem to activate more negative feelings in both therapists and clients. Therapists were less able to implement rupture resolution interventions in confrontation events, which may be associated with the more negative impact that these events have had in the alliance and in the client.

In this study we decided to work with a sample of personality disordered clients due to the theoretical and empirical evidence (e.g., Benjamin & Karpiak, 2001; Muran, Segal, Samstag, & Crawford, 1994) suggesting that the process of alliance formation may be particularly challenging to these patients, suggesting that it is more likely that ruptures emerge in these cases. This had also been supported by the second study of this work, in which we found that on average personality disordered patients started therapy with a lower alliance score that decreased across time, whereas patients with Axis I disorders started therapy with a higher score that increased across time.

O DESENVOLVIMENTO DA ALIANÇA TERAPÊUTICA: PROCESSOS DE RUPTURA E O PAPEL DA EXPERIÊNCIA DO TERAPEUTA

RESUMO

As Rupturas na Aliança Terapêutica constituem o principal tema desta tese, organizando todos os estudos que a compõem. De acordo com Safran e Muran (2000) as rupturas podem ser definidas como "uma tensão ou quebra na relação colaborativa entre o terapeuta e o cliente". As rupturas podem ocorrer quando o terapeuta participa em ciclos interpessoais desadaptados semelhantes àqueles que ocorrem nas relações do cliente fora da terapia (Safran & Segal, 1990), podendo assim, contribuir para a compreensão dos processos que mantém as representações generalizadas do cliente acerca das interacções com os outros.

O conceito de rupturas na aliança que adoptamos neste trabalho, proposto por Safran e Muran, foi fortemente influenciado pela Abordagem Interpessoal (Benjamim, 1990; Mitchell, 1993), segundo a qual quase todos os comportamentos humanos têm um significado interpessoal. Tal como explicamos no primeiro artigo desta tese, de acordo com esta perspectiva, os modelos internos do sujeito sobre si próprio e sobre o mundo são estruturados a partir das experiencias interpessoais que ele vive ao longo da vida. A aliança é vista como o resultado do processo de regulação mútua que ocorre entre o terapeuta e o cliente, o qual é influenciado quer por factores do cliente, quer por factores do terapeuta, sugerindo que as variáveis do terapeuta devem ser tidas em atenção na investigação sobre a aliança.

Vários estudos empíricos que foram por nós revistos no primeiro artigo, haviam indicado que as rupturas na aliança podem contribuir para a mudança se adequadamente geridas (e.g., Stiles et al., 2004; Strauss et al, 2006), ou para a finalização prematura ou insucesso terapêutico quando não resolvidas (e.g., Tryon & Kane, 1995; Muran, 2002). Estes resultados foram replicados no nosso segundo estudo, no qual avaliamos o desenvolvimento da aliança terapêutica numa amostra de 47 díades terapêuticas, utilizando modelos estatísticos de análise longitudinal. Verificamos que nos casos de *dropout*, houve um aumento dos marcadores de ruptura no período imediatamente antes de o cliente ter abandonado a terapia. Verificámos ainda que, o valor do confronto, o qual mede um subtipo de marcador de ruptura, apresentava um crescimento semanal apenas nos casos de *dropout.*

A partir destes resultados, o nosso objectivo no terceiro estudo foi o de compreender, a um nível de análise mais microscópico, o impacto negativo das rupturas não resolvidas, analisando para isso as transacções interpessoais que ocorrem entre terapeuta e

cliente, em casos com episódios de ruptura não resolvidos. Tal foi feito através da análise intensiva de um caso de *dropout* no qual vários marcos de ruptura haviam sido identificados. Atendendo à importância crucial dos factores do terapeuta para a interacção, pretendíamos também explorar a contribuição do terapeuta para esses episódios não resolvidos. Os resultados revelaram que o número de tentativas de intervenção do terapeuta, foi cerca de quatro vezes inferior ao número de intervenções esperadas, de acordo com o Modelo de Resolução de Rupturas de Safran e Muran (2000), o que poderá em parte contribuir para a validação desse modelo. Curiosamente a incapacidade do terapeuta para lidar de um modo terapêutico com as rupturas, pareceu estar mais associada a factores de treino ou supervisão, bem como aos seus processos internos durante os episódios, do que a variáveis pessoais como a organização de vinculação e o tipo de esquemas interpessoais.

Estes resultados conduziram-nos ao último estudo desta tese, no qual exploramos a experiência de terapeutas e clientes acerca de episódios de ruptura não resolvidos. Ao entrevistar ambos os participantes acerca dos mesmos episódios, fomos capazes de comparar a sua experiência no que se refere a dimensões como as causas do episódio, a sua resolução e impacto. Verificamos que os episódios de ruptura pareciam envolver a ocorrência de episódios prévios semelhantes, e a sua emergência foi associada por ambos os participantes ao facto do cliente não estar preparado para aderir a intervenções mais desafiadoras do terapeuta. Em termos dos processos internos durante o episódio, a experiência de ambivalência ou confusão foi frequente para ambos os elementos, sugerindo que as rupturas provavelmente activam alguma surpresa ou dificuldade em assimilar a nova experiencia trazida pelo episódio. Os episódios de confronto pareceram activar mais sentimentos negativos quer no terapeuta, quer no cliente, sendo que os terapeutas foram menos capazes de implementar estratégias de resolução de rupturas nesses mesmos episódios, o que pode estar associado ao impacto mais negativo que estes episódios tiveram na aliança e no cliente.

Neste estudo seleccionamos uma amostra de clientes com perturbação de personalidade, devido a existência de evidência teórica e empírica (e.g., Benjamin & Karpiak, 2001) que sugere que o processo de formação da aliança pode ser particularmente difícil para estes clientes, fazendo com que seja mais provável a emergência de rupturas na aliança. Tal havia sido também sugerido no segundo artigo, no qual verificamos que em média os clientes com perturbações de personalidade começam a terapia com um valor de aliança mais baixo o qual decresce ao longo do tempo, ao passo que os outros clientes começam a terapia com um valor de aliança superior que aumenta ao longo do tempo.

INDICE

APPENDIXES[1]

[1] The appendixes are available in Portuguese in digital format in the CD enclosed.

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INTRODUCTION

"Ultimately, we only come to truly know and experience ourselves through the eyes, the thoughts and the touch of others."

(Villard & Whipple, p176)

INTRODUCTION

In his classical paper of 1936 Saul Rosenzweig, evoked the Dodo Bird´s Verdict, the famous character from Lewis Carroll´s tale: "*Alice in the Wonderland",* to talk about the equivalent efficacy of different psychotherapies. Several studies (Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986; Wampold, 2001) had shown that theoretically and technically different psychotherapies had similarly good outcomes, reminding Dodo Bird´s exclamation at the end of the famous race in the tale: "Everybody has won, and all must have prizes." Since then, the Dodo Bird Verdict became a metaphor of the common factors perspective in psychotherapy. One of the common factors that has been receiving more attention by researchers and clinicians is the therapeutic alliance.

In our view the increasing interest on the alliance is related with the undeniable interpersonal nature of the psychotherapeutic encounter. In fact, beyond its technical dimensions underlying the different theoretical orientations, psychotherapy may be seen essentially as an encounter between *two persons*. However, this is a very peculiar interpersonal encounter because it is intended to promote change in one of its elements - the patient - and it has very specific limits and rules. The idiosyncrasy of this relationship is reflected on most of the existing definitions of the therapeutic alliance.

Among these definitions, the one proposed by Edward Bordin in 1979, was maybe the first that attributed a transtheoretical nature to the concept of the alliance, which freed the concept from the exclusive relationship to the psychodynamic model in which it had had its origins. According to Bordin´s definition, the alliance has three main dimensions: an agreement on therapeutic goals; an agreement on the therapeutic strategies that allow for the achievement of those goals and an emotional bond between

the therapist and the client. Thus the author argues that the alliance comprises some instrumental dimensions more oriented to the therapeutic work and other emotional and affective dimensions, assuming however the interdependence between both. The importance of the ideas of agreement and collaboration underlying Bordin´s definition, that has its origins in the first formulations of the therapeutic relationship made by Freud, is intimately associated with the notion of *negotiation* of the alliance.

Several authors (Benjamim, 1990; Mitchell, 1993) had argued that the essence of the psychotherapeutic process lies in the negotiation between two subjectivities: that of the therapist and that of the patient. In fact, at each moment of the process, each aspect of the alliance is negotiated between both participants in the interaction. This negotiation may be around instrumental aspects such as the therapeutic goals, the schedule and the frequency of the sessions, or it may be related with emotional aspects such as the code of affective behavior between the patient and the therapist.

The ongoing negotiation that occurs, in a more or less explicit way, between both elements of the therapeutic dyad, is what can lead to the emergence of Ruptures in the Therapeutic Alliance – the main subject of this doctoral dissertation, which cuts across all the papers included in this work. This dissertation is composed by four studies: a theoretical paper and three empirical papers. Each study corresponds to one chapter: chapter I correspond to the theoretical paper and chapter II, III and IV correspond to the three empirical papers. In this introduction we´ll briefly describe each of the studies and we will also introduce the reader to the concept of alliance ruptures.

Alliance ruptures have been referred to in the literature by other related concepts: Bordin (1994) uses the concept of strains in the alliance, Lansford (1986) talks about of weakenings and repairs of the alliance, Kohut (1984) refers to empathic failures and Elkind (1992) uses the concept of therapeutic impasses. However the

concept that inspired our work was the one proposed by Safran in 1993, and developed by Safran and Muran in 1996 and 2000.

According to Safran, Muran, Samstag and Stevens (2002), a rupture in the therapeutic alliance may be defined as: "a tension or breakdown in the collaborative relationship between patient and therapist", that may consist of "disagreements about the tasks of treatment, disagreements about the goals of treatment or strains in the bond" (p.236). In their paper of 2006, Safran and Muran argue that although they had defined the concept in various ways in their initial work, ruptures may be more broadly defined as "problems in the quality of relatedness" or "deteriorations in the communicative process." The authors point out that this definition modifies the traditional conceptualization of the alliance as collaboration, and stress the importance of the alliance as a context of authentic relatedness.

Safran and Muran´s conceptualization of the alliance was strongly influenced by contemporary relational psychoanalytic thinking (Mitchell & Aron, 1999). One of the assumptions of relational thinking is that the individual is continually negotiating the needs of the self and the needs of the other. This stems from the fact that the human being is inescapably connected to others, in that, he depends on others to form and maintain his sense of self (Mead, 1934), and he is biologically programmed to seek proximity with other people (Bowlby, 1969; Stern, 1985). However, the individual has also an independent and separate existence from others that comes from the fact that his social environment can never be completely attuned to his needs. As a result the individual spends his life negotiating a paradox between two opposite needs: the need for affiliation or relatedness and the need for agency or self-individuation.

Throughout life these needs coexist in a dialectic tension, and over the time the individual is continually negotiating these needs, trying to find a balance between them,

one that is never fully achieved, and that depends on the interactions he/she establishes with others (Safran & Muran, 2000).

In the psychotherapeutic context, alliance ruptures, are moments in which this human paradox becomes more salient, in that ruptures demonstrate that even in a context of relational proximity, the patient has a separate existence from that of the therapist, an existence with independent wants, needs and wishes. Thus ruptures are moments, in which the patient´s difficulty in negotiating the tension between the needs for agency and relatedness, become more evident.

When coping with this tension, patients differ regarding the type of need they tend to favor (Safran & Muran, 2000), depending on the way during their history significant people had been responsive to both types of needs. Some favor the need for relatedness and affiliation over the need for agency. These patients correspond to *anaclitic* depressives described by Sidney Blatt (Blatt & Blass, 1992), who had developed an anxious dependence on others. According to the author, other individuals prioritize the needs for agency and control; these are patients with *introjective* depression who are compulsively self-reliant and focused on maintaining their autonomy. Depending on the way the patient copes with this tension, ruptures in the alliance may assume different forms. This difference was the basis for the distinction between withdrawal and confrontation ruptures (Harper, 1989; Safran, 1993).

In withdrawal ruptures, when dealing with the difficulty in negotiating the therapist´s needs and his owns needs, the patient avoids or partially disengages cognitively or emotionally from the therapist or some aspect of the therapeutic process (Eubanks-Carter, Mitchell, Muran, & Safran, 2009). Due to his difficulty in affirming his needs within the relationship, the patient expresses it in an indirect way in an attempt to protect the therapist and the relationship. He may adopt a deferent and

compliant posture or answer the therapist in a clipped way accommodating to what he is proposing even if he does not agree with it. The patient may also deny or intellectualize negative emotions or use storytelling as a way of avoiding the contact with his/her immediate experience of the session.

On the contrary, in confrontation ruptures, the patient expresses in a direct way his anger or dissatisfaction with the therapist or the therapeutic process. In these cases, he may express his negative feelings in a hostile way, which may lead to the establishing of an interpersonal cycle of hostility-counter-hostility between the therapist and the patient. Safran and colleagues assume that in some episodes, elements of both withdrawal and confrontation may be present.

Once we consider that this is a clinically relevant distinction, we have taken it into account in all the studies of this dissertation, which we will describe in what follows.

In the first paper, the argument that alliance ruptures and its resolution may be crucial to the change process in psychotherapy is presented in light of the Interpersonal Theory. This theoretical paper explores the notion, that is shared by all the relational models, that our sense of self is structured from the interpersonal experiences we live with significant others throughout life.

Moreover, in this paper, we make an incursion into the field of psychodynamic theory, by exploring some differences between the Harry Stack Sullivan´s Interpersonal Theory (1953) and other relational models such as Fairbairn´s Theory of Object Relations (1952) and Kohut´s Self Psychology (1977).

The stability of the internal models about the self and the world, which are formed through the internalization of interpersonal experiences, is also discussed in light of the Attachment Theory. In light of this theoretical framework, we argued that

this stability may be interrupted by therapy, which occurs when therapy offers an emotional corrective experience to the client - a concept proposed by Alexander and French (1946). Once again, we elaborate on some of the differences between these authors' conceptualization of emotional corrective experience and the one from contemporary interpersonal theorists such as Hoffman, particularly in what concerns the role of the therapist. These interpersonalists question the therapist´s ability to control spontaneous contra-transference reactions and deliberately assume a different attitude from the one that pathogenic figures had assumed in the past. Thus these authors assume that there´s an irreducible subjectivity in everything that the therapist says or does in therapy (Renik, 1993; as cited in Safran, 2000).

We think that the importance attributed by Safran and colleagues to the contribution of therapist´s factors to the therapeutic interactive matrix is what better distinguishes their concept of alliance ruptures from similar constructs. The way these authors formulate the concept of alliance ruptures is framed in the above mentioned contemporary relational models, according to which the alliance is no longer seen as the result of the patient´s transference dynamics, but as the result of the mutual influence between the therapist and the client. From a neutral observer of the patient´s internal processes, the therapist comes to be seen as an active coparticipant in the interaction. This assumption integrates a *Two Person Psychology*, in which the object of study is neither the client nor the therapist, but the patient-therapist relationship, and the way the characteristics that each member brings to the process, shape the interactive matrix that is present at any given moment. The contribution of the therapist´s variables to the development and negotiation of the alliance constitute the second axis that organizes this dissertation.

Personality disorders constitute the third axis that is present in all the studies included in this dissertation. Our research interest by personality disorders came from theoretical and empirical evidence, indicating that ruptures in the alliance may be clinically more relevant to this the group of patients.

From the theoretical perspective of interpersonal models, when the early relationships with important care figures are disturbed, rigid internal schemas about the self and the world, in which the individual anticipates the unavailability and/or rejection from others, are formed. These are the schema we normally find in personality disordered patients. The interpersonal model also argues that the level of flexibility of the individual´s interpersonal schema, predicts his/her ability to anticipate and attribute meaning to the experience. In other words, if the individual has a restricted view of self and others, he/she won´t be able to integrate the diversity of experiences.

Thus, the inflexibility of patients with personality disorders limits the lack of interpersonal behaviors from others that are able to confirm the patient's self concept. The lack of flexibility of the patient´s interpersonal behavior, may compromise the flexibility of the therapeutic relationship, that is, to rigid and repetitive behaviors, the therapist tend to answer with equally rigid and repetitive behaviors, confirming the patient´s dysfunctional interpersonal schema. This is how it becomes more likely that alliance ruptures occur during the therapeutic process with these patients. The fact that personality disorders patients are particularly challenging in what concerns the process of alliance development has been demonstrated by several studies (e.g., Benjamin & Karpiak, 2001; Muran, Segal, Samstag, & Crawford, 1994).

Considering this, the first empirical study of this dissertation aimed to analyze the development of the alliance in clinical cases of axis I and axis II disorders of the DSM-IV. The studies we included in the empirical review of the first paper, indicated

that ruptures may promote therapeutic change if adequately dealt with (Kivlighan & Shaughnessy, 2000; Stiles et. al., 2004; Strauss et al., 2006) or lead to clinical failure or unilateral termination when unresolved (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995; Muran, 2002). Thus, one of the goals of this study was to detect the emergence of ruptures and its impact on the therapeutic process, in both types of disorders. The sample of 47 therapeutic dyads included cases with different types of termination and degree of clinical success (successful, unsuccessful and dropout cases) and different types of diagnosis (axis I and axis II disorders).

The second goal of this study was related to a methodological question: we wanted to see how different methods of rupture detection relate to each other. We compared two of those methods: the self report measure and an observer based measure of rupture detection. This goal was partially due to our initial difficulties in detecting alliance ruptures through the post session questionnaire´s section in which we directly asked the therapist and the client about the emergence of these episodes.

This study´s findings revealed that, in dropout cases, there was an increase of rupture markers in the period immediately before the patient abandoned therapy, which led us to the need to look at the negative impact of unresolved ruptures, at a more microscopic or molecular level of analysis.

In the third study we intended to respond to that research goal by analyzing the interpersonal transactions established between the therapist and the client in a moment to moment basis, and the way they shape the alliance development, namely the rupture´s emergence. This analysis was done in a clinical case study in which several unresolved ruptures led to the dropout.

The abovementioned assumption of the inevitable contribution of the therapist, not only as a technician but also as a person, to every aspect of the therapeutic process,

led us to include in this case study analysis the therapists' personal variables such as his attachment organization and interpersonal schemas. This option was also supported by recent empirical evidence suggesting that the therapist´s factors explain around 9% of the outcome variance (Wampold, 2001; Huppert et al., 2001).

The fact that the results of this study seemed to suggest that more dynamic variables, such as the therapist´s internal processes during the episode, were more determinant for the way ruptures were dealt with, than more static variables such as the therapist´s interpersonal functioning, led us to direct our research goals to the therapist´s experience.

This gave rise to the last study of the dissertation, in which we analyzed the therapists' and patients´ experience of alliance ruptures. We questioned the participants about dimensions such as the rupture´s causes, its resolution and its impact on the process and also their thoughts and feelings during the event. We selected a sample of patients with personality disorders, due to our previously mentioned research interest in this group. We used the Consensual Qualitative Research (Hill, Thompson, & Williams, 1997), in order to understand the therapist´s and the patient´s experience of 14 withdrawal events and 13 confrontation events. The analysis of the consistencies and discrepancies between both therapists' and patients' perspective on the same rupture events, reflect our preference to look at the dyad rather than looking at each of its members individually. As we mentioned before this preference relates to the Two Person Psychology paradigm.

The findings of these studies will be discussed on the conclusion chapter of the thesis.

CHAPTER I

RUPTURES IN THE THERAPEUTIC ALLIANCE: ITS ROLE ON CHANGE PROCESSES ACCORDING TO A RELATIONAL APPROACH

CHAPTER I
RUPTURES IN THE THERAPEUTIC ALLIANCE: ITS ROLE ON CHANGE PROCESSES ACCORDING TO A RELATIONAL APPROACH[1]

1. ABSTRACT

This article presents the basic theoretical assumptions of a Relational Approach to Psychotherapy, particularly in what concerns the interpersonal roots of psychopathology and consequently the way the relational experience therapy provides, may serve to change the client's dysfunctional interpersonal schema subjacent to symptoms. In the second part of the article we present the concept of Ruptures in Therapeutic Alliance, seen as a tension or breakdown in the collaborative relationship between the therapist and the patient. The most important findings that have been collected about the way alliance ruptures can lead to change when efficiently addressed, or to poor outcome or unilateral termination when unresolved, are reviewed in the last part of the paper. Having already accumulated enough evidence about the importance of the therapeutic alliance, a second generation of alliance researchers is now trying to understand the way the alliance is a mechanism of change. The findings reviewed in this paper suggest that the process of repairing weakened alliances may offer an answer to that question.

2. INTRODUCTION

When we think in a psychotherapeutic encounter, in a classical individual setting, we immediately come across the idea of two persons sitting together, engaged in the task of observing one of the elements` internal processes. This relational nature is maybe what best characterizes any psychotherapeutic process.

[1] This work was published in 2009 in the Journal *Análise Psicológica (Vol. 4, p.* 479-491), in coautorship with Eugenia Ribeiro and Jeremy Safran.

According to an Interpersonal Approach to therapy, the process of change that occurs in the client, and eventually in the therapist, is better understood through the processes of development and negotiation of the therapeutic alliance.

Our main argument in this article is that, despite the theoretical approach adopted in a given therapy, the process of development of the therapeutic alliance, particularly the process of going through moments of impasse and ruptures in the relationship between therapist and client, and resolving them in an efficient way, is the main vehicle of change.

In what follows we will first present the theoretical groundings of our argument, derived from an Interpersonal Perspective and then review the empirical evidence that supports it.

3. THE INTERPERSONAL APPROACH

Within an interpersonal or relational theoretical approach, any human behaviour has an interpersonal meaning and may be understood through the principles of human interaction. According to this perspective almost all human needs and motivations are achieved in a social context, and even when we're alone we are still influenced by our internal representations of the others (Mead, 1934). Thus what we call personality must be seen as the social product of the interactions we form and maintain with significant figures in our lives.

This assumption that the intrapsychic is structured in a dynamic way from the interpersonal experiences is central to any interpersonal approach (Sullivan, 1953).

The centrality of the relational experiences to the self development is a common aspect to other approaches such as the British Object Relations theory, the Self Psychology, and the Attachment Theory. As Ghent (2002) suggested: "The term,

relational, was first applied to psycho-analysis by Greenberg and Mitchell back in 1983 when they abstracted the term from Sullivan's theory of interpersonal relations and Fairbairn's object relations theory"(p. 12.)

There is however important differences between the interpersonal approach and the British object relations theory, for example. As Benjamin (1990) so clearly illustrated, the term object itself is a legacy of the classic psychoanalytic intrapsychic theory and Fairbairrn's (1952) concept of object relations, referring to the internalization of the interaction between self and objects, had only let us recognize that "*where ego is, objects must be*". Benjamin argues that the tendency to collapse other subjects into objects is a problematic aspect in psychoanalysis, one that a relational theory should resolve, by defending that "where objects were, subjects must be". As the author points out: "the other must be recognized as another subject in order for the self to fully experience his or her subjectivity in the other´s presence" (p. 35). In the same paper, Benjamin stressed the differences between a relational approach and self psychology, particularly Kohut´s self psychology (1977). She argues that self psychology has been understanding the parent-child relationship in a one-sided way in that "the self was always the recipient not the giver of empathy", as if the other would just have the role of stabilizing the self and respond to his needs, instead of helping the self to learn how to truly recognize the other and be aware of the outside, which is more coherent with a real interpersonal approach.

The author that is seen as the father of the interpersonal perspective is Harry Stack Sullivan (1953). He developed a theory that explains the way psychopathology develops and consequently the way human change may take place.

His Theory of the Interpersonal Introjection (Sullivan, 1953) argues that our self-concept develops through the internalization of the way others communicate with us

and about us in the past, that is, people learn to relate to themselves in the same way significant others related to them. Relationships with primary caregivers lead to repertoires of internal models about the self and the world that determine subsequent interpersonal relations. In other words, internal models lead people to engage in interpersonal transactions that confirm them through the dynamics of interpersonal complementarity (Kiesler, 1983). When the early relationships with caregivers and other figures are disturbed, the individual internalizes the unavailability and/or rejection of the other, which manifests itself in the formation of internal schemas of self-destruction and self-judgment.

Despite the use of different terminology, several theoretical orientations, agree that these internal models are directly associated with the affective experience and the maladaptive behavioural patterns underlying psychopathological symptoms (Schacht, Binder, & Strupp, 1984). Thus psychopathology is seen in terms of recurrent patterns of maladaptive interpersonal behavior, because the internal schemas are acted out in the subsequent interactions the individual participates. When interacting with others, the individual tries to consolidate the image he constructed about himself, thus these confirmatory interactions are complementary by nature (Kiesler, 1996).

The individual with a psychopathological functioning has a very rigid image about himself and the others, which can only be validated through a restricted set of behaviors from the other. As an example, we may think of someone with a narcissistic personality disorder, whose sense of superiority and grandiosity needs to be continually confirmed by a behavior of submission and admiration by others. These individuals are often perceived by others as someone who coerces them to adopt a particular interactional pattern, which may lead others to respond by distancing or rejecting them. Thus there's usually a vicious circle in which the disturbed individual becomes more and more

isolated. This feeling of isolation may be interpreted by the subject as an evidence of his uniqueness and superiority, at a surface level, and at the same time he is confronted with the lack of love and support from others, confirming this way his negative interpersonal schema. This is the process through which internal models tend to remain relatively stable throughout the life span (Sullivan, 1953).

Empirical evidence for the notion of stability of internal models comes from longitudinal studies in the Attachment Theory field. In 2000, Waters, Weinfield and Hamilton presented three long-term longitudinal studies which assessed infant and adult attachment. The authors found that attachment security was significantly stable in two of the three studies. In all of them the discontinuity in the attachment security was related to salient life events and external circumstances. Another number of studies from the Minnesota parent-child project, that has been following families at risk for more than thirty years, have been showing that when the contexts keep relatively stable an insecure attachment in infancy is strongly related with behavioural problems in the pre-school and school years and with psychopathology in adolescence (Sroufe, Egeland, Carlson, & Collins, 2005). Hence there´s seem to be contextual variables that determine the degree of stability of internal working models across the life span, suggesting that despite the importance of early experiences, the content of the individual´s internal models may change across the life span.

The relational experience offered by therapy might constitute one of the contexts in which this change takes place. As other relationships, the one established between the therapist and the client is the relational stage in which client´s interpersonal schemas are acted out, therefore the interpersonal transactions between the therapist and the client may function to perpetuate client's internal schema, or to disconfirm them through an *emotional corrective experience*. The concept of emotional corrective experience has its

origins in the Franz Alexander, who argued that the fact that the analyst's reactions are different from that of the patient´s parents is a crucial therapeutic factor because it "...gives the patient an opportunity to face again and again, under more favorable circumstances, those emotional situations which were formerly unbearable and to deal with them in a manner different from the old…"(Alexander & French, 1946, pp. 66-67)" About a decade later, Alexander further elaborated the concept, arguing that the analyst should use his knowledge about the patient´s early interpersonal experiences to intentionally assume a different attitude from the parental original one. This new attitude was likely to correct the pathogenic emotional influences of the patient´s early experiences.

As Wallerstein (1990) illustrated, some authors like Gill saw the concept of emotional corrective experience as proposed by Alexander as not analytic, once the goal of psychoanalysis is an intrapsychic modification in the patient. In fact, it is easy to see how Alexander´s concept defies Freudian classic psychoanalytic principles of the analyst neutrality. As Gill (as cited in Wallerstein, 1990) noted: "Certainly to meet the patient's transference behavior with neutrality is to give him a corrective emotional experience without the risks attendant on taking a role opposite to that which he expects"(p. 292).

Relational approaches influenced both by British Fairburn´s object relation theory and American Sullivan´s Interpersonal theory, argue that the relationship with a consistent and trusting figure may function to correct the previous disturbed relationships. It´s easy to recognize that this view resembles Alexander ideas about the emotional corrective experiences though, according to Wallerstein (1990), there are still important differences to note. The new interpersonal relationship therapy offers is also very much valued by relational approaches, but they question the kind of deliberate

ability to control the spontaneous countertransference processes advocated by Alexander. Interpersonalists like Hoffman stress the fact that the therapist is constantly vulnerable to countertransference reactions likely to repeat the patient´s interpersonal patterns.

The concept of emotional corrective experience lead us to think that the alliance can no longer be seen as a precondition that allows the implementation of specific intervention strategies, but it must be seen as an active mechanism of change, due to the opportunity it offers to challenge the client´s dysfunctional interpersonal schema.

Thus the therapeutic alliance should not be separated from the technical aspects of therapy. As Strupp, Butler and Rosser (1988) pointed out the distinction between specific and non-specific psychotherapeutic factors is erroneous, because differently from a pharmacological treatment in which the biochemistry action may be distinguished from the symbolic meaning of the treatment, psychological interventions can never be disconnected from the relational context in which they are applied.

Referring to the topic of non-specific factors in therapy, Castonguay (1993) illustrates the distinction between them and common factors, stressing that the alliance constitutes a common factor in therapy, but not a non-specific factor. This is to say that not only the alliance is present in every therapy (dynamic, humanistic or cognitive-behavioural), but it is also a concrete mechanism that helps us understand why people change in therapy. This justifies the importance of therapeutic interventions directly addressing the alliance formation and development.

4. THE THERAPEUTIC ALLIANCE

This concept of therapeutic alliance has its origins in Freud´s early theoretical work on transference (1912). The author pointed out the importance of the positive

transference to the success of the analytic process. From Freud´s pioneering work different perspectives on the therapeutic relationship emerged. The origins of the concept of therapeutic alliance are attributed to Elizabeth Zetzel (1956), who saw it as an aspect of the total analysand-analyst relationship based on the capacity and willingness of the patient's to ally with the analyst and the work of analysis in order to achieve the understanding and cure. She argued that the patient´s capacity to form a trusting relationship with the therapist, which is essential to the alliance formation, depends on early developmental experiences. She was also one of the first authors who pointed out the distinction between the "real" and the transferential aspects of the relationship between therapist and patient.

Influenced by ego analysts who focused on the real aspects of the therapeutic relationship, Greenson (1971) developed the notion of the working alliance which is seen as the ability of the patient and the therapist to work collaboratively in the treatment goals they pursue. He used the term working alliance to stress the patient´s willingness to actively cooperate in the treatment and follow the therapist insights and instructions.

Luborsky (1984) also proposed that the therapeutic alliance was one of the curative factors of dynamic therapy. The author defined the strength of the alliance as its capacity to withstand the stresses from internal and external sources without breaking and its degree of persistence and dedication in the therapeutic work for overcoming obstacles in one´s self. Luborsky tried to articulate both the conscious-rational versus unconscious-transferential aspects in his concept of therapeutic alliance, as well as the facilitative versus active ingredient dichotomy.

According to Safran and Muran (2000), within the relational approaches the concept of the therapeutic alliance it is no longer seen as a reflection of the patient´s

transference, instead it is seen as an ongoing negotiation process between two different subjectivities. In other words it is a product of a mutual influence between therapist and patient that occurs at both conscious and unconscious levels. This conception of the alliance has to do the increasing importance of therapist´s flexibility and spontaneity and authentic aspects of the therapeutic relationship within these approaches.

The therapeutic alliance as proved to be an important component of change within psychotherapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Safran, Muran, Samstag, & Stevens, 2002), however the question clinicians and researchers try to answer in the present, has to do with the way it can function as a mechanism of change.

Therefore, we need to formulate more specific research questions about the relation between alliance and outcome, particularly in what concerns the way this relationship is mediated by the emergence of alliance ruptures and their effective negotiation.

5. INTERSUBJECTIVE NEGOTIATION AND ALLIANCE RUPTURES

Because as we mentioned before, the therapeutic relationship is essentially an encounter of two different persons, there are some periods in which the negotiation between these two subjectivities can lead to moments of ruptures and impasse in the relationship. Safran and Muran´s conceptualization of alliance ruptures (2000) was influenced by the assumption that human beings are always struggling with the challenge of learning to negotiate the needs of the self versus the needs of others (Benjamim, 1990; Mitchell, 1993). This negotiation serves an important human function: the definition of who we are in the relationship with the other.

The authors argue that, even in a very directive and structured therapy, the negotiation between the needs of the patient and those of the therapist, is always

present, even if it takes place without conscious awareness. During rupture episodes the process of negotiation becomes more explicit, thus ruptures can be an opportunity for the patient to learn how to negotiate the needs of self and the needs of the other in a constructive fashion, without compromising the self or treating the other as an object. This capacity was referred by Benjamim (1990) as the capacity for intersubjectivity - the capacity to experience both self and other as subjects - which is a necessary condition to develop a true capacity for intimacy or authentic relatedness. This notion illustrates the process of mutual recognition and regulation in psychotherapy and is inspired by feminist psychoanalytic criticism and Hegel philosophy.

According to Hegel (as cited in Safran & Muran, 2000), in order to develop a sense of subjects or the experience of oneself as a self, we need the recognition of the other, but at the same time the other is a danger for us because it threatens our self-sufficiency. Thus the individual tries to control him to assure his sense of independence, however if he controls the other destroying his subjectivity, he can no longer constitute an independent existence necessary to confirm his existence as a subject. Therefore the individual is always caught up in this paradox in which the need for relatedness or proximity colludes with the need for agency or autonomy.

In the therapeutic situation this paradox is also present, and becomes even more evident in moments of ruptures and strains in the alliance, in which both elements are experiencing the tension between the need for recognizing and negating the other as a separate centre of subjectivity. Influenced by Winnicott´s thinking (1969), Benjamin points out that using the other as the object of one's aggression, can at the end make us experience him as an independent subject, who was able to survive our intent of destruction, and can thus confirm our own subjectivity.

Interestingly, Bordin's (1979) conceptualization of the Alliance, contemporary to Benjamin's perspective, as comprising an agreement on therapy tasks and goals and the bond, also stresses the opportunity that therapy offers to clients (and eventually to therapists according to a real interpersonal model) to learn how to negotiate the needs of the self versus the needs of the others. This is a tension human beings have to deal with in every interpersonal situation and many of our clients` problems come from difficulties in managing this in a satisfactory way.

According to Bordin´s conceptualization we may think in an alliance rupture as consisting in a disagreement about the goals of therapy (e.g., the patient seeks the improvement of his social abilities and the therapist considers the goal should be understand the relation between social anxiety and infantile experiences), about the tasks (e.g., the patient is expecting a more didactic strategy, with the use of role play and modelling exercises and the therapist considers that it is important to adopt experiential strategies as the empty chair technique) and a strain in the bond (e.g., the patient feels the therapist is being critical and not supportive).

All these examples can lead to deterioration in the relationship between therapist and patient. Moreover all the examples given, illustrate the need to learn how to deal in a constructive way, with the paradox between the need for maintaining relatedness with others and the need for self-definition.

Individuals differ in the way they tend to deal this paradox: there are some clients that privilege the need for relatedness, developing an anxious dependence on others. They may give up on their own needs and wishes in order to keep the proximity with others. With these clients it's more frequent to detect withdrawal rupture markers, in which the patient partially disengages from the therapist his/her emotions or experience of the therapeutic process (Safran & Muran, 2000).

There are other patients however, who privilege the need for self-agency, developing a compulsive self-reliance. They may sacrifice their needs for proximity and care and present themselves in a controlling and dominant way in the relationships. In these cases confrontational rupture markers, in which the patients directly express their anger or dissatisfaction with the therapist or the therapy, are more frequent (Safran & Muran, 2000).

These different tendencies derive from the internal schemas about the self and the world developed in the early relationships with important figures, as mentioned earlier.

When these internal schemas are acted out in the therapeutic relationship, the client is *inviting* the therapist to behave in a way that confirms his schema. For example, a very submissive patient who has learned that the expression of anger and other negative feelings can lead to the other's response of rejection and abandonment, may present himself in a very deferential way in therapy, coercing the therapist to behave in a more dominant way. As mentioned earlier, this is justified by the principles of interpersonal complementarity: submissive behaviour is complementary to dominant behaviour. If the therapist responds in a way that confirms the patient's dysfunctional interpersonal schemas, he participates in maladaptive interpersonal cycles similar to those that occur in the patient's other relationships (Safran & Segal, 1990). Moments of rupture or impasse suggest thus a critical opportunity to explore and understand the processes that maintain the client´s generalized representations of self-other interactions (Safran & Muran, 2000).

As Safran and Muran (2000) argue they are also an entry point to what Greenson (1971) has defined as the central feature of the therapeutic alliance: the collaboration between patient and therapist in the task of observing the patient's experience. In this perspective the building and repair of the alliance is more than the establishment of a

relation to facilitate treatment acceptance. It corresponds to the treatment itself by breaking the interpersonal cycles that maintain the client's dysfunction.

6. REVIEW OF EMPIRICAL EVIDENCE

One of the most robust findings in psychotherapy research has to do with the association between the quality of the therapeutic alliance and the therapy outcome. In the first meta-analysis of 24 studies Horvath and Symonds (1991) found a correlation of 0.26 and more recently Martin et al. (2000), in an attempt to update the previous meta-analysis with several studies that had been conducted more recently, found a correlation of 0.22. The authors stress that although this is a moderate correlation, it seems to be very consistent across different studies and reliable. They argue that due to the increasing quality of the research on this topic derived from the refinement of the measures, we may rely on these results.

However, the relationship between alliance and outcome is not free of controversy mainly due to the limitations of the studies reporting it.

First it is reasonable to think that some methodological aspects may interfere with the relationship found between alliance and outcome. According to Luborsky (1994) some of such factors are: the type of measure that is used (whether it is a self-report questionnaire or an observer judgement); the point of view that is used (patient´s, therapist's, observer´s); variations in the size of the database used for the alliance measure; the moment in which alliance is measured (whether it is in the initial stages of alliance development or it is measured repeatedly across therapy) and also the length of treatment.

On the other hand the relationship between alliance and outcome is mediated by other variables such as the client and therapist´s personal characteristics and the type

of treatment that is conducted. In what concerns the treatment modality the majority of studies looking at this relationship are still with dynamic therapies, however the alliance seems to be a significant predictor in other therapies as well (Marmar, Gaston, Gallagher, & Thompson 1989, as cited in Luborsky, 1994).

Concerning the mediating effect of client´s characteristics, research indicates that the quality of early experiences with parents affects clients' ability to form a working alliance with their therapist (Mallinckrodt, 1991). Also client´s mental health facilitates the formation of the alliance. Goldman (2005) found that the more comfortable a client was with closeness and intimacy, the higher the client rated the working alliance.

On the therapist side, certain characteristics and behaviors (e.g., warmth, flexibility, accurate interpretation) are positively associated with strong alliances (Ackerman & Hilsenroth, 2003), while others (e.g., rigidity, criticalness, inappropriate self-disclosure) interfere negatively with the alliance formation (Ackerman & Hilsenroth, 2001). Also therapists who relate in an hostile manner toward themselves are more likely to act in an hostile way toward their clients (Henry, Strupp, Butler, Schacht, & Binder, 1993).

As Barber and colleagues pointed out in 2000, another limitation of most of the studies reporting a relationship between alliance and outcome, is the fact that they also do not control the influence of the early improvement in that relationship. Most of them assessed change in outcome without controlling the effect of the early symptomatic improvement. In order to address that limitation Barber and colleagues in 2000, examined change in outcome from the time alliance was assessed, so that they could take into account the role of previous symptomatic improvement on subsequent symptom change. The authors were able to find for the first time that alliance at

sessions 2, 5 and 10 significantly predicted subsequent symptomatic change in dynamic therapy. Their findings suggest that although the alliance early in treatment might be influenced by previous symptomatic change, it is still a significant predictor of subsequent improvement.

Although the findings about the relationship between alliance and outcome do not address the topic of alliance ruptures, we may see them as an indirect sort of evidence of their importance, because if a strong alliance is somehow related to good outcome cases, the process of repairing breakdowns in its quality, is supposed to be related to good outcome cases. This proposition is supported by the fact that weakened alliances are associated with dropouts (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995).

The strength of the alliance varies over the course of treatment, thus decreases in its quality, that is, alliance ruptures, are almost inevitable in therapy. Binder and Strupp (1997) in a revision about negative processes in therapy, concluded that the kind of interpersonal process involved in rupture resolution is present in every therapy, independently of the theoretical approach.

Although moments of impasse or rupture in the alliance may occur quite often, it is not always easy, for therapists, to identify them. One of the evidences comes from Rennie´s qualitative study (1994), which used the grounded theory to analyse tape assisted recalls of fourteen patients gathered immediately following an hour of therapy. The author found that patients not always reveal their feelings of discomfort or dissatisfaction, presenting themselves in a deferential way in the session. They hide their negative reactions in an attempt to protect the therapist and maintaining the relationship, which suggests that it is very important for therapists to remain attentive to

shifts in the alliance, even when they are subtle, and address them in a way that allows the client to explore his concerns without anxiety.

Regan and Hill (1992) findings go in the same direction. They asked twenty four patients and respective therapist to report on thoughts and feelings that they were unable to express in treatment, using the Things Left Unsaid Inventory and the Session Evaluation Questionnaire. They then asked the therapists to guess what patients had left unsaid. They found that even experienced therapists were able to identify only 17% of the covert processes of their patients, that is to say, feelings and cognitions they had felt but were not able to express.

Two years later Rhodes, Hill, Thompson and Elliot (1994) asked nineteen therapists and therapists-in-training to recall misunderstanding events from their own treatment and made a qualitative analysis of the events. Client satisfaction was measured by Client Satisfaction Questionnaire and the addressed versus unaddressed misunderstanding events were measured by Retrospective Misunderstanding Event Questionnaire. They found that in all the cases, the misunderstanding was associated to one of the following situations: the therapist had done something the client didn't wanted or needed (e.g., therapist gives unwanted advice), or the therapists failed to do something the patient wanted or needed (e.g., therapist fails to remember important details). In a resolved misunderstanding event, the patient was able to assert negative feelings and therapist remained flexible and accepting, recognizing his responsibility for the event or changing his behaviour. In contrast, in non-resolved events, patients concealed from their therapists their negative emotions and therapists remained unaware of what was happening until the patient quit therapy.

Therapists´ unawareness of patient's negative reactions can be detrimental to outcome because therapists cannot explore and deal with client's reactions they are not

aware of. However, even if none of the elements is aware of each other´s covert processes they still interfere with treatment.

On the other hand, some studies suggest that therapists´ awareness of their client's negative reactions is not always beneficial to treatment (Fuller & Hill, 1985; Martin, Martin, & Slemon, 1987). As Safran, Muran, Samstag and Stevens (2001) argue, we may interpret this evidence hypothesizing that therapists become more rigid in their adherence to a specific treatment model instead of addressing the strain in the alliance they just detected, in a flexible and open way, Another explanation the authors point out has to do with therapists expression of their own negative feelings as a way to cope with their clients dissatisfaction.

Therapist´s "retaliation" may compromise the alliance and the agenda of the session, and, at the same time, it may confirm the patient dysfunctional interpersonal schemas of hostility, for example. Any interpersonal schema is formed within a relational scenario and contains information of the form: "if I do X others will do Y" (e.g. "if I'm angry others will retaliate"), so an hostile client who goes through this cycle of hostility-counter-hostility in therapy is collecting more evidence that being aggressive is the only way of being in the world.

In a study of change in cognitive therapy, Castonguay, Goldfried, Wiser, Raue and Hayes (1996) clarified the hypothesis that therapists may become more rigid when they are aware of their client´s negative reactions. In thirty cases of brief cognitive therapy they correlated the outcome measure (Beck Depression Inventory), the Working Alliance Inventory, the Experiencing Scale and the Coding System of Therapist Feedback. They found something unexpected: therapist's focus on the impact of distorted cognitions of depressive affect was negatively linked with outcome. Conducting a more intensive qualitative analysis of those poor outcome cases, they

realized that therapists, when confronted with ruptures, adhered in an even more rigid fashion to the cognitive model, becoming more and more focused on challenging distorted cognitions.

A similar process of therapist´s rigid adherence to the model might have happened in another study of Piper, Azim, Joyce, and McCallum (1991). Sixty-four dyads composed the sample and the treatment consisted of 20 sessions of short term psychodynamic therapy. Therapist Intervention Rating System was used to categorize interventions and a comprehensive set of outcome measures was provided by patients, therapists and independent assessors. The authors found that the increased proportion of transference interpretations was negatively associated with both the quality of the alliance and outcome. A subsequent qualitative analysis suggested that therapists may have used transference interpretations to deal with an impasse in the alliance, but the way that intervention was used increased the vicious cycle both therapist and patient were involved. Although these results didn't consider the adequacy of the interpretation, nor the type of patient or phase of therapy as intermediate variables, they seem to suggest that an inflexible adherence to any specific technique, as a way of avoiding the exploration of the here and now of the relationship, is counter-productive.

This is supported by studies in which the therapists were able to be flexible and open to the exploration of the immediate relational context of the session. Foreman and Marmar (1985), in a small sample study correlated the California Therapeutic Alliance Scale with patient, therapist and independent ratings of outcome and compared to a list of therapist actions. They found that interpretations focused on client's defences against feelings about the therapist or the therapeutic relationship, improved the alliance and were related to good outcome. By contrast interpretations that didn't address directly the alliance impairment were not helpful.

One year later Lansford (1986) correlated measures of initial alliance, alliance weakness and repair with observer ratings of outcome. The author was able to find an important result: the higher levels of patient alliance ratings were preceded by episodes of rupture and repair, in which both elements were able to talk about the interaction, and the level of successful resolution of these episodes was related with good outcome. And once again more transference allusions were present in poor outcome cases.

All the studies mentioned above are more qualitative and tried to detect the emergence of alliance ruptures at a molecular or microscopic level.

However there is another set of studies which address the possible benefits of alliance rupture resolution processes at a more global or macroscopic level, analysing the pattern of development of therapeutic alliance over the course of treatment.

Drawing on theoretical and research literature and using clinical examples Gelso and Carter in a paper of 1994, examined the idea consistent with Mann´s theory (1973) that there are different stages in the process of alliance development. Those stages are: the initial phase characterized by patient's optimism and positive expectations; an intermediate stage in which the patient questions the value of therapy and its usefulness and finally, when this ambivalence is successful dealt with, the patient experiences positive reactions, this time more reality based.

Golden and Robbins (1990) found through the analysis of two successful cases, that patient's alliance ratings increased, dropped and increased again during the course of the therapy. The authors used the Vanderbilt Psychotherapy Process Scales and the Working Alliance Inventory to determine patterns of alliance development.

Using a quantitative methodology, studies by Patton, Kivlighan, and Multon (1997) and Kivlighan and Shaughnessy (2000) collected empirical support to the hypothesis that a quadratic high-low-high pattern of alliance development was related to better

outcome. In the first study Patton et al. videotaped sixteen patients and six therapists over two semesters and using hierarchical linear model analysis found that a quadratic pattern of alliance development was present and related to improved outcome. In the second study by Kivlighan and Shaughnessy (2000), the authors used cluster analysis, instead of hierarchical linear model, to determine patterns of alliance development which were then correlated with the Inventory of Interpersonal Problems and the Battery of Interpersonal Capabilities. Again the high-low-high quadratic pattern was found to have the greatest association with treatment outcome.

In an attempt to replicate the results of the previous study, Stiles and colleagues (2004) measured alliance fluctuations in different types of therapy for depression, using data from the Second Sheffield Psychotherapy Project. The alliance was measured by the Agnew Relationship Measure and outcome was measured by the Beck Depression Inventory and Brief Symptom Inventory. The authors could not find the same ***U*** pattern identified by Kivlighan and Shaughnessy (2000) four years before, and none of the four patterns they found was differentially associated with good outcome. However, further analysis lead to the identification of a subset of patients, who went through rupture-repair sequences. These clients with brief ***V*** shaped deflections were those who presented better outcomes.

In a more recent study, Strauss et al. (2006) found, in a sample of 30 patients with obsessive-compulsive and avoidant personality disorder receiving cognitive therapy, that the sequences rupture-resolution were significantly related with symptom relieve, both in depressive and personality symptoms, respectively assessed by the Beck Depression Inventory and the Wisconsin Personality Disorders Inventory. These gains were registered even after controlling for the effect of the number of sessions and the

early in-treatment improvement. The alliance was measured by the California Psychotherapy Alliance Scale.

We may conclude that the investigation of alliance ruptures episodes seems to be a promising research topic for clinicians and academics who believe that the therapeutic alliance is more than a non-specific factor in therapy.

We believe that in the future the efforts to replicate with larger samples the findings about the effect size of the alliance on the outcomes, should be replaced by the effort to clarify the processes by which the alliance namely the negotiation of ruptures plays its role.

The process of alliance development and its interaction with the patient´s change process is a multidimensional and very complex one. Thus in order to improve our knowledge on this processes, researchers need to address specific questions such as the way the patient´s and the therapist´s characteristics interact with the process of alliance formation; the role that the patient's internal representation of the therapeutic relationship plays in the change process; the way that the mutual regulation between the therapist and the patient that occurs in resolved rupture episodes may contribute to change.

We believe that these research questions might require a shift from larger samples and quantitative methods, to single case designs and qualitative analysis methods. This might also require a shift from a more molar level of analysis to a molecular one, focused on the micro analysis of moment to moment shifts in the interactive process of the therapeutic dyad. As Ackerman and Hilsenroth (2003) suggest:

> … it is likely that the most promising strategy for future research may be to examine the interpersonal exchanges between the patient and therapist that impact alliance

development. Investigating these in-session interactions may deepen our understanding of the nature of alliance development and the specific variables impacting it. (p.29)

7. REFERENCES

Ackerman, S.J. & Hilsenroth, M.J (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy Practice and Research,* 38,(2), 171-185.

Ackerman, S.J. & Hilsenroth, M.J (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 23, 1–33.

Alexander, F., & French, T.M. (1946) *Psychoanalytic Therapy.* New York: Ronald Press

Barber, J.P., Conolly, M.B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2000) *Alliance Predicts Patients' Outcome Beyond In-Treatment Change in Symtoms.* Journal of Consulting and Clinical Psychology, 68, 1027-1032

Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology*, *7,* 33-46.

Binder J.L., & Strupp, H.H. (1997). Negative process: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults". *Clinical Psychology Science and Practice, 4,* 121-139.

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

Castongway, L.G. (1993). "Common factors" and "nonspecific variables": Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration, 3,* 267–286.

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J. & Hayes, A.M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factores. *Journal of Consulting and Clinical Psychology, 64,* 497-504.

Fairbairn, W.R.D. (1952) *Psychoanalytic studies of the personality*. London: Tavistock.

Foreman, S.A., & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry, 142*(8), 922-926.

Freud, S. (1912/1958). The dynamics of transference. In standard edition (Vol.12, pp. 97-108) London: Horgarth Press.

Fuller, F., & Hill, C.E. (1985). Counselor and helpee perceptions of conselor intentions in relation to outcome in a single counselling session. *Journal of Counselling Psychology, 32,* 329-338.

Gelso, C.J., & Carter, J.A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296-306.

Ghent (2002) http://www.iarpp.org/library/download/enews1pdf

Greenson, R. (1971). The real relationship between the patient and the psychoanalyst. In M. Kanzer (ed), *The unconscious today* (pp.213-232). New York: International Universities Press

Golden, B.R.; Robbins, S.B. (1990) The working alliance within time-limited therapy: A case analysis. *Professional Psychology: Research and Practice. 21*(6), 476-481.

Goldman, G.A. (2005). *Quality of object relations, security of attachment, and interpersonal style as predictors of the early therapeutic alliance.*. Unpublished doctoral dissertation, Ohio University, Athens.

Henry, W.P., Strupp, H.H., Butler, S.F., Schacht, T.E., & Binder, S.L. (1993) Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61,* 441-447.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology, 38,* 139-149.

Kiesler, D.J. (1983). The 1982 Interpersonal Circle: A taxonomy for complementarity in Human transactions. *Psychological Review, 90,* 185 – 214.

Kiesler, D.J. (1996). *Contemporary interpersonal theory and research: Personality, Psychopathology and Psychotherapy*. New York: Wiley.

Kivlighan, D.M. & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counselling Psychology, 47,* 362-371.

Lansford, E. (1986). Weakenings and Repairs of the Working Alliance in Short-Term Psychotherapy, *Professional Psychology, Research and Practice, 17*(4), 364-366.

Loewald, H.W. (1972). Freud's Conception of the Negative Therapeutic Reaction, with coments on instinct theory. *Journal of the. American. Psychoanalytic. Association*. *20*, 235-245.

Luborsky, L. 1984 Principles of Psychoanalytic Psychotherapy: *A Manual for Supportive-Expressive (SE) Treatment* New York: Basic Books.

Luborsky (1994) *Therapeutic Alliances as Predictors of Psychotherapy Outcomes: Factors Explaining the Predicitve Sucess*, In: Horvath A. & Greenberg (Eds) The Working Alliance: Theory, Research and Practice (pp. 51-84) New York: Wiley.

Mallinckrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. *Journal of Counseling Psychology, 38,* 401–409.

Mann, J. (1973).*Time-limited psychotherapy*. Cambridge, MA: Harvard University Press.

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 Consulting and Clinical Psychology , 68*(3), 438-45

Martin, J., Martin, W., & Slemon, A. (1987). Cognitive Mediation in person-centered and rational-emotive therapy. *Journal of Counselling Psychology*, 34, 251-260.

Patton, M.J., Kivlighan, D.M., Jr., & Multon, K.D. (1997). The Missouri Psychoanalytic Counselling Research Project: Relations of changes in counselling process to client outcomes. *Journal of Counselling Psychology, 44*, 189–208.

Piper, W.E., M., Azim, H.F. A., Joyce, A.S. & McCallum, M. (1991). Transference Interpretations, therapeutic alliance and outcome in short term individual psychotherapy. *Archives of General Psychiatry, 48*, 946-953.

Regan, A. M., & Hill, C. E. (1992). Investigation of what clients and counsellors do not say in brief therapy. *Journal of Counselling Psychology, 39*, 186-174.

Rennie, D.L. (1994). Client's deference in psychotherapy. *Journal of Counselling Psychology, 41*(4), 427-437.

Rhodes, R.H., Hill, C.E., Thompson, B.J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counselling Psychology, 41*(4), 473-483.

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 & Research, 5*, 126-143

Safran, J. D., Segal Z. (1990), *Interpersonal Process in Cognitive Therapy.* Aronson London

Safran, J.D.; Muran, J.C. (2000). *Negotiating the Therapeutic Alliance, A Relational Treatment Guide*. New York: The Guilford Press.

Safran, J.D.; Muran, J.C.; Samstag, L.W.; Stevens, C. (2001). Repairing Alliance Ruptures, *Psychotherapy*, *38*, 406-412.

Safran, J.D.; Muran, J.C.; Samstag, L. W., & Stevens, C. (2002). Repairing Alliance Ruptures. In Norcross (Ed.), *Psychotherapy Relationships That Work*, (pp. 235-254). New York: Oxford University Press.

Schacht T. E., Binder J. L., & Strupp H. H. (1984). The dynamic focus. In H. H. Strupp & J. L. Binder (Eds.), *Psychotherapy in a New Key* (pp. 65-109). New York: Basic Books.

Sroufe, L.A., Egelend, B., Carlson, E. & Collins W.A. (2005) *The development of the person: The Minnesota study of risk and adaptation from Birth to Adulthood*. New York. Guilford Publications.

Stiles, W. B., Glick M. J, Osatuke K., Hardy G. E., Shapiro D. A., Agnew-Davies R., Rees A., & Michael Barkham (2004). Patterns of Alliance Development and the Rupture–Repair Hypothesis: Are Productive Relationships U-Shaped or V-Shaped*? Journal of Counseling Psychology*, *51*(1), 81-92.

Strauss J. L., Hayes A.M., Johnson S. L., Newman C. F., Brown G. K., Barber J., Laurenceau J., & 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*(2) 337–345.

Strupp, H.H., Butler, S.F., & Rosser, C.L. (1988). Training in Psychodynamic Therapy. *Journal of Consulting and Clinical Psychology*, *56*, 669-689.

Sullivan, H.S. (1953) *The Interpersonal Theory of Psychiatry*. New York: NortonTryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance and type of therapy termination. *Psychotherapy Research*, *5*, 189-198.

Villard K.L., & Whipple, L.J. (1976). *Beginnings in Relational Communication*. John Wiley & Sons Inc

Wallerstein, R.S. (1990). The Corrective Emotional Experience: Is Reconsideration Due?. *Psychoanalytic Inquire, 10*, 288-324.

Waters, E., Weinfield, N. & Hamilton, C. (2000). The stability of attachment security from infancy to adolescence and early adulthood: General Discussion. *Child Development, 71*(3) 703-706.

Winnicott, D.W. (1969) The Use of an object. *International Journal of Psychoanalysis, 50*, 711-716.

Zetzel, E.R. (1956). Current Concepts of Transference. *International Journal of Psycho-Analysis, 37*, 369-375.

CHAPTER II

THE DEVELOPMENT OF THE THERAPEUTIC ALLIANCE: ASSESSING RUPTURE EVENTS TROUGH DIFFERENT METHODS

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THE DEVELOPMENT OF THE THERAPEUTIC ALLIANCE: ASSESSING RUPTURE EVENTS TROUGH DIFFERENT METHODS[2]

1. ABSTRACT

The main goal of this study is to compare two methods of evaluating the development of the therapeutic alliance particularly the emergence of alliance ruptures: the self report questionnaire (WAI) and an observational system of rupture markers. Our sample included 47 therapeutic dyads including dropouts, successful and unsuccessful cases. The sample was composed by patients with personality disorders and patients with axis I disorders. At the end of each session, alliance was measured using the WAI filled by the patient. Six judges trained in the observational system of rupture markers rated 201 videotaped sessions from this sample. The two methods were highly consistent with each other. On average personality disordered patients started therapy with a lower WAI score that decreased across time, whereas Axis I patients started therapy with a higher score that increased across time.

2. INTRODUCTION

Ruptures in therapeutic alliance, seen as moments in which the collaborative relationship between therapist and patient is compromised, constitute inevitable and clinically relevant events in therapy. According to Bordin´s (1976) conceptualization of the alliance, we may think of an alliance rupture as a disagreement on the goals and/or tasks of therapy; and a strain in the bond.

[2] This work was submitted to the Journal *Psychotherapy Research*, in coautorship with Eugenia Ribeiro, Ines Sousa and Jeremy Safran

According to Safran and Muran (2000) there are two main types of alliance ruptures. In withdrawal ruptures, in moments of tension or inability to negotiate the alliance, the patient in some way avoids or moves *away* from the therapist or from the therapeutic process. The patient may give minimal responses to the therapist´s questions or may be overly deferential and appeasing. By withdrawing from his/her internal experience of dissatisfaction or discomfort with therapy, the patient tries to protect the relationship. In contrast, in confrontational ruptures, the patient expresses in a direct and sometimes hostile way his anger or dissatisfaction which may lead to a cycle of hostility-counter-hostility. For example, the patient may complain about the therapist as a person or may try to pressure or control the therapist telling him what to do.

In the great majority of therapeutic cases, even in the successful ones, one or more alliance ruptures emerge in any moment of the process (Safran, Muran, & Samstag, 1994). Its emergence and intensity seems to depend on several factors, such as the kind of theoretical orientation that is being used in the process, the therapist´s factors, the problem the patient presents and also his or her personal features, such as interpersonal schema and personality organization. In fact patients with a rigid interpersonal functioning such as those who present a personality disorder diagnosis, seem to be particularly challenging when it comes to the process of alliance formation (Benjamin & Karpiak, 2001; Muran, Segal, Samstag, & Crawford, 1994; Muran et al., 2009). Due to their inflexible patterns of interpersonal behavior they tend to evoke in the therapist stronger negative reactions, which, if not appropriately dealt with, may lead to the repetition in the therapeutic interaction of the patient´s typical dysfunctional interpersonal cycles. Therefore the process of resolution of alliance ruptures may play a crucial role in the treatment process of patients with an Axis II disorders.

Most of the time, ruptures are not easily recognized either by the therapist or the patient, which prevents the possibility of resolving them and use them to defy patient´s dysfunctional interpersonal patterns. The frequent difficulty in detecting rupture episodes makes the topic of the efficiency of different methods of rupture identification a relevant one. Thus the main purpose of this paper is to contribute to that research topic by comparing the alliance development when assessed by different methods.

The topic of alliance development and ruptures emergence has received the attention of different authors. Several studies (Golden & Robbins, 1990; Patton, Kivlighan, & Multon, 1997; Kivlighan & Shaughnessy, 2000; Stiles et al., 2004), tracked the alliance development across time, and, using different longitudinal statistical methods, were able to identify distinct patterns of development and its association with outcome.

In general the above mentioned studies seem to suggest that both a linear increase and a quadratic high-low-high pattern of alliance development were related to good outcome. In the study by Stiles et al. (2004), the authors could not find the quadratic pattern but were able to identify a subset of patients who went through rupture-repair sequences signalized by brief ***V*** shaped deflections. Those were the patients who presented better outcomes. These results were replicated by Strauss et al. (2006) who found, in a sample of patients with obsessive-compulsive and avoidant personality disorders, receiving cognitive therapy, that the sequences of rupture-resolution were significantly related with symptom relieve both in depressive and personality symptoms.

All the previous studies used self-report methods, which, in fact, constitute one of the most used strategies of assessing the alliance. In their review on alliance measurement, Corbella and Botella (2003) found that there are more than 20 measures of alliance self-report measures. Examples of widely used measures are the California

Psychotherapy Alliance Scale (Marmar, Weiss, & Gaston, 1989); the Helping Alliance Questionnaire (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985) and the Working Alliance Inventory (Horvath & Greenberg, 1989) which was the measure used in the present study.

Despite the benefits of self-report questionnaires such as its easier administration and results interpretation, this is not always the best method to evaluate the alliance. As with any other self-report method, the way the subject responds to the questionnaire depends on several factors, such as his/her degree of social desirability or even his/her momentary subjective experience when completing the questionnaire (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). This seems to be particularly relevant when it comes to the alliance evaluation as studies on patient´s deference to the therapist indicate (Rennie, 1994). Often patients are not able or willing to reveal their discomfort or dissatisfaction with the therapist or any aspect of the therapeutic process (Regan & Hill, 1992; Gonçalves, 2009). Thus the same kind of protection of the therapeutic relationship that happens in withdrawal ruptures may also occur when the patient is completing the post-session self-report measures, that is, the patient may try to protect the therapist or the therapeutic relationship by evaluating the quality of the alliance in a positive way.

Thus, as Westen and Shedler, (1999, as cited in Colli & Lingiardi, 2009) pointed out, self-report measures of alliance may be flawed because of bias on the subject´s part or poor self-reflection and because they rely on a retrospective recall of the session. In session relational episodes, such as alliance ruptures, may evoke in the patient emotional experiences of anxiety, anger and guilt, which may make them difficult to acknowledge or be remembered by the patient.

Therefore, the limitations of self-report methods for alliance evaluation have implications for the detection of alliance ruptures as we may see when we look at the results of the frequency of ruptures identified with different methods. In studies in which ruptures are detected through the use of self-report measures (Nagy, Safran, Muran, & Winston, 1998), the frequency of ruptures ranged from 11% to 38%, according to the patient perspective and from 25% to 53% according to the therapist perspective. However, when ruptures are evaluated through observational systems, the percentage of ruptures detected is significantly higher: 77% in the study of Sommerfeld, Orbach, Zim, & Mikulincer (2008). In a sample of 20 CBT cases, Muran, Safran, Gorman, Eubanks-Carter, & Banthin (2008) found that patients reported ruptures in 11.2% of the sessions and in 60% of the cases, while indirect measurement of ruptures, based on analysis of patients' alliance (WAI) ratings using control charting, identified ruptures in only 8.67% of the sessions, but in 100% of the cases.

Additionally, the frequency of ruptures that are reported seems to depend on the perspective that is used in the study. Therapists in the study by Eames and Roth (2000) reported ruptures in nearly half of the sessions, whereas, patients reported them in just under one fifth.

Discrepancies were also found in a recent study in which twenty sessions that had been evaluated by the patient as having a very high alliance (score higher than 6 for the total WAI score), were rated with the Ruptures Resolution Rating System (Infante, 2009). From the twenty sessions analyzed, fourteen presented at least one rupture marker, which corresponded to 70% of the sample. A total of eighteen withdrawal markers and twenty one confrontation markers were found, which means that the patients rated the quality of the alliance very positively, despite problems that were occurring in the alliance.

As we can see, previous longitudinal studies (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006) that used self-report methods were already able to discriminate different patterns of alliance development and its relationship with therapy success; however, there are other studies (Sommerfeld et. al., 2008; Muran et al., 2008), that make us think that, at least, in what concerns the detection of alliance ruptures, the observational systems may be more efficient.

Considering the discrepancy that exists between studies that use self-report measures and those that use observational systems, in this paper we aimed to explore the following research question:

How do these two methods of alliance´s evaluation relate to each other in cases with different type of diagnostic (axis I versus axis II disorders) and in cases with different outcome/type of therapy termination (dropout, successful and unsuccessful cases)?

3. METHOD

3.1 Participants

The sample was composed by forty-seven therapeutic dyads participated in the study. Although, due to the impossibility to rate the videos of all the cases for the comparative analysis of the two measures a subset of 35 cases was used. The patients were seen in a university clinical center, presenting different psychopathological and psychological problems. The final sample ranged in age from 18 to 56 years old with a mean age of 29 (*SD*= 8.24) years. Sixty-eight percent (n=32) were female. This subsample included 10 successful cases, 19 dropouts and 6 unsuccessful cases. The distinction between success and unsuccessful cases was based on the clinical criteria, considering the therapeutic gains that the client made by the time therapy terminated. In unsuccessful cases there was an agreement on the termination, but the therapist considered the client had not yet

achieved the necessary therapeutic goals; in successful cases the therapist considered that the client had made significant clinical changes and in dropout cases the client had dropped from therapy without letting the therapist know. The subsample included 30 cases of different Axis I disorders (depression and anxiety disorders) and 8 cases of Axis II disorders (Clusters B and C). The diagnosis were based on the DSM and were established by researcher-clinicians that administered the Structured Clinical Interview for DSM-IV I and II (First, Spitzer, Gibbon, & Williams, 1995), as a part of the assessment protocol used in the university clinical center.

3.2 Treatment

The treatment consisted of weekly sessions of cognitive-behavior therapy. With personality disordered patients, the treatment process incorporated principles of cognitive interpersonal therapy (Safran & Segal, 1990). Therapists´ level of experience ranged between 2 and 5 years of clinical practice. Although treatment adherence was not measured in this study, the weekly supervision received by the therapists monitored therapists´ adherence to the CBT protocol.

3.3 Measures

Working alliance - WAI- cl (Working Alliance Inventory, Horvath & Greenberg, 1989): The WAI measures the three dimensions of the working alliance (goals, tasks and bond) independent of the therapist's theoretical orientation. Internal consistency estimates for the WAI range from .88 to .93 for the WAI–cl (Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990). Considerable evidence of validity has been amassed for the WAI (Horvath & Symonds, 1991). The Portuguese version of the WAI has good levels of internal consistency and reliability for the total scale and each subscale

(Machado & Horvath, 1999). The short form of the WAI that was used in this study includes 17 items on a 7-point Lickert scale anchored by 1 (*never*) and 7 (*always*); higher scores reflect stronger therapeutic alliances. This questionnaire was a part of a more global measure of the session: the Post Session Questionnaire (PSQ; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Alliance ruptures - 3Rs (Rupture Resolution Rating System, Eubanks, Mitchell, Muran, & Safran, 2009): The Rupture Resolution Rating System is an observational system of rupture markers and its resolution. While watching the session, the rater decides if there is any moment of a lack of collaboration or tension between therapist and patient which indicates the emergence of a rupture. Then the rater decides on the type of rupture that is present: confrontation ruptures (when the patient moves *against* the therapist by expressing anger or dissatisfaction) and/or withdrawal ruptures (when the patient either moves *away* from the therapist or the patient moves *toward* the therapist, but in a way that denies an aspect of his/her experience). For each confrontation or withdrawal marker identified, the rater should choose a specific category of rupture marker (e.g., denial, complains about the progress of therapy, etc) and rate its clarity and intensity in a 5 Lickert scale. An overall withdrawal and confrontation score is also attributed to the session. This score ranges from 1 *"Withdrawal/confrontation ruptures did not occur, no significance for the alliance."* to 5 *"Withdrawal/confrontation rupture(s) occurred, major significance for the alliance".* In this study the inter-rater agreement assessed with the Intraclass Correlation Coefficient (ICC), was very satisfactory. The ICC calculated based on 30% of the total number of sessions was .73 for the withdrawal global ratings and .96 for the confrontation global ratings.

3.4 Procedures

This study belongs to a research project that was approved by the Scientific Council of the University of Minho, and permission was also obtained from the University Clinical Center to realize the study in that institution. Patients were informed about the implications of their participation in the research and, after that, they signed an informed consent[3].

After completing the PSQ, at the end of each session the patients were instructed to introduce their forms in a closed envelope, so that the confidentiality of the answers was assured. They were informed that only the researchers would have access to their evaluation of the therapeutic alliance in order to reduce social desirability effects.

A total of 201 videotaped sessions were rated by 6 judges who had received a weekly training of two months on this observational system and got reliable in its rating as the ICC values demonstrate. The number of rated sessions per case is variable because some sessions had not been recorded.

3.5 Data Analyses

3.5.1 Non-Parametric Analyses

We have considered a non-parametric smoother to summarize the trend of the response variable as a function of the type of diagnostic and the type of therapy termination. The advantage of such smoother is that we do not have to impose any rigid form for such function. This non-parametric estimate emerges as a solution of an optimization problem, of minimizing simultaneously the residual sum of squares and second derivative of such a function (Hastie & Tibshirani, 1990).

[3] The informed consent for the therapist and the client that were used in all the studies of the dissertation may be found in the Appendix I.

3.5.2 Parametric Analyses

We have used a longitudinal statistical model, including a subject specific random intercept, as well as a serial correlation component with an exponential correlation structure (Diggle, Heagerty, Liang, & Zeger, 2002). This can also be called a mixed effect model, as it models parametrically both the expected value and the correlation structure in the data. Let Y_{ij} be the WAI score measured at subject i in session j.

Remember j is a natural number, of the session number, and these are by design at distance of one. However, there are some situations of intermittent *missingness*, which are assumed to be missing completely at random (Little & Rubin, 1987). We assume the model

$$Y_{ij} = \mu_{ij} + U_i + W_i(t_{ij}) + \epsilon_{ij}$$

where, U_i is a subject specific random intercept with distribution N(0, ν^2), the stochastic process $W_i(t_{ij})$ is a serial correlation within subject with variance σ^2 and correlation structure Corr($W_i(t_{ij}), W_i(t_{ik})$) = exp(-ϕ $|t_{ik} - t_{ij}|$). The term ϵ_{ij} is the measurement error from the distribution N(0,τ^2). This model allows us to separate the different sources of variability, the variability between subjects, within a subject, and measurement error.

We fit the model to the data available using maximum likelihood techniques, and made inference about the parameters of interest. Under the model fitted, we detect sessions that have a higher than population average decrease in alliance score WAI. We have used the variance of the serial correlation process to detect ruptures in the alliance.

The data analysis was developed using the R software: *http://cran.r-project.org*

4. RESULTS

We´ll present the results of the alliance development when assessed by each method. We´ll first present the results of the self report method that corresponds to the WAI score, and then the results of the scores attributed by the judges using the observational system (3RS). The 3RS measures the intensity of both withdrawal and confrontation rupture markers that correspond respectively to the global withdrawal and confrontation scores. Because we wanted to analyze the relationship between the different methods in cases of different outcome and different patient´s diagnosis, for each variable (WAI, Withdrawal score and Confrontation score), we divided the sample according to the patient´s type of diagnosis (Axis I or Axis II disorder) and according to the type of therapeutic termination the case has had (whether successful, unsuccessful or dropout).

4.1 Nonparametric models

4.1.1 WAI Results

The black solid line in the plot of Figure II - 1 represents the non-parametric estimate of the observed data (Keele, 2008) with respective 95% confidence intervals, within each group.

As we can see, on average, there was an initial increase in the alliance until the fifth session, which seems to constitute a turning point from which the variability between individuals increases. In both success and unsuccessful cases, the alliance kept increasing, whereas in the dropouts the alliance stopped increasing.

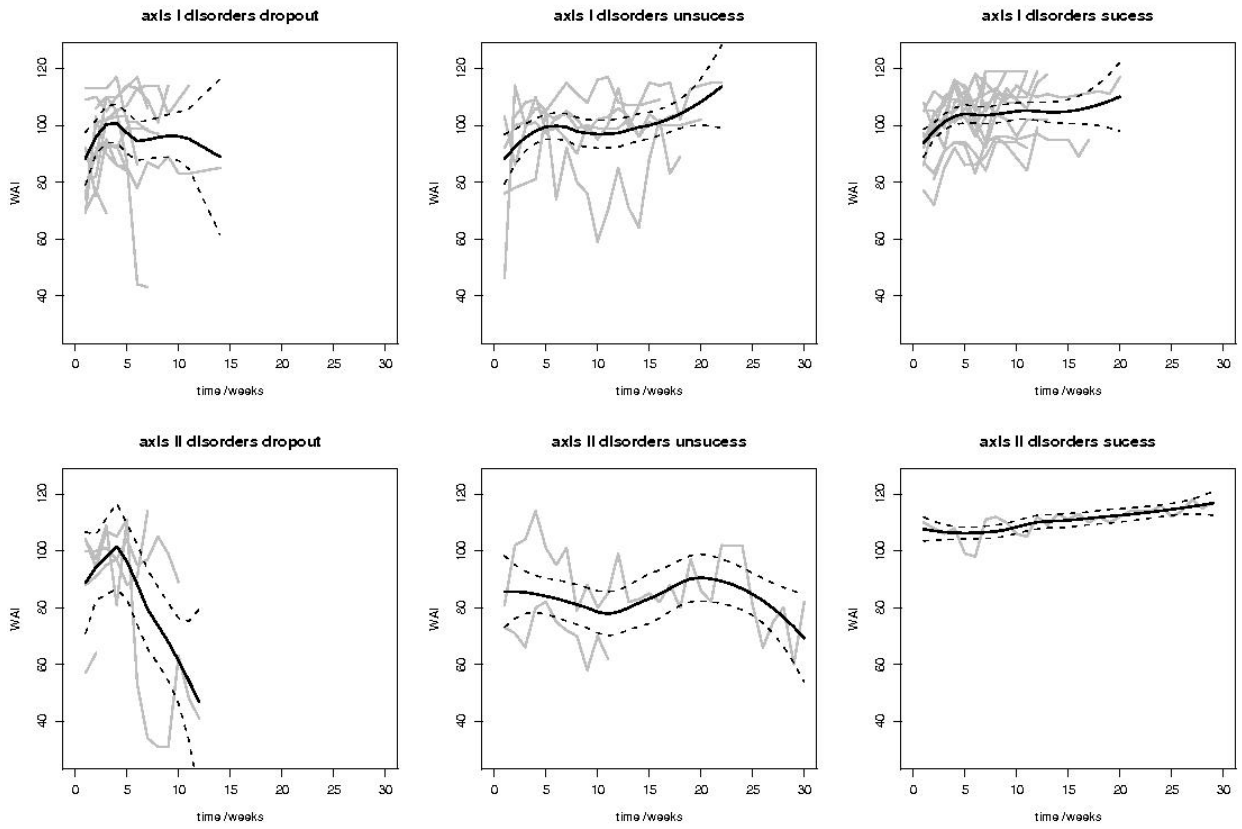

Figure II - 1. Individual longitudinal profiles and non-parametric estimate for population average for WAI scores.

Note. The grey solid line represents the Individual longitudinal profiles, the black solid line represents the non-parametric estimate for population average and the black dash lines represents, the 95% confidence intervals.

By plotting the data with the time 0 corresponding to the last session of each patient (see Figure II – 2), we were able to see what happened with the alliance immediately before the patient leaves treatment. We observe that in the dropout cases, there was a decrease in the alliance before the patient left treatment, while in the other cases, the decrease in the alliance before the last session did not occur.

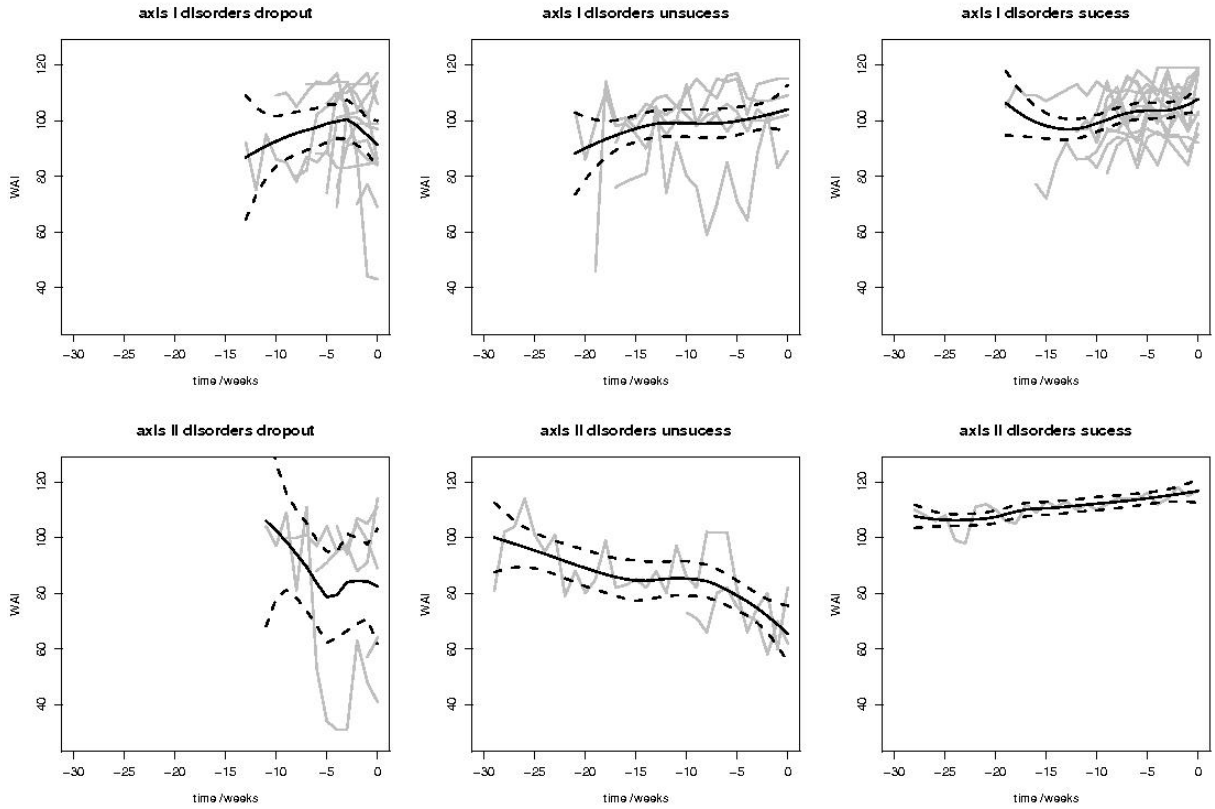

Figure II- 2. Individual longitudinal profiles and non-parametric estimate for population average for WAI scores when time 0 is the time of the last observation.

4.1.2 Confrontation Results

In what concerns the confrontation scores (see Figure II - 3), in the dropouts, the confrontation scores increased right from the beginning; whereas, in both success and unsuccessful cases, confrontation was stable in the initial phase of therapy.

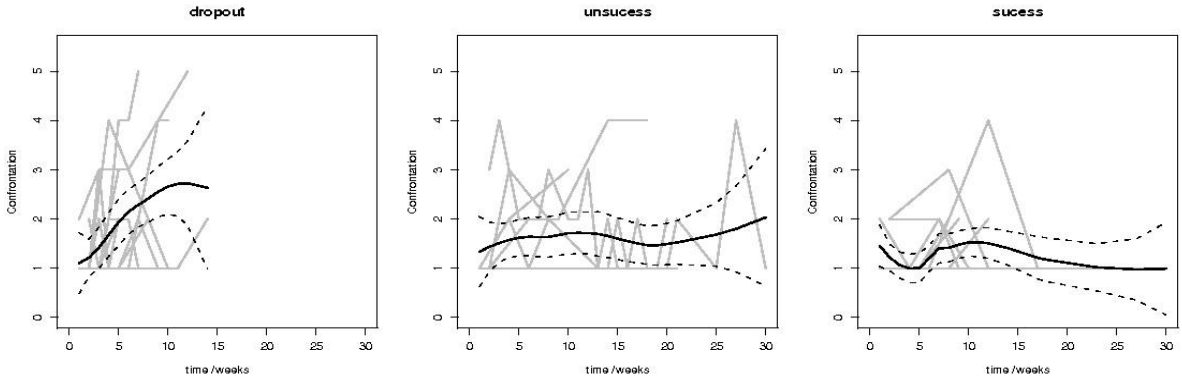

Figure II – 3. Individual longitudinal profiles and non-parametric estimate for population average for Confrontation scores.

When we plotted the data with time 0 corresponding to the last session (see Figure II - 4.) we observed that in the dropouts there was an increase in confrontation immediately before the patient left therapy, whereas, in both success and unsuccessful cases, that increase did not occur. Confrontation reached higher values in the cases of personality disordered patients.

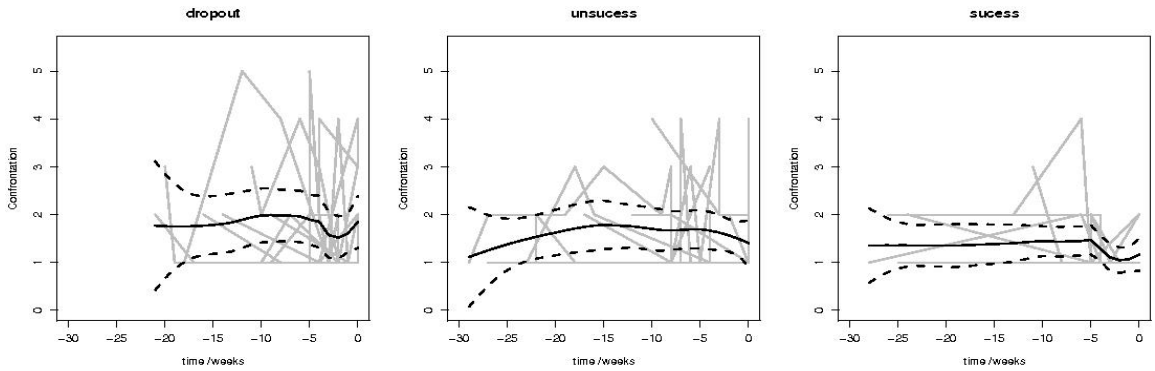

Figure II -4 Individual longitudinal profiles and non-parametric estimate for population average for Confrontation scores when time 0 is the time of the last observation

4.1.3 Withdrawal Results

In what concerns the withdrawal scores, we found that in the beginning the withdrawal tends to increase in all cases (see Figure II – 5.)

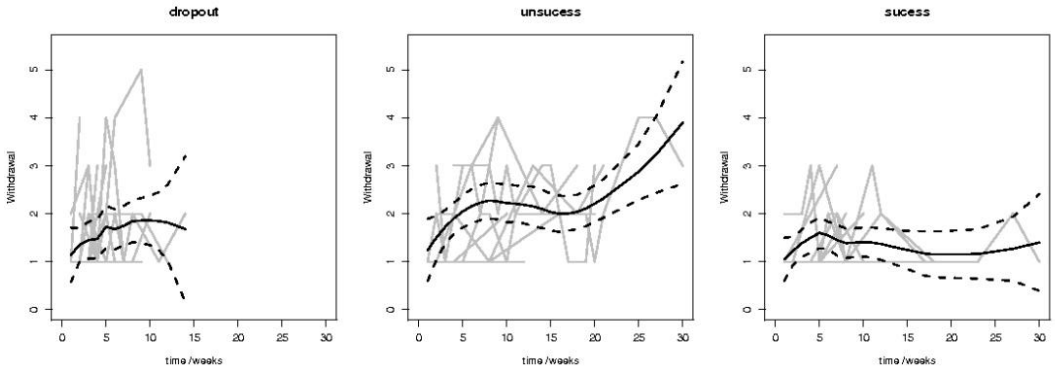

Figure II – 5. Individual longitudinal profiles and non-parametric estimate for population average for Withdrawal response

However in the last phase of therapy (see Figure II -6), there were differences between cases. In the dropouts, immediately before the patient leaves therapy there was a clear increase in the withdrawal, while in both the unsuccessful and successful cases, the withdrawal kept stable before the patient terminates treatment. Cases of personality disordered patients started therapy with a higher score of withdrawal.

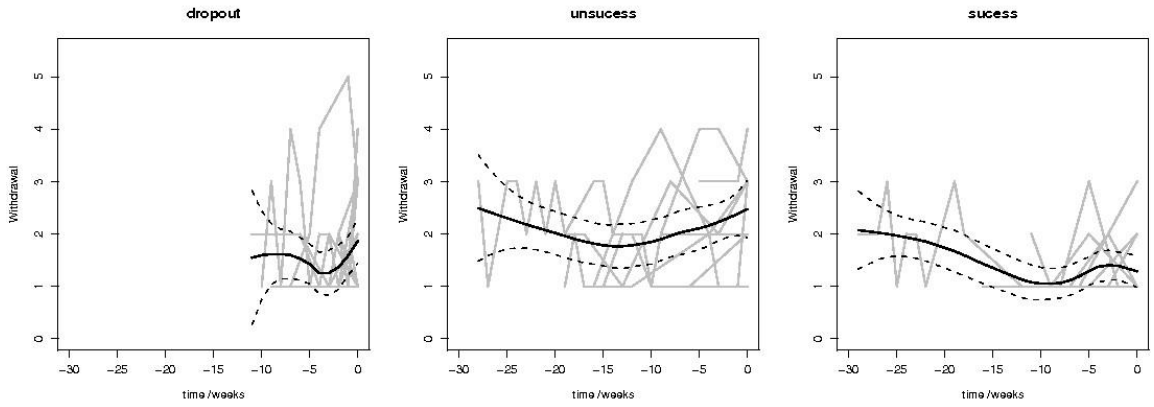

Figure II - 6. Individual longitudinal profiles and non-parametric estimate for population average for Withdrawal response, when time 0 is the time of the last observation.

4.1.4 Comparison between the three variables considering the type of diagnosis

As Figure II – 7 shows, in Axis I patients, there seems to be an increase in the alliance assessed with the WAI, that is stronger in the beginning of therapy followed by relative stability; and also, the confrontation and the withdrawal increases in the beginning, which is not coherent with the increase in the WAI.

We can also see that in Axis II patients there seems to be more coherence between measures, in that the WAI and confrontation curves seems to be symmetric, there is, in the beginning the WAI decreases and the confrontation increases, then the WAI increases and the confrontation decreases and in the last phase of therapy the WAI drops again and the confrontation is stable. The withdrawal scores present a similar pattern.

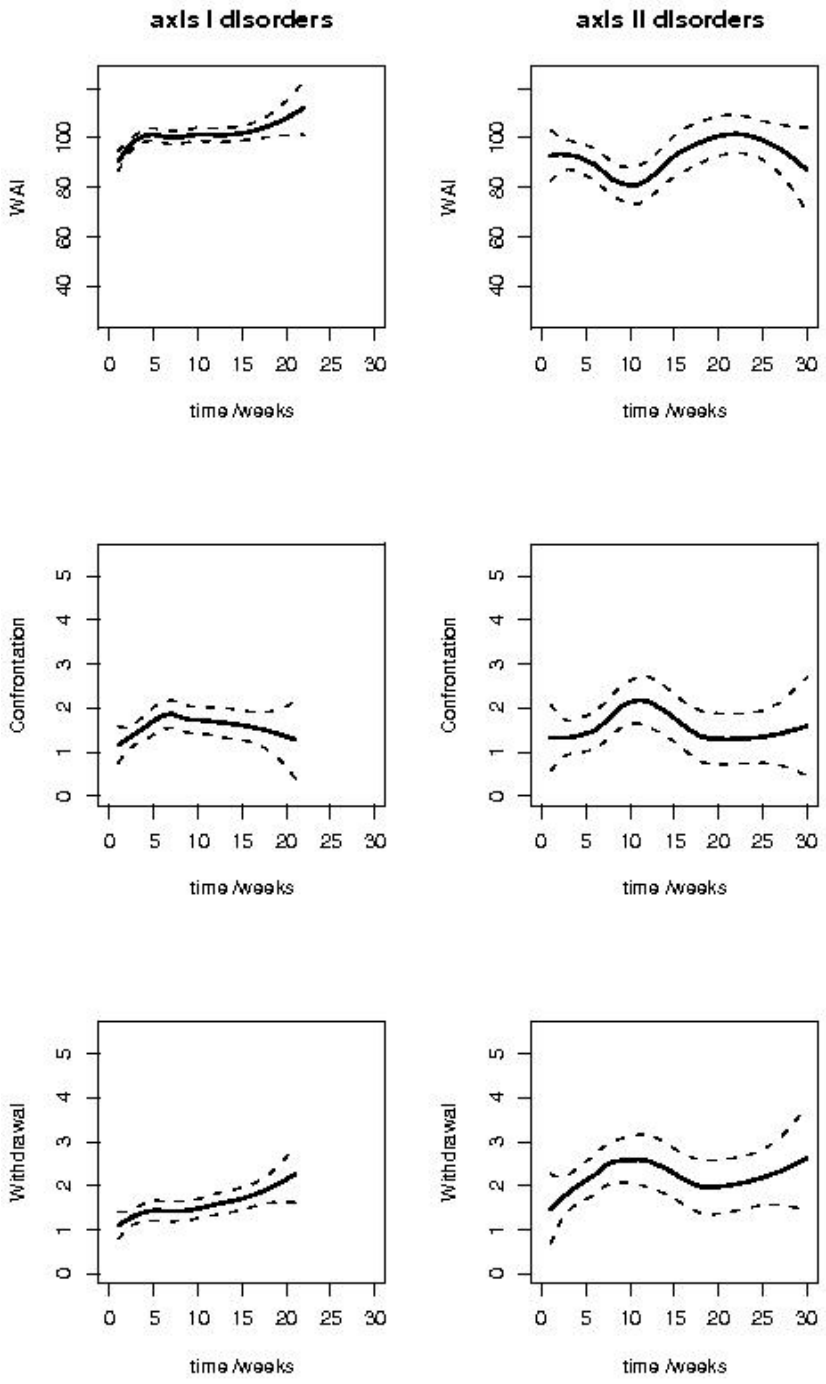

Figure II - 7. Non-parametric estimates for population average, on WAI, Confrontation and Withdrawal scores, for Axis I and Axis II disorders.

Note. The black solid line represents the non-parametric estimate for population average and the black dash lines represents, the 95% confidence intervals.

4.1.5 Comparison between the three variables considering the type of therapy termination

Considering the type of therapy termination (see Figure II - 8) the three measures appear to be quite consistent with each other.

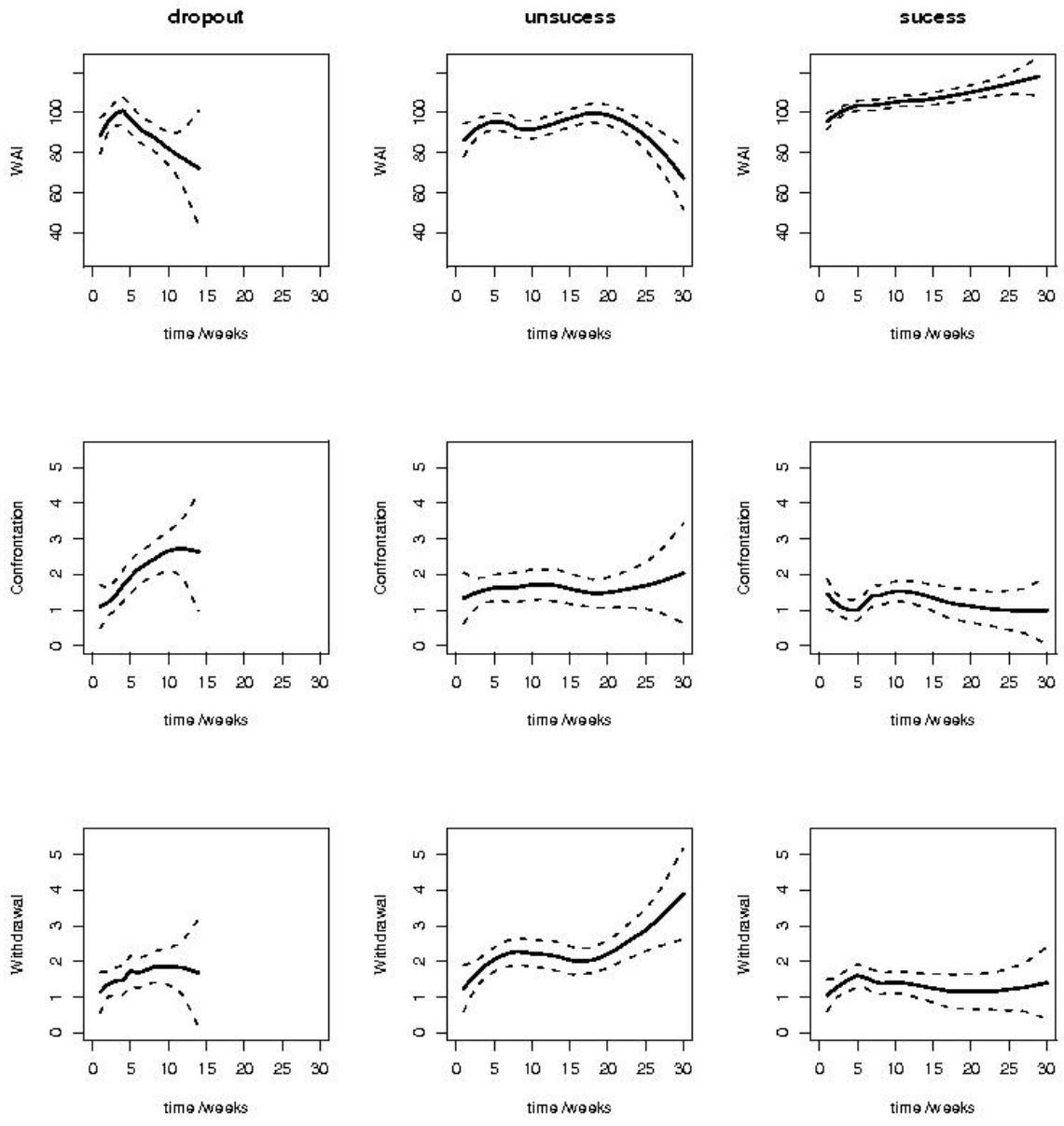

Figure II- 8. Non-parametric estimates for population average, on WAI, Confrontation and Withdrawal responses, for dropouts, success and unsuccessful cases.

In the dropout cases, there was an increase in the WAI in the very beginning of therapy, immediately followed by a decrease, and this decrease happened at the same time both confrontation and withdrawal increased. In the unsuccessful cases there seems to be stability both in the WAI and confrontation scores and an initial increase in the withdrawal. Also in the successful cases there is coherence between measures, in that a pattern of high and stable WAI with gradual increase occurred together with low and stable levels of either confrontation or withdrawal. The same coherence was found when we looked at what happened before the patient left treatment. Here the dropout cases again differed from those that stayed in therapy, being that in dropouts there was a decrease in the WAI and an increase in both confrontation and withdrawal right before the patient left therapy, whereas for the other cases there was relative stability in the three variables in the period before the last session.

Although these data illustrate a global coherence between the three measures, they don´t allow us to see whether the different measures are able to detect rupture episodes in the same moments of the therapeutic process.

In order to answer to that question we first looked to the WAI scores to identify cases with rupture markers. To identify ruptures we used a criterion that was based on the parametric model we fitted to the data. A rupture episode was defined as a time point where the WAI decreased and the variability between the previous and the actual time point was higher than the estimated for population average. Then we saw where a withdrawal or a confrontational rupture was detected by the 3RS, using the 3RS criteria of a withdrawal or confrontation score equal or higher than 3 *("3= Withdrawal/confrontation rupture(s) occurred, clear significance for the alliance").*

We found that for all the cases in which we detected ruptures using the abovementioned criteria adopted to detect decreases in the WAI, in those sessions in which the rupture emerged, at least one of the two observational measures (withdrawal and confrontation) also detected a rupture. We selected two individual cases, presented in Figure II- 9, that illustrate this temporal coincidence between the WAI decrease and the withdrawal or confrontation score ≥ 3. As we can see in both cases, for each point signaling a rupture using the WAI score, there is also, in the same session, a point that signals a rupture of withdrawal and/or confrontation, which suggests the two methods are capturing ruptures at the same moment of the therapeutic process.

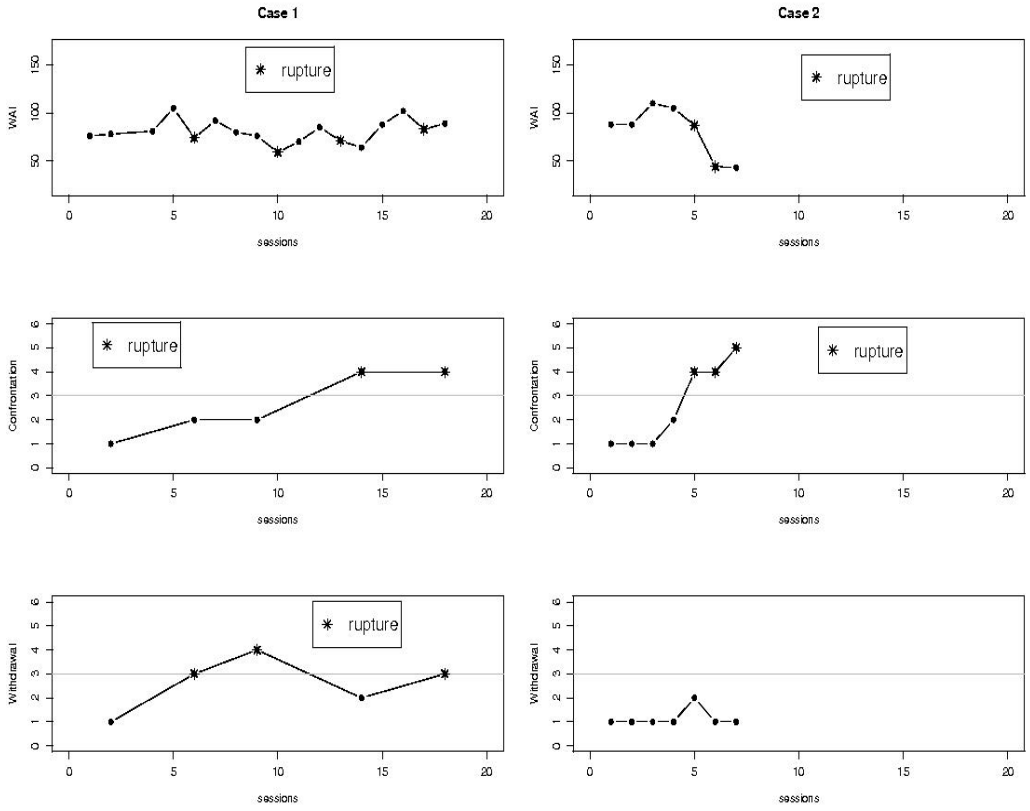

Figure II- 9. Longitudinal profiles for WAI, Confrontation and Withdrawal scores, on case 1 and case 2, with identification of ruptures according to defined criteria

4.2 Parametric Models

Table II -1 presents the statically significant effects that were found. As we may see in what concerns the WAI scores, on average, patients with Axis I disorders start therapy with a WAI score of 93.64 and that score increases 0.78 per week. Axis II patients start therapy with a WAI score of 89.78 and that score decreases 0.22 per week, although this decrease was statistically non significant.

In what concerns the confrontation scores, we see that, on average, patients with Axis I disorders start therapy with a confrontation score of 0.90, while patients with Axis II personality disorders start therapy with a confrontation score of 0.95. Thus what distinguishes subjects regarding to the initial confrontation score with which they start therapy is the type of diagnosis. In what concerns the progression of confrontation across time dropout cases increase the score 0.17 per week, while for both success and unsuccessful cases there was no evidence of significant variation in confrontation across time.

Finally, in what concerns the withdrawal scores, patients with Axis I disorders start therapy with a value of 1.26 (1), while patients with Axis II disorders start therapy with an average score of 1.95 (2). It is important to note that this difference corresponds to a difference between level 2 ("*Withdrawal ruptures may have occurred; possible significance for the alliance.*") and level 1 ("*Withdrawal ruptures did not occur; no significance for the alliance"*). That value increases 0.02 per week in both cases, that is, the type of therapy termination does not influence the progression of the withdrawal across time. Note that while the withdrawal tends to increase in all cases, the confrontation only increases in the dropout cases. Thus the progression of the self-report measure seems to depend more on the type of patient´s diagnosis (Axis I or II), while

the progression of the confrontation seems to depend more on the type of termination of the case.

Table II - 1. Parametric Estimates for the parametric model for WAI, Confrontation and Withdrawal

	Parameter	Estimator	Standard-errors	p value
WAI Model	Diagnosis (Axis I)	93.64	2.70	< 0.001
	Diagnosis (Axis II)	89.78	5.04	< 0.001
	time (Axis I)	0.78	0.23	< 0.001
	time (Axis II)	-0.22	0.29	0.4525
Confrontation Model	Diagnosis (Axis I)	0.90	0.24	0.001
	Diagnosis (Axis II)	0.95	0.28	0.002
	time (dropout)	0.17	0.04	< 0.001
	time (unsuccessful)	0.01	0.02	0.618
	time (success)	-0.007	0.02	0.716
Withdrawal Model	Diagnosis (Axis I)	1.26	0.02	< 0.001
	Diagnosis (Axis II)	1.95	0.17	< 0.001
	time	0.02	0.01	0.022

5. DISCUSSION

The first finding of this work is that there is an initial increase in the alliance assessed by the WAI for all the patients. After that initial increase, the fifth session emerges as a turning point from which the variability between individuals increases. It is in this moment that a lot of patients dropout, as if the fifth session works as a first filter of those cases that *survived* with success to the period of alliance formation. This is consistent with previous studies (Horvath & Symonds, 1991) that indicate the quality of the alliance as measured in the first four sessions to be the best predictor of therapeutic outcome. It is also consistent with the idea that the alliance development takes place in early sessions (de Roten et al., 2004), but may need to continue until the last session to be productive and result in a good outcome case (Kramer et al., 2009). Garfield (1994) had already found a median length of treatment of about six sessions, because the majority of dropouts occur within the first sessions.

The second relevant finding is that successful cases presented a pattern of high and increasing alliance which is consistent with the literature in this area that has shown that either the pattern of linear growth or the V pattern, in which the alliance decreases and increases again, may be associated with good outcome (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). In this study, only the linear model emerged, that is, we found no statistical evidence for a quadratic model to fit into this data. This is consistent with Kramer et al. (2009) findings indicating that a linear progression model was the most adequate to explain the alliance development in a sample of 50 patients receiving a manual based time limited therapy. As the same authors pointed out, the cubic shape of alliance is more likely to be found in single case studies than in studies like ours that use agglomerated data based on mean scores.

Also the local V shaped patterns, which indicate the presence of rupture-repair sequences, are more likely to be found looking at particular dyads, as Stiles et al. (2004) study showed. Likewise in our study, only when we looked at particular cases looking for those who filled our mathematical criteria for a rupture episode were we able to find those sequences.

We hypothesize that in those cases from our sample in which ruptures occurred, they were not efficiently resolved by the therapist, having lead to unsuccessful or dropout cases, as the decrease in WAI and increase in confrontation and withdrawal scores immediately before the patient abandoned therapy, suggest. This increase in both types of rupture markers before the patient quitted therapy, confirms the importance of interventions of rupture resolution to prevent the patient´s dropout. This is consistent with Tryon and Kane (1995) finding that weakened alliances are associated with therapy unilateral termination. Also Muran, Safran, Samstag, and Winston (2005) found that brief relational therapy, which is focused on alliance negative fluctuations and its repair, had significantly lower dropout rates.

Another relevant finding was the coherence observed between the different measures with each other and with the type of termination, which may in a way contribute to the recovery of the confidence in self-report measures of the alliance. In all the cases in which ruptures were detected using the mathematical criteria for the decrease in the WAI, the observational system was also able to detect a withdrawal and/or a confrontational marker with significant intensity in the same session.

This coherence makes us think that the two measures are capturing the same kind of clinical phenomena which suggest that the point made by Colli and Lingiardi (2009), that these methods are more suitable to assess the therapeutic alliance as a general factor

related to the outcome, rather than to detect the interactional patterns between therapist and patient, may not be completely true.

It is true that measures such as the WAI evaluate the alliance at a session level, which means that they can only detect ruptures through the analysis of its fluctuations from session to session. Because they are not located at a micro-level of analysis like observational systems such as the 3RS do, they cannot allow for the identification of changes in the quality of the collaborative relationship occurring in a moment to moment basis. However, as our study showed, the WAI had a distinct developmental pattern in successful cases and dropouts, for example. Besides, its results were consistent with those obtained by the observational system. Similarly Muran et al. (2009) found that direct measures of rupture intensity were significantly related to standard measures of psychotherapy process and outcome, that is, lower rupture intensity was associated with better ratings of the alliance.

However, it is important to stress that from the three variables (WAI, Withdrawal and Confrontation), the one that seemed to be more related with the type of therapy termination (successful, unsuccessful or dropout case) was the confrontation score, being that the WAI and its progression was more related with the type of patient diagnosis. In other words, the confrontation score seems to be the measure that better discriminates dropout from non-dropout cases, which suggest that it might be more capable of detecting negative alliance events such as ruptures. Thus we think that even if a rupture is occurring, it may not be as well identified through the assessment of the quality of the alliance made by the patient in the self-report questionnaire, as it is by judges using the observational system.

Therefore, if it´s true, according to our findings, that, as we said before, we may rely on measures such as the WAI to evaluate changes in the dynamics of the

therapeutic alliance, it is also true that this kind of measure is more easily subject to different sources of bias from the participants who fill them, because they are based in a retrospective recall of the session. This supports the point made by Westen and Shedler, (1999, as cited in Colli & Lingiardi, 2009).

Finally, the fact that the coherence between measures was higher in personality disorders is also an interesting finding. Also, the fact that these patients start therapy with lower WAI scores and have higher levels of withdrawal and confrontation, corroborates the point made by other authors (Benjamin & Karpiak, 2001; Muran, Segal, Samstag, & Crawford, 1994; Muran, Safran, Samstag, & Winston, 2005) that these are the patients who benefit the most from therapeutic interventions focused on alliance negotiation. In their study, Muran and colleagues (2005) found that in a sample of highly comorbid personality disordered patients, the dropout rate was lower in the brief relational therapy condition comparing to the cognitive behavior and short-term dynamic therapy. The rigid interpersonal schema of these patients and their emotional deficits makes it more likely that the therapists encounter ruptures in the alliance with these patients.

The majority of studies on this topic limit their analysis to the initial period of alliance development or, when they analyze longer therapies, the necessary number of sessions per case is predefined as in the study of Kramer et al. (2009). Whereas in our study, we included therapeutic dyads with different paths and types of terminations including the dropout, which was reflected in the variable lenght of the therapeutic processes that composed our sample. We think this methodological option increases the ecological validity of studies whose goal is to study the alliance development, because by including only the longer cases or the cases with the same duration we may be limiting the analysis to those cases whose time of survival in the study is longer, which

means that all of them have had a better alliance development compared to the cases that dropout.

We acknowledge that the fact that, in this study, the distinction between success and unsuccessful cases was based on the clinical criteria, may constitute a methodological fragility by not allowing for the comparison with other studies that in the great majority use standardized measure of clinical significant change.

Another limitation of our work is the fact that we did not take into account therapist´s variables such as the level of clinical experience and treatment adherence that may influence the alliance development.

Finally, this study was able to compare the patient´s and the observer´s perspective on the alliance development, but we did not include the therapist´s perspective, which has also been referred to as important. We intend to include it in future papers on alliance development.

6. REFERENCES

Benjamin, L.S., & Karpiak, C.P. (2001). Personality disorders. *Psychotherapy*, *38*, 487–491.

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

Colli A., & Lingiardi V. (2009). The collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research*, *19*(6), 718- 734.

Corbella, S., & Botella, L. (2003). La alianza terapéutica: historia, investigación y evaluación. *Anales de Psicologia, 19*(2), 205-221.

de Roten, Y., Fisher, M., Drapeau, M., Beretta, V., Kramer, U., Fravre, N., & Despland, J. (2004). Is one assessment enough? Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy, 11*, 324-331.

Diggle P.J., Heagerty P., Liang K.Y. & Zeger S.L. (2002). *Analysis of Longitudinal Data*. (2nd ed.) Oxford: Statistical Science Series.

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*(4), 421 – 434.

Eubanks-Carter, C., Mitchell, A., Muran, J.C., & Safran, J.D. (2009). Rupture resolution rating system (3RS): Manual. Unpublished manuscript.

Little R. & Rubin D. (1987). *Statistical Analysis with Missing Data*. London: John Wiley & Sons.

First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B.W. (1995). *Structured Clinical Interview for DSM– IV.* New York: Biometrics Research Department, New York Psychiatric Institute.

Garfield, S.L. (1994). Research on client variables in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). New York: Wiley.

Golden, B., & Robbins S. (1990). The working alliance within time-limited therapy: A case analysis. *Professional Psychology: Research and Practice, 21*(6), 476-48

Gonçalves, A. (2009). Compreensão da mudança terapêutica a partir da co-construção de episódios terapêuticos significativos, Unpublished Dissertation. University of Minho. Braga.

Hastie, T., & Tibshirani, R. (1990). *Generalized additive models, Volume 43 of Monographs on statistics and applied probability*. London: Chapman & Hall.

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

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149.

Infante, C.A. (2009). Rupture episodes not reported by the client in high therapeutic alliance sessions. (Unpublished master's thesis). Universidade do Minho, Braga.

Keele L. (2008). *Semiparametric regression for the social sciences*. London: John Wiley & Sons.

Kivlighan, D.M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology, 47*, 362–371.

Kokovic, A., & Tracey, T. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology*, *37*(1), 16-21.

Kramer U., De Roten, Y., Beretta V., Michel, L., & Despland J. (2009). Alliance patterns over the course of short dynamic psychotherapy: The shape of productive relationships. *Psychotherapy Research, 19*(6), 699-706.

Luborsky, L., McLellan, A.T., Woody, G.E., O'Brien, C.P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602-611.

Machado P.P., & Horvath A. (1999). Inventário da Aliança Terapêutica – W.A.I. In M. R. Simões, M. M. Gonçalves & L. S. Almeida (Eds.), *Testes e Provas Psicológicas em Portugal* (Vol.2, pp.87-94). Braga: APPORT/SHO.

Marmar, C.R., Weiss, D.S., & Gaston, L. (1989). Towards the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 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 Consulting and Clinical Psychology*, *68*(3), 438-45.

Muran, J.C., Safran, J.D., Gorman, B.S., Eubanks- Carter, C., & Banthin, D. (2008, June). *Identifying ruptures & their resolution from postsession self-report measures.* Paper presented at the annual meeting of the Society for Psychotherapy Research, Barcelona, Spain.

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*(2), 233–248.

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

Muran, J.C., Segal, Z.V., Samstag, L.W., & Cawford, C. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 62,* 185–190.

Nagy, J., Safran, J.D., Muran, J.C. & Winston, A. (1998). *A comparative analysis of treatment process and therapeutic ruptures.* Paper presented at the international meeting of the Society for Psychotherapy Research, Snowbird, UT.

Patton, M.J., Kivlighan, D.M., & Multon, K.D. (1997). The Missouri Psychoanalytic Counseling Research Project: Relation of changes in counseling process to client outcomes. *Journal of Counseling Psychology, 44*, 189–208.

Podsakoff, P.M., MacKenzie, S.B., Lee, J., & Podsakoff, N.P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology, 88*(5), 879-903.

Regan, A.M., & Hill, C.E. (1992). Investigation of what clients and counsellors do not say in brief therapy. *Journal of Counselling Psychology*, *39*, 186-174.

Rennie, D.L. (1994). Client's deference in psychotherapy. *Journal of Counselling Psychology, 41*(4), 427-437.

Safran, J.D., & Segal, Z.V. (1990). *Interpersonal Process in cognitive therapy*. New York: Basic Books.

Safran, J.D., & Muran, J.C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guilford Press.

Safran, J.D., Muran, J.C., & Samstag, L.W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath and L. S. Greenberg (Eds.), *The Working alliance: Theory, research and practice* (pp. 225-255), New York: Wiley.

Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice & Research, 7,* 126–143.

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 evaluations. *Psychotherapy Research, 18,* 377–388.

Stiles W.B., Glick M.J, Osatuke K., Hardy G.E., Shapiro D.A., Agnew-Davies R., Rees A., & Barkham M. (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., Laurenceau, J., & Beck, A.T. (2006). Early 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*(2), 337–345.

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

CHAPTER III

INTERPERSONAL TRANSACTIONS IN ALLIANCE RUPTURE EPISODES: A CASE STUDY ANALYSIS OF A DROPOUT

CHAPTER III

INTERPERSONAL TRANSACTIONS IN ALLIANCE RUPTURE EPISODES: A CASE STUDY ANALYSIS OF A DROPOUT[4]

1. ABSTRACT

In this study we present the intensive analysis of a dropout case in which several unrepaired rupture events were identified. We focused our analysis on the therapist´s contribution to these unresolved episodes. The number of therapist intervention attempts was about four times less than the number of expected interventions according to Rupture Resolution Models (Safran & Muran, 2000). The main therapist´s failures were: inability to attend to the rupture marker; inability to validate the client's emotional experience and to acknowledge her own responsibility for the problem. Therapist´s assessment indicated a good interpersonal and psychological functioning which suggests that her inability to adequately resolve ruptures was less related with this kind of variable and more related to the level of clinical experience and training or supervision factors. The clinical implications of these findings will be discussed.

2. INTRODUCTION

There seems to be strong evidence regarding the importance and effect of therapist variables on the therapeutic process and outcome. Recent studies found that about 8% of the variance in psychotherapy outcomes was due to therapists´ factors (Wampold, 2001; Kim et al. (in press) as cited in Wampold & Brown, 2005; Huppert et al., 2001). As Wampold and Brown (2005) argue this is a very significant result considering that the therapeutic alliance, which is usually referred to as the most important common

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factor, explains around 5% of the outcome variance. This makes us think that psychotherapy research might benefit from the study of therapist variables.

Research also suggests that the influence of therapist factors on therapeutic outcomes, may work through its impact on the alliance formation, in other words, therapists who have a better ability to negotiate the alliance in an efficient manner seem to be the most successful ones. Departing from this assumption, we consider that the relationship between therapist variables and the process of alliance formation and development is an important research topic.

In their review of therapist characteristics and techniques negatively impacting the therapeutic alliance, Ackerman and Hilsenroth (2001) found that therapist's personal attributes such as being rigid, uncertain, critical, distant, tense, and distracted contributed negatively to the alliance. Therapist techniques such as over structuring the therapy, inappropriate self-disclosure, unyielding use of transference interpretation, and inappropriate use of silence were also found to contribute negatively to the alliance.

Two years later, the same authors made a review of therapist characteristics and techniques positively impacting the therapeutic alliance and concluded that therapist's personal attributes such as being flexible, honest, respectful, trustworthy, confident, warm, interested, and open; and therapist techniques such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience were found to contribute positively to the alliance (Ackerman & Hilsenroth, 2003). Also flexibility (Kivlighan, Clements, Blake, Arnzen, & Brady, 1993) and affiliative behaviors such as validation, support, and affirmation (Bachelor, 1995) have been associated with strong alliances.

We may notice that some of the positive attributes and interventions identified by these studies, such as the therapist being open, flexible and respectful and being able to

facilitate the expression of affect and attend to the client´s experience, correspond to those that Safran and Muran (2000) consider as being necessary to resolve alliance ruptures. An alliance rupture can be defined as a tension or breakdown in the collaborative relationship between the therapist and the patient (Safran & Muran, 1990). According to Bordin´s conceptualization of Therapeutic Alliance, rupture episodes are moments in which the negotiation of therapeutic tasks and goals or the emotional bond between therapist and client seem to get compromised.

This supports the notion that the contribution of therapist´s personal variables to the therapeutic process is not of equal importance throughout the entire course of therapy, that is, those moments, in which the dyad goes through alliance ruptures, are the ones in which therapists characteristics seem to play a more important role, for better and for worse.

Previous studies on alliance ruptures have shown what might prevent therapists from resolving alliance ruptures in an adequate way. Rhodes, Hill, Thompson, and Elliot (1994) asked nineteen therapists to recall misunderstanding events from their own treatment and made a qualitative analysis of the events. They found that in a resolved misunderstanding event, the patient was able to assert negative feelings and therapist remained flexible and accepting, recognizing his responsibility for the event or changing his behaviour. In contrast, in non-resolved events, the patients described their therapists as non-responsive, defending in a dogmatic way their point of view without even considering the patient´s point of view. Therapists remained unaware of what was happening until the patient quit therapy.

Although this study showed that therapists´ unawareness of patient's negative reactions can be detrimental to the negotiation of the alliance, there is also some

evidence suggesting that this awareness is not always beneficial. In 1996, Castonguay, Goldfried, Wiser, Raue, and Hayes clarified the hypothesis that therapists may become more rigid when they are aware of their client´s negative reactions. In this study of change in cognitive therapy they found something unexpected: therapist's focus on the impact of distorted cognitions of depressive affect was negatively linked with outcome. Conducting a more intensive qualitative analysis of these poor outcome cases, they realized that when confronted with a rupture, therapists adhered in an even more rigid way to the cognitive model, becoming more and more focused on challenging distorted cognitions.

A similar process of therapist´s inflexible adherence to the model seem to have happened in another study on dynamic therapy by Piper, Joyce, Azim, and McCallum (1991), in which the authors found the excessive use of transference interpretations was negatively associated with the quality of the alliance. A subsequent qualitative analysis suggested that therapists may have used transference interpretations to deal with an impasse in the alliance, but the way that strategy was used increased the vicious cycle both therapist and patient were involved in. These results are consistent with those obtained by Foreman and Marmar´s study (1985), in which they found that interpretations focused on the real relationship between client and therapy improved the alliance but those that didn't address directly the alliance impairment were not helpful.

The crucial importance of therapist characteristics and abilities to the alliance negotiation process should not cause us to ignore the equally central role that the client plays in the alliance formation. As Ackerman and Hilsenroth (2003) suggest:

> … it is likely that the most promising strategy for future research may be to examine the interpersonal exchanges between the patient and the therapist that impact alliance development. Investigating these in-session interactions may

deepen our understanding of the nature of alliance development and the specific variables impacting it. (p29*)*

The general goal of the present study was to investigate the interpersonal exchanges between therapist and patient referred to by Ackerman and Hilsenroth, particularly those that occur in rupture episodes. We intended to cross this with the analysis of therapist´s variables such as his/her attachment organization, and the therapist´s experience of the rupture episodes. We think the intersection of these aspects in a single-case study is a novel contribution to the research on alliance ruptures.

3. THE CASE STUDY APPROACH

We believe that case studies may constitute an interesting methodological tool that we can use to implement the recommendation by Ackerman and Hilsenroth (2003) for future research, that is, to study both therapist and patient characteristics and their interaction in the process of alliance formation. We think this method is better able to reflect the interactive nature of alliance ruptures and its complexity, because by using videotaped and transcribed material of all sessions it strongly relies on the actual transactions that occurred between the participants over time. Besides it considers different variables that can interfere with the interactive process, assessed both by quantitative and qualitative measures, and also by different perspectives: the therapist´s, the patient´s and the observer´s perspective.

Therefore we decided to make an intensive analysis of a dropout case, in which the premature termination at session seven was due to several unrepaired rupture episodes. We intended to understand what went wrong in this dyad´s negotiation process, that is, why the dyad was unable to deal with the ruptures in a different way.

We believe that the study of unresolved rupture events may help clinicians to learn how to identify and avoid the same kind of failures in their clinical practice.

Safran and Muran's (2000) research on alliance ruptures had already described different types of ruptures that can occur and had also defined and tested different ruptures resolution strategies adequate. Case studies like the one we present here, allow us to evaluate the application of Rupture Resolution Models in the context of a specific relationship between an individual patient and an individual therapist.

Thus, our study aimed to achieve two specific goals:

1) to analyze the interpersonal transactions that occurred in the rupture episodes in order to compare the strategies the therapist adopted to deal with them with those that Safran´s model of rupture resolution propose;

2) to understand what characteristics of this therapist may explain her inability to resolve the alliance ruptures in a more efficient manner.

4. METHOD

4.1 Participants

Patient: Laura (fictitious name) was a 23 year old female undergraduate student. She was from a Latin American country and was doing a six months international student program. She was referred to the university counseling center by the international student services. Prior to this therapy, Laura had been in other therapy. Her main complaint had to do with adaptation difficulties to the new city and country. She also presented intense humor oscillations and interpersonal problems namely with her mother. Laura was feeling lost and undecided about what she wanted to do after leaving Portugal. She was diagnosed by the therapist with a Bipolar Disorder NOS. She also presented some features of schizotypical and borderline personality disorder The GAF

(Global Assessment of Functioning) at the intake was 40. Laura had two younger sisters and her parents got divorced when she was eight. The relationship with her father was described by her as "*distant"* and since their parents got divorced the relationship with her mother was role inverted. She was struggling with the fact that she was not capable of asserting her needs when her mother asked her for money, for example.

Therapist: Dr. S. was a white, female, 23 years old clinical psychologist. She was in her first year of clinical practice. She had been trained in cognitive-behavioral therapy and also the supervision she received in this case was CBT oriented. This was a very structured weekly supervision and every two weeks the therapist had clinical team meetings where she could present her clinical work and related difficulties. Because this was her first year of clinical practice, the supervisor tried to protect the therapist, when they realized how severe Laura's symptoms seemed to be. The need for psychiatric assessment and medication was suggested by the supervisor as a way to ensure the patient´s safety. Dr. S.´ Interpersonal Schema were assessed by the Interpersonal Schema Questionnaire (ISQ; Hill & Safran, 1994; Gouveia, Cunha, & Robalo, 1997), which evaluates individuals' prototypic ways of construing interactions with important others. Respondents are asked to imagine themselves in 16 different interpersonal scenarios and then to indicate the kinds of responses they expect from the other person (mother, father and romantic partner or close friend). The ISQ yields three key indices: affiliation index (with positive scores indicating greater friendliness/affiliation in the expected responses and negative scores indicating greater hostility); control index (with positive scores indicating dominance expected responses and negative scores indicating submissive responses) and desirability index that represents subjects' perception of the desirability of the expected responses from others [scores range from 1 (least desirable)

to 7 (most desirable)]. Our therapist´s interpersonal schemas with both parents and boyfriend were positive (desirability index close to 7 for the three important others); she had expectations of friendliness from mother (4.5) and boyfriend (7), and neutral from father (0.5); in terms of control she had neutral expectations of dominant behavior from mother and boyfriend (0.5 and 1) and submissive behavior from father (-1.5). In terms of Affect Regulation (assessed by the Affect Regulation Scale (ARS; Schaffer, 1993; Baptista, 2009), results showed that when confronted with experiences of anxiety or painful feelings, Dr. S. tended to use more action and contemplative strategies. She had no tendency to use sexual or aggressive strategies. The self-report measure of Wisdom (Self-assessed Wisdom Scale (SAWS; Webster, 2004; Coutinho, Fernandes, & Safran, 2008[5]) had indicated high scores in all the subscales: emotional regulation (the highest); experience; reflection; humor and openness. Finally her attachment organization assessed through the AAI (Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) revealed a secure pattern of attachment with no use of deactivation or hyper-activation strategies.

4.2 Treatment

The treatment consisted of weekly sessions of cognitive-behavior therapy. In order to reduce the mood lability symptoms, daily mood records were used and psycho education about mood lability was done. Sleep habits were also registered. Due to the interpersonal problems with the patient´s mother a training of assertiveness was conducted.

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[5] In order to use the Self-Assessed Wisdom Scale in our study, we adapted the instrument to Portugal. The paper that describes the adaptation process as well as the psychometric properties of the Portuguese version of the SAWS was published in "*Actas da XIII Conferência Internacional "Avaliação Psicológica: Formas e Contextos"* and may be found in the Appendix II of this dissertation.

Due to the unresolved ruptures the treatment ended prematurely at the 7th session.

4.3 Measures

- Therapeutic Alliance - The Post-Session-Questionnaire (PSQ; Samstag, Batchelder, Muran, Safran, & Winston, 1998). This self-report questionnaire is a composite of different measures of the session. In this study we used the scores of the short form of the WAI-S (Working Alliance Inventory, Horvath & Greenberg, 1989). The WAI measures the three dimensions of the working alliance (goals, tasks and bond) independent of the therapist's theoretical orientation. The short version includes 17 items, from the 36 that compose the long version, on a 7-point Lickert scale anchored by 1 (*never*) and 7(*always*); higher scores reflect stronger therapeutic alliances. The WAI has three versions: the therapist version (WAI-t), the client´s (WAI-c) and the observer version. In this study we used the therapist and client versions, whose items are very similar but adapted to the therapist and the client. Internal consistency estimates for the WAI range from .88 to .93 for the WAI–C (Horvath & Greenberg, 1986; Kokotovic & Tracey, 1990). Considerable evidence of validity has been amassed for the WAI (Horvath & Symonds, 1991). The Portuguese version of the WAI has good levels of internal consistency and reliability for the total scale and each subscale (Machado & Horvath, 1999). In the second part of the questionnaire, the patient is asked to indicate whether or not there was a problematic event in his/her relationship with the therapist during the session. If the patient identified such a problem, he/she is asked to indicate whether the problem arose at the beginning, middle, or end of the session and to rate the tension this problem caused on a 5- point scale, ranging from “very low” (1) to “very high” (5).

- Alliance Ruptures - The Rupture Resolution Rating System (Eubanks et al., 2009) is an observational system in which the rater while watching the session, decides if there is any rupture and what´s the type of rupture: confrontation ruptures (when the patient moves *against* the therapist by expressing anger or dissatisfaction) and/or withdrawal ruptures (when the patient either moves *away* from the therapist or the patient moves *toward* the therapist, but in a way that denies an aspect of his/her experience. For each confrontation or withdrawal marker identified, the rater must choose a specific category of rupture marker (e.g., denial, complains about the progress of therapy, etc) and rate its clarity and intensity in a 5 Lickert scale. An overall withdrawal and confrontation rating is also attributed to the session.

- Therapeutic Outcome - The Outcome Questionnaire (OQ45; Lambert et al, 1996) is a 45-item self-report measure that takes about 5 minutes to complete and was designed for repeated measurement of patient status through the course of therapy and at termination, because it is sensitive to changes in psychological distress over short periods of time. Each item on the OQ-45 is rated on a 5-point scale (0 = *never,* 1 = *rarely, 2 = sometimes,* 3 = *frequently,* or 4 = *almost always),* yielding a range of possible scores from 0 to 180, with higher values indicating poorer functioning.. Lambert et al. (1996) reported adequate internal consistency for the OQ-45 *(r* = .93). The 3-week test-retest value for the OQ-45 is also satisfactory *(r* = .84; Lambert, Burlingame, et al., 1996). Concurrent validity as estimated by correlating the total score with other outcome measures were all significant at the .01 level (rs = .50-.85). The Portuguese version, currently being validated by Fassnacht & Machado (in preparation) showed adequate psychometric properties.

- Therapist´s Experience - The Brief Structured Recall (BSR; Elliott, 1993) is a tape-assisted recall method used to access participant´s internal experience of specific

moments in therapy. While tapes of parts of sessions are played back for the participant, the researcher tries to elicit descriptions of the experiences and perceptions of particular conversational events. In this study those events corresponded to the rupture episodes previously identified. The interview included questions such as: "*What were you feeling during this episode? What personal or professional features of yours might have influenced the way this episode evolved? What impact do you think this episode might have had in your patient?"*

4.4 Procedure

This study belongs to a research project that was approved by the Scientific Council of University of Minho and permission was also obtained from the University Counseling Center to realize the study. Both patient and therapist were informed about the implications of their participation in the research and after that they signed an informed consent. At the beginning of the treatment the therapist completed the ISQ, the ARS and SAWS and was administered the AAI.

At the beginning of each session the patient completed the OQ45 and after each session both therapist and patient completed the PSQ. After completing the PSQ, patient and therapist were instructed to introduce their forms in a closed envelope, so that the confidentiality of the answers was assured. In order to reduce social desirability effects, they were informed that only the researchers would have access to their evaluation of the therapeutic alliance. All the sessions were videotaped and transcribed verbatim. All the information that could possibly identify the patient was removed.

For the identification of rupture episodes three different methods were used: the tracking of WAI fluctuations across sessions; the direct inquiry in the PSQ to therapist and patient about the occurrence of any moment of misunderstanding or tension during

the session; and the use of the Rupture Resolution Rating System (Eubanks, Safran, & Muran, 2009). The way rupture episodes were identified is described in more detail in the next section.

The first author administered the BSR about the rupture sessions, to both patient and therapist separately approximately one week after the session.

5. RESULTS

5.1 Identified Rupture Episodes

Several unrepaired rupture episodes emerged in this case, all of them related to the same topic. The content of the episodes was related to an evident disagreement around therapeutic goals and tasks: the therapist considered it crucial that the patient looked for psychiatric assistance to be medicated, considering this was a pre-condition for the patient to be ready to start working on her difficulties. The patient did not see that as necessary to continue the therapeutic work, nor even consider it helpful because she was afraid of medication dependence and its secondary effects. In the PSQ the patient reported that the fact that this was presented as a precondition for the therapeutic work to continue was felt as an ultimatum and as a disregard for her needs. The first episode started at session five (though there were some previous indicators of disagreement at session four), and became more and more severe throughout sessions six and seven ending up in the dropout which occurred at session seven.

Concerning the emergence of the rupture markers, we found that the three different methods we used to identify them were consistent, as we may see in what follows:

- In the PSQ questionnaire, both therapist and patient reported the first rupture marker at session five:

The therapist reported: "*The patient said she would not look for a psychiatrist, in order to get her mood stable, and I told her that that decision would put at risk the continuation of the therapeutic process. She got upset and cried*."

The patient reported: "*My therapist said that she could only work with me if I look for a psychiatrist and get medication. I felt pressured so I submitted to her, I felt that she made that requirement as a pre condition so that therapy could continue".*

- Analyzing the session using the Rupture Resolution Rating System (Eubanks et al., 2009) we were able to identify several confrontational markers: a) complaints about the activities of therapy; b) complaints about therapist as a person; c) complaints about the parameters of therapy; and one withdrawal marker: d) deferential and appeasing. The first author coded 100% of the data (the 7 sessions) and 50% of the sessions were coded by other two judges (each one coded 2 sessions). The inter-rater agreement for both withdrawal and confrontational global ratings evaluated through the Intraclass Correlation Coefficient was .80.

- Looking at the WAI ratings (see Figure III- 1) we may see that from the patient´s perspective, the quality of the alliance decreased in session 5 (from a WAI score of 6.17 in session 4 to a WAI score of 5.11 in session 5), though it was in session 6 that the decrease in the WAI ratings was more evident (from a WAI score of 5.11 to 2.58). If we consider four as the medium point of the WAI seven point scale, we notice that the alliance dropped from a score above the medium point to a score below the medium point.

From the therapist´s perspective, the decrease in the alliance was not so significant and it occurred before: during session four, when the patient first expressed her reluctance to look for psychiatric help (from a WAI score of 6.58 in session 3 to a score of 5.47 in session 4).

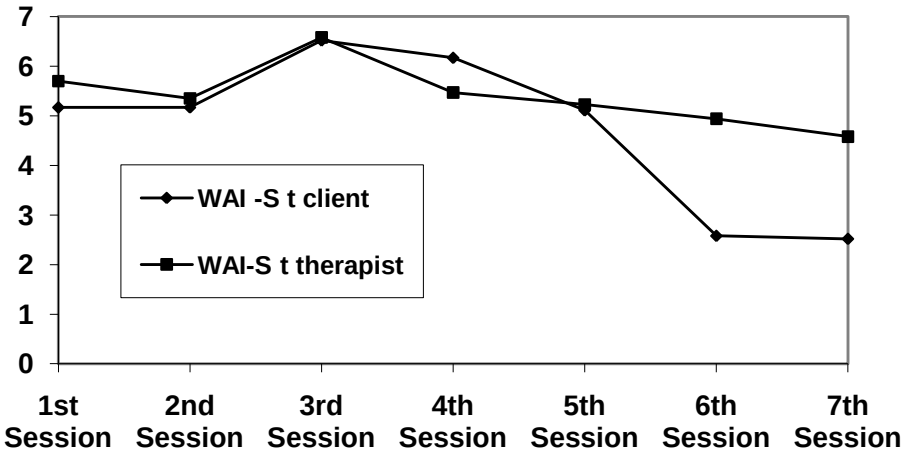

Figure III – 1. Therapist´s and Client´s Alliance Scores across Sessions

Note. WAI- S t = Working Alliance Inventory Short Form (Horvath & Greenberg, 1986; Kokotovic & Tracey, 1990) - total score, Client and Therapist´s versions.

It is important to note that by the time the patient´s WAI scores were decreasing, the OQ45 (Outcome Questionnaire) scores were increasing (see Figure III -2.), that is, by the time the quality of the alliance was getting compromised, the patient´s symptoms were getting worse. The OQ45 score at assessment was 69 and at termination it was slightly higher (71).

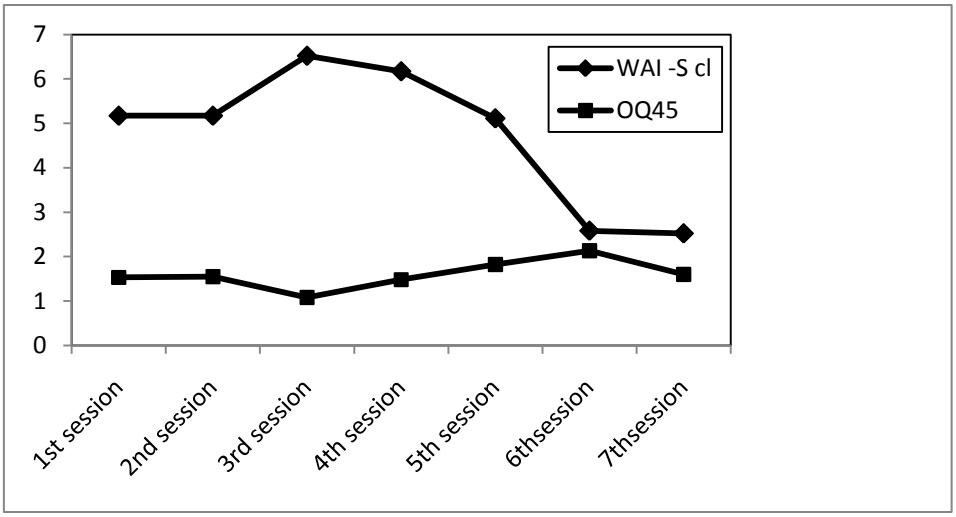

Figure III - 2. Client´s Outcome Measure across Sessions

Note: WAI- S cl = Working Alliance Inventory Short Form (Horvath & Greenberg, 1986; Kokotovic & Tracey, 1990), client´s version; OQ-45= Outcome Questionnaire 45 (Lambert et al. 2002). To facilitate the reading of the graphic the scores of the OQ45 were divided by the number of items of the instrument.

Looking at the different alliance dimensions evaluated by the three WAI subscales: goals, tasks and bond, (see Figure III - 3 and 4) we may see that until the third session patient and therapist WAI ratings on all the subscales are pretty much similar. It was at fourth session that things started to look different when we compare therapist and patient scores. As the Figure III - 3 shows, from the patient´s perspective there's seems to be more coherence and interdependence between the three alliance dimensions: the decrease in tasks and goals was accompanied by a decrease in the bond dimensions.

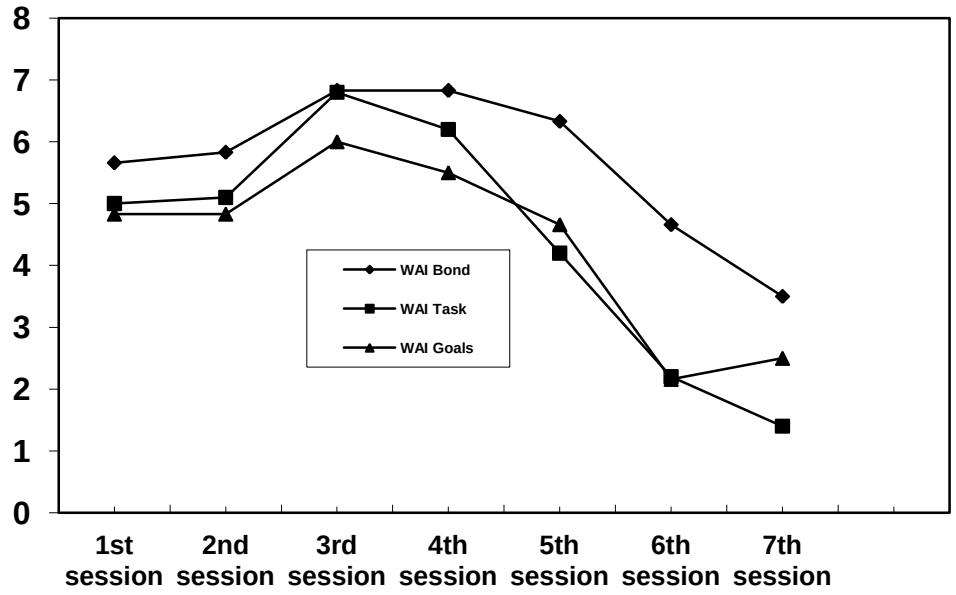

Figure III - 3. Client´s Alliance Scores across Sessions by Subscale
Note. WAI- S = Working Alliance Inventory Short Form, client´s version (Horvath & Greenberg, 1986; Kokotovic & Tracey, 1990)

On the contrary from the therapist´s perspective (see Figure III - 4.), the bond dimension stayed high until the end of the process, only the scores of the tasks and the goals dimensions were compromised by the patient´s reluctance to seek the psychiatrist, but that seemed to be independent from the affective bond which remained high until the end of therapy.

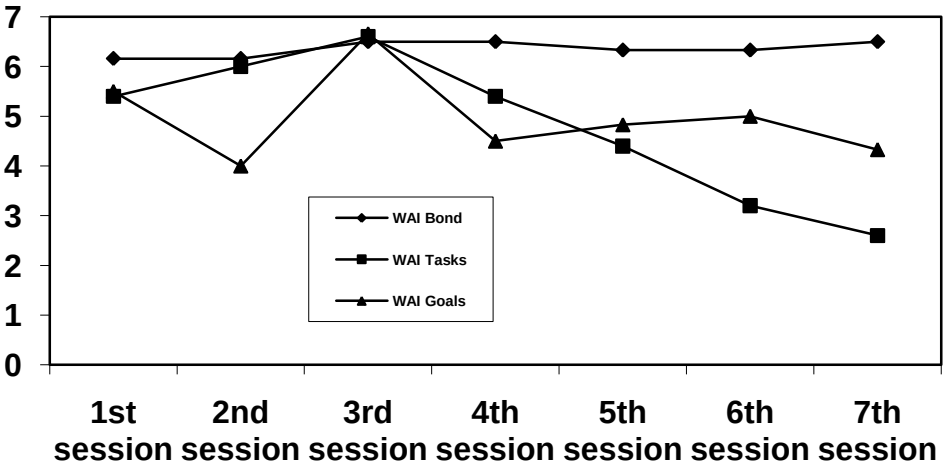

Figure III – 4. Therapist´s Alliance Scores across Sessions by Subscale

In fact therapist and patient did not have the same experience or perspective about what was happening in the alliance and this may have partly contributed to their difficulty in resolving the alliance ruptures.

5.2 Therapist's Rupture Resolution Interventions

We compared the strategies that the therapist adopted to deal with the several rupture markers, with those proposed by Safran and Muran´s (2000) Rupture Resolution Model. In order to do that, we carefully examined each episode, looking for implemented and non-implemented resolution strategies. This qualitative analysis was done independently by the two first authors using a grid of rupture resolution interventions adapted from the Rupture Resolution Rating System (Eubanks et al, 2009)[6]. After their independent analysis of the episodes, the two judges discussed their ratings. For the total of 22 rupture markers, there were 10 therapist´s rupture resolution attempts and 36 failures in the expected interventions according to Safran and Muran´s Resolution Model, that is, the number of resolution attempts was about 4 times less than the expected one. In what follows we illustrate some of the markers and their respective resolution attempts and failures.

As we'll see, in all the rupture episodes identified, the key element which contributed to the therapist´s inadequacy was her rigidity shown in the way she followed her own agenda, without taking into account the patient´s experience about the rupture episode.

Early in session five, Laura was talking about the problems she had with her boyfriend during the previous week, and immediately after the patient´s expression of

[6] The grid of rupture resolution interventions as well as the transcriptions of the episodes and the respective ratings, may be found respectively in the Appendixes III and IV.

distress, the therapist asked her about the psychiatrist (something they had already talked about in the fourth session):

P (Patient): .... *I feel like calling him* (boyfriend), *but then I think: I don't know if that's what I want, I don't know… I'm very confused...*

T (Therapist): *Besides, did you try to get information about the psychiatrist?*

P: *No, But I have already decided... It´s like I've already told you, I'm against medication, I don't know if that would help me, and I really don't have money to pay for that, I thought it wouldn't be worth.* (Rupture Marker which we will call from now on RM)

T: *Your indecision seems to be interfering with the relationship with your boyfriend. I must tell you that it is really important that you consult a psychiatrist because that will help you stabilize your mood... you´re making very important decisions in your life, and if you were more stable you would do it more consciously, if your mood kept stable for some time you would be able to think in a better way about things. Does that make any sense?*

P: *You're not the first person who has given me the advice to look for a psychiatrist, but... I don't know.... I have some resistance...* (RM)

T: *Of course, but you're not going to the psychiatrist because you're happy...*

In this segment we see that after a subtle attempt to provide a rationale for the task by explaining the utility of looking for psychiatric help, which corresponds to a rupture resolution intervention, the therapist failed to implement another important intervention: inviting the patient to express her concerns about the task and validate them.

They then went through an argumentation sequence in which both repeatedly defended their arguments. There was a moment in which Laura cried while the therapist was explaining the need for the medication. After the argumentation, Laura accommodated to one part of the therapist request, agreeing in setting the medical

appointment, but the therapist remained inflexible and instead of exploring Laura´s fears of becoming dependent on the medication, she made her an ultimatum:

> **P:** *I may set a doctor appointment, but I don't know if I´ll be able to take the medicine, I don't know... I'll have to think about it, it's something that might make me feel even worse.* (RM)
>
> **T:** *But worse in what way?*
>
> **P:** *In the sense that I'm stable just because of the medication dependency.* (RM)
>
> **T:** *At this point you only have two options: I will only work with if you're on medication, because you are not stable and as a technician I know you need medication, so it's not ethical if I work with you without you even seeing a psychiatrist and listening to his opinion. And this medication will help you find your own resources, those that are within you, but you first need some help to find them, do you understand?*

After a timid attempt to invite the patient to express her concerns about the task ("*But worse in what way?")*, the therapist failed several expected resolution strategies: to attend to the rupture marker and the vicious cycle they were getting involved in; to recognize her responsibility for that vicious cycle; to disclose her internal experience within the context of the rupture and to change the task or reframing it in response to patient´s concerns.

The session kept going and any topic Laura brought to the session was reframed by the therapist as evidence that Laura needed to get medication. Laura cried for the second time in the session while the therapist was talking and ended up agreeing to schedule the medical appointment. Although Laura accommodated for the second time in the session, she continued expressing her fears and doubts about the medication, and the therapist kept repeating the same argument in an apparently never ending debate.

P: *But I can't get this because I think that the work must begin within me, those are things that I may try to do, because in a way I have agency in the process, it´s not the medication that is going to determine things.* (RM)

T: *But the medication will stabilize your mood.*

P: *Right, but I may try to do that by myself.* (RM)

T: *But it will be much more difficult...*

P: *Yes, but I believe that everything it's possible.* (RM)

T: *The thing is: in terms of our work, in terms of ethics the person has to be stable so that we can work, because if the person is in constant ups and downs.... this happens with a lot of people and there are a lot of people that manage to stabilize their mood through the medication, and then later we'll find some techniques to help us control those moments of crisis.*

In this segment we notice the therapist failure in several resolution interventions: to attend to the rupture marker and the interactive cycle they´re involved in; to link this rupture with previous interpersonal patterns within the therapeutic relationship in which the therapist had the same felling of fighting with the patient for example; to disclose her experience of the interaction and to acknowledge her responsibility for the problem in the interaction.

The next session started in a very similar manner: they began by looking at the mood daily records and while talking about Laura´s mood during the week, the therapist re-introduced the same topic in a non-responsive way to patient´s emotional needs.

T: *And you started feeling down again... and also today you´re feeling down?*

P: *Yes, I´m am...*

T: *And what about the psychiatrist? did you try to get the doctor appointment?*

P: *... If I really don't want to go and take the medicine, do you think that puts at risk the therapeutic process?*

T: *Yes, I do, because it will affect your ability to make decisions.*

P: *And we won´t be able to continue our sessions?*

T: *No.*

P: *No?! Why?*

T: *I already told you that! How can I work with you if your mind is not capable of doing it in a conscious way? That wouldn´t be responsible, because right now you're very fragile, you're overwhelmed by emotions that don´t allow you to make the most correct decisions...*

P: *I see... but I think it´s delicate...* (RM)

T: *Ok and it´s up to you to do what you think is the best for you, you are free to do what you want.* Note that the patient is open to the therapist point of view (*"I see..."),* but the therapist is not.

P: *But I´m feeling pressured... In the beginning I didn´t know whether this would help me or not but then I started to trust this treatment and I invested a lot on this therapy, but now I´m feeling pressured...* (RM)

T: *I´m doing what's the best for you, I can´t work with you knowing that you´re not able to make decisions, that would be very irresponsible, right?*

P: *I don´t know, I think that should be other ways…* (RM)

T: *You´re really reluctant to take the medicine?*

P: *I don´t know....*

In this segment after several rupture markers in which the patient expressed she was feeling pressured, the therapist again failed important interventions: to invite the patient to directly express her negative sentiments and vulnerability and to acknowledge her responsibility for the problem in the relationship by saying something like: "I see how you may have felt hurt by what I said". According to Safran and Muran´s model (2000) this is a crucial rupture resolution intervention because it frames the impasse as a mutual experience which strengthens the alliance.

In the next segment the patient gave the therapist another "opportunity" to validate her experience of feeling pressured within the relationship, and again the therapist attributed Laura´s experience to cognitive distortions derived from her mood lability:

....

P: *Yes… I just don't think things need to be this extreme: is this or nothing…*(RM) *I need help because in this moment things are very extreme in my life...*

T: *Things look extreme to you now, because your mood only allows you to see things in extreme ways: either I do this or I do not.*

P: *I believe in intermediate solutions, but situations are leading me to extreme positions. My boyfriend for example, I never chose to lose the bond I had with him, I really wanted to keep it… but because I chose something different (*to study abroad*), he's not able to look at what we had in the past anymore. Suddenly the bond we had, which I didn't want to lose is at risk. I only made a choice but the love I feel about him did not change, I feel we could find an intermediate solution...*

T: *If you agree on taking the medicine, we'll manage to keep on working about your concerns, but first you need to be stable, that's what the medicine will help you to do.*

Even after Laura´s suggested that there was a parallel between what she was feeling in the session and what she felt in other relationships, the therapist was unable to link the rupture to larger interpersonal patterns in the patient´s life and to acknowledge her responsibility for what was happening. Both strategies could have been implemented by saying something like: "I see that you may be feeling a little pressured right now and that feeling may be somehow related with what you´ve been feeling in other relationships..."

This session ended with the therapist saying that she would wait until Laura went to the psychiatrist, to schedule the next session. Since Laura decided not to see the psychiatrist, the therapist´s ultimatum eventually led to the dropout. The dyad scheduled a termination session in which Laura expressed her feelings in a more affirmative way.

She started by talking about how she trusted this therapy, despite the differences she found between the therapist and herself:

P: *There were some things that helped during this treatment, I appreciated your willingness to help me but I got really upset with your attitude about the psychiatrist.* (RM)

T: *I see... I understand*

P: *And... You know... I think people who work with human beings should have some flexibility and admit that although there´s a standard procedure, each person is unique,* (RM) *thus each person will need a specific treatment and will....*

T: *Right and you had a specific treatment for your case...*

P: *Yes... yes... but the fact that just because I didn't agree with that treatment you told me: "It is all or nothing, because you´re making very important decisions in your life and I can´t be responsible for that." Those are decisions I´ll make any way, so I could have had the support you think is the best for me, or I could have had at least the one I´m able to receive in this moment. I felt pressured and I really think that´s not right* (RM). *In fact I would like to write this down and present this complaint to the team, because I think this is something that cannot be imposed... I really trusted this therapy, I thought it would be a support for me and suddenly I lost that support too...* (RM)

T: *I already listened to what you had to say, but you also have to understand that our job here is to do what we consider to be the best for people, and we thought this was the best for you in this moment.*

We see that once again the therapist was not able to acknowledge her responsibility for the patient feelings and to disclose her internal experience within the context of the rupture, by saying something like: "I was worried about your symptoms and this may have caused me to insist too much on stabilizing them"…

P: *Right, but it could be the best option according to your perspective but if it´s not a viable option for me, an intermediate solution, a negotiation must be found...*

T: *Right...*

P: *So it's something a little extreme, it does not work...*

T: *I understand your revolt... this was like a shock for you right? You received kind of a…it's almost…when you talk about it seems like something was imposed to you right?*

Here we identify the first therapist´s attempt to acknowledge her responsibility for the problem and invite the patient to directly express her negative feelings. Later in the session:

P: *I guess the condition that was imposed made me lose the confidence I had in this therapy. I felt that I was the one that was being helped but I was not respected as a decision maker.* (RM) *So if I was not being respected on this which was the pre-condition for the therapy success, I would not be able to bring up any of my real problems to the sessions.*

T: *So you didn't bring up the real issues that were disturbing you?*

P: *I brought them... What I´m saying is that since regarding this first decision about the psychiatrist I was not feeling respected, in what concerns the other decisions I wouldn´t be, you know... my voice wouldn't be truly listened to. This work was productive by helping me having things more organized: the daily sleep and mood records and the training on assertiveness, but I needed more than that....*

T: *What did you need?*

P: *I don´t know... I needed a therapy that was with me, with whom I really am*

5.3 Therapist´s Variables

This therapist came out looking good in terms of the various measures we used to evaluate her: she was securely attached, she had positive interpersonal schemas, she had no tendency to use aggressive affect regulation strategies and she scored high in all the

wisdom dimensions. Considering these results we may wonder: why was she unable to do a better job negotiating these ruptures?

The answer to this question might be found when we look to a different sort of variables such as the therapist´s internal states during the session. In other words, the ability to negotiate the alliance in a beneficial way, might depend not only on therapist´s more stable features such as her attachment organization, but also on more dynamic features such as the way the therapist was feeling in this session with this particular patient, at this particular moment of her career.

To assess this kind of variables we relied on a phenomenological methodology and used the interpersonal process recall. We asked the therapist about her experience during the rupture episodes right after she watched the video of each episode.

The fact that she was a novice therapist, in the very beginning of her clinical practice and the very structured supervision she received, were referred by the therapist as the factors that contributed to the way she dealt with the ruptures. *"The fact that I was a novice and everything was new for me was determinant, if I was a more experienced therapist I could have reacted in a different way. Also the instructions I received from my supervisor, that the best thing to do was to look for psychiatric help... My supervisor thought that her symptoms were severe, in my opinion they were not that severe… We could have found another solution, but considering that she was much more experienced than me, it was safer to do that."*

While watching the episodes, the therapist said more than once that she had experienced an internal conflict between two contradictory needs: *"I wanted to keep my role as a therapist and do what I thought it was correct, but on the other hand I could feel the suffering of my patient..."* This internal conflict could have been disclosed in an adequate manner, however it was internally experienced by the therapist contributing

to her increasing anxiety, which, in turn may have led to the rigid insistence on the need for medication and in some defensive behaviours: *"I felt I needed to defend myself, that´s why I kept on talking about technical aspects*."

It might have been more beneficial to the alliance to metacomunicate about this internal struggle saying something like: "Right now it feels like we are in an impasse: you're feeling that my support is contingent on your giving into your beliefs about medication.... I'd like to but I'm afraid of the consequences. Is there any way we can work our way out of this without either of us feeling that we're doing something that feels unacceptable?"

As Safran and Muran (2000) argue this kind of intervention may serve to open an internal space that will free the therapist from the need to defend her/himself. The ability to metacomunicate about the interaction, in such a way is a complex therapeutic skill and may require specific training in relational interventions. Therefore, we think another important variable was the therapist´s lack of training in this sort of alliance negotiation skills, which is common in CBT oriented training and supervision.

6. **DISCUSSION**

This dyad was not able to negotiate the strains in the alliance in an efficacious way. When we carefully looked at the transcriptions of the episodes, we found that few of the proposed rupture resolution interventions proposed by Safran et al. (2000) were implemented.

Dr. S´s inflexibility, which, as we saw in the previous section, resulted from her experience of anxiety and ambivalence, probably made it more difficult for her to implement the first step in the resolution process: to attend to what was going on in the interaction. Therefore all the other interventions: to validate the patient´s needs, to make

links to broader pattern of interaction, to acknowledge the mutual nature of the impasse, and to negotiate a new task, failed.

The fact that the therapist was so committed to the application of the therapeutic technique closed the door to the exploration of the patient´s experience. Therapist´s persistence with the implementation of the technique regardless of patient dissatisfaction or disagreement is a common error in unresolved rupture episodes. Castonguay et al. (1996) found that in poor outcome cases, therapists tended to deal with ruptures increasing their adherence to the cognitive model and kept on trying to fit the patient negative experience in the distorted cognitions instead of responding to the rupture marker in a flexible way. This same process seems to have occurred with our CBT therapist.

Rhodes et al. (1994) examined the memory of the patient for resolved and unresolved rupture moments and found that in the resolved cases the therapist had apologized, accepted his/her responsibility for the misunderstanding or simply changed his behavior. Again these were actions our therapist was unable to do.

Alliance ruptures resolution processes may promote patient´s change process, in that they help the patient to become aware of the interpersonal cycles they tend to establish in the interaction with others (Safran & Muran, 2000). Because the therapeutic relationship constitutes a protected and emotional safe context with someone who is able to metacomunicate about the relationship and in doing that is able to answer to the patient in a different way, the patient will be given a chance to defy his/her maladaptive interpersonal schema. In this case, once ruptures were not addressed in a beneficial way, we believe Laura could not achieve significant therapeutic gains from them as the OQ45 scores reveal. The problematic interpersonal issues the client brought to therapy were acted out in the therapeutic relationship, but they could not be challenged.

This study provided a rich description of the interpersonal exchanges between therapist and patient in unresolved rupture events and it also shed some light on the therapist variables that might have influenced the therapist´s inability to respond to the rupture markers in a beneficial way.

However the analysis is at the single case level, which prevents us from making any generalizations about other cases. Replication case studies following the same structure would be needed in order to empirically validate the hypothesis that therapist variables such as lack of training in alliance negotiation interventions; a very directive and structured supervision or the experience of an internal conflict might negatively influence rupture resolution processes.

Another obvious limitation of this study has to do with the absence of a comparison to a good outcome case in which the rupture episodes were dealt with effectively. That would clarify the distinctions between adequate and inadequate alliance negotiation interventions. In fact, the great majority of rupture cases in our sample corresponded to non-resolved cases, which might be related to the therapists' lack of training in more relational interventions, due in part to their basic CBT orientation.

Finally the use of a recall video assisted interview is not free from limitations because the reports provided by the participants about the episode had already been cognitively and emotionally processed, so they might not be able to capture all the aspects of the participants' real experiences. Some would argue that we can never assess participant´s internal states through introspective methods, because some aspects of people´s experiences constitute *blind spots* the person is not even aware of. However, despite the controversy around this methodological issue, we think the BSR is still an alternative to help the subject to provide a credible and useful description of his

experience, because it is very systematic, precise and easy to tie to specific session events (Elliott, Slatick, & Urman, 2001).

7. IMPLICATIONS FOR PRACTICE AND FUTURE RESEARCH

The main contribution of this study is the enhanced comprehension about what can prevent the therapist to implement crucial rupture resolution interventions, leading to repetitive alliance strains, which may, in turn, culminate in therapeutic dropout.

We think that replication of results across case studies with different patients is necessary for us to consolidate what we already know about rupture resolution processes. The findings of this case study consolidate the ones obtained by previous case studies such as Aspland et al. (2008), in which the authors found that therapist´s inflexibility led to the inability to attend to the rupture marker and explore the patient´s experience. Nevertheless, we believe this study made a special contribution by exploring the therapist´s experiences of the rupture episodes and also by evaluating therapist internal variables such as attachment organization.

In our view, the fact that a psychologically healthy therapist, at least as much as we could assess through the instruments we used, was unable of negotiating the alliance in a therapeutic way, is an important aspect that should inform future research on therapist variables. If we really want to know what specific factors help the therapists deal with alliance strains in a beneficial way, we need to consider not only more stable variables, such as the therapist´s attachment organization, but also more dynamic ones, such as the therapist´s internal states during the episodes, as well as the therapist's processes outside the session that may be related to the episodes. This means we should use methods that allow us to assess this kind of variables, which may also require the

extension of the analysis to the broader context of the psychotherapeutic process, that is, the supervision, the political and theoretical values of the mental health service, etc.

We think the main implication of our case analysis has to do with therapists' training. It is reasonable to think that therapists with the characteristics this therapist possessed (positive interpersonal schema; secure attachment organization; good affect regulation skills) will be good at negotiating ruptures, but though necessary those characteristics may not be enough. Even those clinicians, who are psychologically healthy, with very positive interpersonal histories, need to learn how to deal with the inevitable anxiety caused by alliance ruptures. Only a very restrictive group of therapists will do it intuitively, the great majority will have to be taught to learn how to do it, the same way they are taught to learn how to do cognitive restructuring or systematic desensibilization.

These are complex therapeutic skills and the fact that they have to be implemented in a context of tension and anxiety, as usually happens in rupture episodes, makes them even more complex, as the words of our therapist illustrate: *"I felt that I was inside a boat in the sea… until the end of the third session the sea was very quiet, but suddenly the waves started to grow and although I was very frightened I had to hold on to be able to get off that storm…. At the end of the session I went home and I wondered if I had done the right thing..."*

8. REFERENCES

Ackerman, S.J., & Hilsenroth, M.J (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy Practice and Research, 38,*(2), 171-185.

Ackerman, S.J., & Hilsenroth, M.J (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1–33.

Agnew, R.M., Harper, H., Shapiro, D.A., & Barkham M. (1994). Resolving a challenge to the therapeutic relationship: A single case study. *British Journal of Medical Psychology, 67,* 155-70.

Aspland H., Llewelyn S., Hardy G., Barkham M., & Stiles W.B. (2008). Alliance Ruptures and Rupture Resolution in Cognitive Behavior Therapy: A Task Analysis. *Psychotherapy Research, 18*(6), 699-710.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: a qualitative analysis. *Journal of Counseling Psychology, 42*(3), 323–337.

Baptista, A. (2009). Escala de regulação do afecto: estudo para a adaptação portuguesa (unpublished master's thesis). Universidade do Minho, Braga.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychology, 4,* 53-63.

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy. *Psychology and Psychotherapy, 79,* 395-418.

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J. & Hayes, A.M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497-504.

Coutinho, J, Fernandes E., & Safran J. (2008). Versão Portuguesa da Escala de Auto-Avaliação de Sabedoria Pessoal. *Actas da XIII Conferência Internacional "Avaliação Psicológica: Formas e Contextos"* Braga.

Derogatis, L.R. (1993). *Brief Symptom Inventory: Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Elliott, R., & Shapiro, D.A. (1988) Brief Structured Recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology, 61*, 141-153.

Elliot, R., Slatick, E., & Urman, M. (2001). Qualitative Process Research on Psychotherapy: Alternative Strategies. In J. Frommer, & D. L. Rennie (Eds.), *Qualitative Psychotherapy Research: Methods and Methodology*. Lengerisch: Pabst Science Publishers.

Eubanks-Carter, C. Muran, J.C., & Safran, J.D. (2009). Ruptures Resolution Rating System (3R's) Manual. Unpublished manuscript, New York: Beth Israel Medical Center.

Fassnacht, D, & Machado, P.P. (in preparation). The Outcome Questionnaire (OQ-45.2) in a Portuguese population: Psychometric properties, norms and confirmatory analysis.

Foreman, S.A., & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry*, *142*(8), 922-926.

George, C., Kaplan, N. & Main, M. (1985). Attachment interview for adults. Unpublished manuscript. University of California at Berkeley.

Gouveia, J.P., Cunha M., Robalo, M. (1997). Avaliação de Esquemas Interpessoais: A versão portuguesa do Questionário de Esquemas Interpessoais de Safran e Hill. *Psychologica, 17,* 105-127.

Gratz, K.L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioural Assessment, 26*(1), 41-54.

Hill, C., & Safran, J. (1994). Assessing interpersonal schemas: Anticipated responses of significant others. *Journal of Social and Clinical Psychology, 13,* 366-379.

Horowitz, L,, Rosenberg, S., Baer, B., Ureiio, G., & Villasefior, V.S. (1988). The Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885-892.

Horvath, A.O., & Greenberg, L. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford Press.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Huppert, J.D., Bufka, L.F., Barlow, D.H., Gorman, J.M., Shear, M.K., & Woods, S.W. (2001). Therapists, therapist variables, and cognitive– behavioral therapy outcomes in a multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology, 69,* 747–755.

Klein, M.H., Mathieu, P.L., Gendlin, E.T., & Kiesler, D.J. (1969). *The Experiencing Scale: A research and training manual.* Madison, WI: Wisconsin Psychiatric Institute.

Klein, M.H., Mathieu-Coughlan, P., & Kiesler, D.J. (1986). The experiencing scales. In L. Greenberg & W. Pinsof (Eds.), *Psychotherapeutic process* (pp. 21–71). New York: Guilford.

Kivlighan, D.M., Clements, L., Blake, C., Arnez, A., & Brady, L. (1993). Counselor sex role orientation, flexibility, and working alliance formation. *Journal of Counseling and Development, 72,* 95–100.

Kobak, R. (1993) *The attachment Q-sort.* Unpublished manuscript University of Delaware.

Lambert, M.J., Burlingame, G.L., Umphress, V.J., Hansen, N.B., Vermeersch, D., Clouse, G., & Yanchar, S. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3,* 106-116.

Lambert, M.J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., Huefner, J.C., & Reisinger, C.W. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ 45.2).* Wilmington, DE: American Professional Credentialing Services.

Machado P.P., & Horvath A. (1999). Inventário da Aliança Terapêutica – W.A.I. In M. R. Simões, M. M. Gonçalves & L. S. Almeida (Eds.), *Testes e Provas Psicológicas em Portugal* (Vol.2, pp.87-94). Braga: APPORT/SHO.

Orlinsky, D.E., & Howard, K.I. (1975). *Varieties of psychotherapeutic experience.* New York: Teachers College Press.

Piper, W.E., Joyce, A.S., Rosie, J.S., Ogrodniczuk, J.S., Mccallum, M., O'Kelly, J.G., & Steinberg, R.I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy, 36(*2) 114-122.

Rhodes, R.H., Hill, C.E., Thompson, B.J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counselling Psychology, 41*(4), 473-483.

Safran, J.D., & Segal Z. (1990), *Interpersonal Process in Cognitive Therapy*. London: Aronson.

Safran, J.D., & Muran, J.C. (2000) *Negotiating the Therapeutic Alliance, A Relational Treatment Guide* New York: The Guilford Press.

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 & Research, 5,* 126-143.

Shaffer, C. (1993). *The role of Adult Attachment in the Experience and Regulation of Affect* Unpublished doctoral dissertation, Yale University, New Haven

Tracey, T.J., & Kokotovic, A.M., (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 50*(1), 207-210.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B.E., & Brown G.S. (2005) Estimating Variability in Outcomes Attributable to Therapists: A Naturalistic Study of Outcomes in Managed Care. *Journal of Consulting and Clinical Psychology, 73*(5), 914–923.

Webster, J.D. (2007). Measuring the character strength of wisdom. *International journal of aging & human development, 65*(2), 163-183.

CHAPTER IV

THERAPISTS´AND CLIENT´S EXPERIENCE OF ALLIANCE RUPTURES

CHAPTER IV

THERAPISTS´AND CLIENT´S EXPERIENCE OF ALLIANCE RUPTURES[7]

1. ABSTRACT

The process of going through moments of ruptures in the therapeutic alliance, and resolving them in an efficient way, may play an important role in successful treatment, especially for clients with a rigid interpersonal function such as personality disordered clients. This paper explores the client and the therapist´s experience of alliance rupture events. 8 therapists and 8 clients with personality disorders participated in this study. Ruptures were identified using the Rupture Resolution Rating System. All the sessions of each case were videotaped and rated with the System. Approximately one week after the session both client and therapist were separately interviewed with an adapted version of the Brief Structured Recall (Elliott, 1993). The interview included questions related to the causes of the event; the way it evolved; its impact on the therapeutic process and the participants´ experience during the event The interviews were analyzed by 5 judges using the Consensual Qualitative Research. We discuss the results of this qualitative analysis and their clinical implications for psychotherapeutic practice and training.

2. INTRODUCTION

Ruptures in the therapeutic alliance are moments of tension or breakdown in the alliance between the therapist and the client (Safran & Muran, 2000).

[7] This work is in the last phase of preparation before submission, in coautorship with Eugenia Ribeiro, Clara Hill and Jeremy Safran.

The experience of rupture episodes typically involves negative feelings such as anger, defensiveness, boredom, and failure on the part of both the participants in the interaction (Elkind, 1992).

During ruptures, both participants typically experience negative feelings such as anger, defensiveness, boredom, and failure (Elkind, 1992).

We do believe, however, that the two different types of ruptures described by Safran and Muran (2000) - withdrawal and confrontation ruptures - probably activate different types of experiences in the therapist and the client and could also have a different impact on the therapeutic process. In withdrawal ruptures, the client either moves away from the therapist or the client moves toward the therapist, but in a way that denies an aspect of the client's experience, whereas in confrontational ruptures, the client moves against the therapist, either by expressing anger or dissatisfaction or by trying to pressure or control the therapist. In addition, according to Safran and Muran (2000) the resolution process of the two types of markers is a different one. In withdrawal ruptures the therapist should explore in an empathic way the client´s internal processes that prevent the client to fully experience and express his emotions, so that the client can accept and express his/her more vulnerable feelings and underlying needs. In confrontation markers the therapist should be consistent in the attempt to survive the client´s aggressive behaviour without reacting with counter-hostility so that client´s anger and aggressiveness can give place to primary emotions and needs that the client was not able to process.

Because ruptures offer an opportunity for both the therapist and the client to learn how to negotiate the needs of the self and other in a context where the interpersonal relatedness is threatened (Safran & Segal, 1990), they may constitute key moments in the psychotherapeutic process, thus these events are important to study.

Although some studies have explored such related concepts as therapeutic impasses (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) and therapeutic misunderstandings (Rhodes, Thompson, Hill, & Elliott, 1994), there are no studies that have directly addressed therapists' and clients' experiences of alliance ruptures. Therefore, the main goal of this study was to investigate therapists' and clients' experiences of rupture events.

2.1 Empirical Research

In terms of the experience of the participants during the events, Hill et al. (1996) found that therapists felt frustrated, disappointed, angry, hurt, confused, and less self-efficacious during therapeutic impasses. After the episode, the therapists tried to understand what had gone wrong and had self-doubts about their own abilities as a result of the impasse. Although Hill et al. did not investigate the effects of the impasses on clients, therapists reported that their clients may have gone through the same kind of negative experience. They indicated that clients often felt blamed, abandoned, and criticized by the therapist, disappointed, hopeless, and discouraged or self-blaming about the lack of progress.

In terms of factors associated with the emergence of misunderstanding, Rhodes et al. (1994) found that in the subsample of unresolved misunderstanding events clients reported that there was initially a poor relationship. In the immediate moment just before the event clients reported that they were involved in a therapeutic task but that the therapist had done something either that the client did not want or need or that the therapists failed to do something the client wanted or needed.

Also in the Hill et al. (1996) study the impasses were characterized by therapists as involving an ongoing general disagreement between therapists and clients about the

way in which therapy was conducted, rather than as involving a single negative event. These were dyads whose therapeutic relationship had a previous history of power struggles over the tasks and goals of treatment. The authors found a list of other variables related to the occurrence of impasses such as clients major interpersonal problems (e.g., a diagnosis of a personality disorder, a history of problems with their families- of-origin or current intimate relationships); possible therapist mistakes (e.g., being too pushy or confrontative, being unclear, being inconsistent in terms of the strategies they adopted, or being inaccurate in their diagnosis of clients); the interference of another person such as the client´s partner or parent in therapy; transference issues and therapist personal issues. Some of them reported that their family-of-origin issues were activated by the clients; several had difficulty in dealing with the clients' expression of anger towards them or with the client´s suicidal ideation.

The activation of therapist´s personal issues and difficulties in dealing with client´s behaviors such as the expression of anger, gives evidence to the Relational Models which assume that the therapist can never look at the therapeutic interaction from an outsider perspective because he is continually participating in it, not only as a technician but also as a person (Safran & Muran, 2000). This is coherent with a *Two Person Psychology* according to which both client and therapist factors may contribute either to the emergence or to the way alliance ruptures are resolved. Therefore it is important to explore the client´s as well as the therapist´s experience of rupture events.

In what concerns the way the therapists dealt with the impasses Hill et al., (1996) found that, most tried to explore with the clients what had happened so that they could help them gain some insight into the situation, but they did not acknowledge or apologize to the clients for their mistakes, as did therapists in the resolved misunderstanding cases in Rhodes et al. (1994).

The strategies that therapists tend to adopt in dealing with ruptures seem to depend, among other factors on their theoretical approach and on whether or not they had been trained in more alliance focused interventions, such as those that are included in Safran and Muran´s Rupture Resolution Model (2000). Some of those resolution interventions are: attending and recognizing the rupture marker; metacomunicating about what is happening in the interaction in the immediate moment and exploring the client´s and the therapist´s own experience of the interaction; and encouraging the client to express his/her feelings toward the therapist or their relationship and underlying needs.

Different studies have shown that when dealing with an alliance rupture therapists may not be able to implement this kind of intervention and may act in a nonproductive way by defending dogmatically their point of view without even considering the patient´s point of view (Rhodes, Hill, Thompson, & Elliot, 1994), by adhering in an inflexible way to the therapeutic model they are implementing (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Piper, Azim, Joyce, & McCallum, 1991) or by reacting with hostility to client´s hostility (Binder & Strupp, 1997).

2.2 Purpose of the Present Study

Our purpose in the present study was to investigate therapists' and clients' experiences or withdrawal and confrontation ruptures as identified by trained judges. We first wanted to know what led to the rupture. Then we were interested in the participants' internal experiences during the rupture event. We were also interested in the interventions therapists used to deal with the ruptures and the helpfulness of these

interventions. Finally, we explored the outcome or the impact of the rupture event on the therapeutic process and on the client.

We believe that the way both participants experience and attribute meaning to rupture events, will determine their capacity to deal with ruptures in a beneficial way. Therefore, if we want to help our therapists to resolve alliance ruptures, we have to use our comprehension about both participant´s perspective to inform our training and supervision programs.

Due to the exploratory nature of those research questions, we used the consensual qualitative research (CQR; Hill et al., 2005; Hill, Thompson, & Williams, 1997) method to analyze the data. Because it allows for an in-depth exploration of participants´ experiences, CQR allows for an in-depth exploration of participants´ experiences and it controls for biases by relying on consensus among different judges (Hill, Thompson, & Williams, 1997).

3. METHOD

3.1 Participants

3.1.1 Therapists and clients.

Eight therapist-client dyads participated in this study. All initially contracted for 30 sessions, but there was a range from 7 to 30 sessions, due to the occurrence of 4 dropouts.

The therapists (7 women, 1 man, all Portuguese, ranging in age from 23 to 34 years of age) worked in a university counseling center. Their clinical experience ranged from 2 to 9 years, with 4 being at the end of their master's program and 4 being at the end of their doctoral program. Their respective 8 clients were all female and Portuguese, ranging in age from 24 to 60 years old. Seven were also receiving psychotropic

medications under the care of psychiatrists while they participated in the study. Using the Structured Clinical Interview for DSM-IV I and II (Spitzer, Williams, & Gibbon, 1997) prior to the start of therapy, 3 of the patients were diagnosed with borderline personality disorder; 2 with histrionic personality disorder, 1 with avoidant personality disorder, 1 with paranoid personality disorder, and 1 with obsessive personality disorder. Their symptoms were quite severe, all having had at least one episode of suicidal or para-suicidal behavior.

3.1.2 Judges.

Five judges coded the occurrence of rupture events. They were four master students (all Portuguese women ranging in age from 22 to 24 years of age), plus the primary investigator (a 27 year old Portuguese woman) trained in the observational system for coding rupture markers.

Another team, with a total of five (all Portuguese female, ranging from 24 to 33 years of age) doctoral psychology students participated as judges for the CQR. All judges were experienced CQR researchers and had participated in other studies using this method. Two espoused an interpersonal theoretical orientation, two a narrative constructivist orientation, and one a cognitive-behavioral orientation. Two groups of three judges were created, such that one three-person team coded the therapist interviews and another 3-person team coded the client interviews (the primary investigator was on both teams and interviewed all the therapists and clients). As is typical in CQR, we present here the biases of the judges so that readers can evaluate the results within this context. The primary investigator believed that ruptures are crucial moments in therapy and likely activate a different type of experiences depending on whether the rupture is a withdrawal or confrontation. She also believed that some

aspects of the participant´s experiences of ruptures are not easily accessed through introspective recall, and thus the interviewer must probe during the interview to help the participant access his/her experience but must also be careful to not unduly influence their answers. A second researcher believed that alliance ruptures are uncomfortable moments in the relationship that occur because the therapist and client have different perspectives. Ruptures are very challenging for the therapist not only in terms of technical knowledge but also at the personal level, because they test the therapist´s ability to deal with difficult moments. A third researcher believed that ruptures represent a break in the relationship related to a disagreement on the therapeutic tasks or goals, a disruption of the emotional connection between the therapist and the client or a difficulty in sharing perspectives. A fourth researcher believed ruptures, occur when the client disagrees with the therapist´s requests or formulations. The fifth researcher thought that ruptures are inevitable moments in therapy when there is disagreement between therapist and client; and that these ruptures can jeopardize the relationship and so must be resolved. Thus, all 5 judges believed that ruptures are critical moments in therapy.

The auditor, one of the authors of this paper, was a 45 year old female professor with more than 20 years of clinical practice, an expertise in psychotherapeutic process research, and familiarity with CQR. She believed ruptures are inevitable episodes in therapy, signalizing a noncollaborative mismatch between therapist and client. If adequately resolved, ruptures may foster the purposive and collaborative dyad interaction.

3.2 Measures

- Alliance Ruptures - The Rupture Resolution Rating System (3RS; Eubanks - Carter, Mitchell, Safran, & Muran, 2009) is an observational system for coding rupture markers and resolution. While watching the session, judges record moments when there is a lack of collaboration or tension between therapist and client indicating the emergence of a rupture. Once identified, the judges code whether the rupture is a confrontation and/or a withdrawal; whether the marker is a denial or complaint about the progress of therapy, and then rate the clarity of the event on a 5-point Likert scale (1 = marker did not occur, 5 = many clear or very clear examples of the marker). Finally, after watching the entire session, the judges rated the overall intensity or impact on relatedness of withdrawal and confrontation ruptures using a 5-point Likert scale (1 = withdrawal/confrontation ruptures did not occur, no significance for the alliance, 5 = withdrawal/confrontation rupture(s) occurred, major significance for the alliance). The intraclass correlation coefficient for the overall ratings of withdrawal and confrontation calculated for 30% of the sessions was .73 for the withdrawal ratings and .96 for the confrontation ratings.

- Participants´s Experience - Interview - We used a semi-structured video-assisted face-to-face interview adapted from Elliott´s brief structured recall for helpful moments in therapy[8]. During this interview, the participant was instructed to put him or herself back into the event as much as possible by trying to remember what was going on for him or her before answering the questions.

Similar to the Rhodes et al. (1994) study of misunderstanding events, the interviewer asked for (a) the background and causes of the event, (b) the participants´

[8] The interview protocol (therapist´s and client´s versions), may be found in the Appendix V.

experience during the event (including feelings and thoughts), (c) the way the episode evolved, and (d) the impact or importance of the episode to the process and to the client´s change process. In addition, we asked clients about the similarities between the rupture event and outside life, what the therapist said or did that was useful, and what she/he had expected the therapist to do. For the therapists, we added a question about the influence of his/her professional and personal characteristics in the way they dealt with the event.

3.3 Procedures

3.3.1 Recruiting.

Collaborating psychiatrists from a nearby public hospital were asked to recruit clients. These psychiatrists told clients that they would receive 30 free videotaped psychotherapy sessions at a university clinic. If interested, potential clients signed an informed consent form and were then interviewed by researcher-clinicians using the Structured Clinical Interview for DSM-IV I and II (Spitzer, Williams, & Gibbon, 1997). They were selected for the study only if diagnosed with a personality disorder. Seven clients were recruited in this manner (five additional potential clients were not selected because they were hospitalized due to suicide attempts). The eighth client had sought help at the university clinic and was asked to participate after being diagnosed with a borderline personality disorder; she agreed and signed an informed consent form.

Once clients were identified, their therapists were asked if they would participate, all agreed and signed informed consent forms.

3.3.2 Therapy sessions.

Therapy sessions, which were videotaped, took place on a weekly basis. Therapists also attended weekly group supervision meetings, in which they discussed a clinical case and watched the videos of sessions for that case.

3.3.3 Identification of rupture events.

After being trained to high reliability to use the 3RS, at least one judge watched the videotapes of the sessions during the week that the session occurred. They used the 3RS to identify all the withdrawal and confrontation events in the 150 sessions of the 8 cases. All identified events were rated for clarity. At the end of each session in which events were identified, session-level ratings were made about the intensity/impact of all the rupture events in the session. From the identified rupture events we selected the 14 withdrawal and 13 confrontational events with the highest intensity/impact ratings (≥ 3 on the Likert scale), with 2 to 5 events per case.

3.3.4 Interviews.

The primary investigator separately interviewed the therapist and the client about the identified rupture events in a given session approximately one week after the session and at a different time from the regular session. The researcher first showed the excerpt of the event and then asked the questions from the semi-structured interview protocol. Each interview lasted about 30 to 45 minutes. Each client and therapist was interviewed 2 to 5 times depending in the number of identified events.

3.3.5 Data preparation.

Two research assistants and the primary researcher transcribed verbatim the audiotapes of the interviews, omitting all identifying information. The transcripts were then checked against the audiotapes to verify the accuracy of the transcription.

3.3.6 Coding into domains.

Each judge first independently developed domains by reading through the first four cases. They then met and discussed the domains until they arrived at consensus about the list. They then used the domain list to code the remaining four cases, revising the domains to fit the emerging data (and going back to code the previous cases if domains changed). In all team meetings, the order of speaking first was rotated to avoid any team member becoming too dominant.

3.3.7 Abstracting core ideas.

After reaching a consensus version of the division of each interview into domains, the judges independently constructed core ideas that summarized the content of the interview data in each domain while keeping as close to the data as possible. They then met as a team to discuss and come to consensus on the wording for each core idea.

3.3.8 Auditing of domains and core ideas.

The consensus version was audited by the external auditor, who then met with the primary team to discuss her feedback. In most cases, the auditor´s recommendations were accepted by the primary team after extensive discussion.

3.3.9 Cross-analysis.

The judges individually created categories that reflected the themes present in the core ideas for each domain across cases, and then met to resolve discrepancies and create a final list of categories via consensus. During this phase, some of the domains and core ideas were revised to better reflect the data.

3.3.10 Auditing of cross-analysis.

The external auditor audited the cross analysis, primarily making suggestions about merging some of the categories into more global ones. The auditor again met with the team to discuss the audit. Once again, most of the auditor's suggestions were accepted and incorporated by the primary team.

4. RESULTS

Table IV - 1 shows the results for the therapist interviews, and Table IV - 2 shows the results for the client interviews for the 14 withdrawal events (which we will call from now on WD) and 13 confrontation events (which we will call from now on CF). Following Hill et al.'s (2005) recommendation, categories were considered general if they applied to all or to all but one of the events of one type, typical if they applied to more than half of the events (7 to 13), and variant if they applied to at least two cases up to the cutoff for typical. Categories that applied to only 1 event were dropped or merged into other related categories. In comparisons of the two types of events (WD and CF), frequencies had to vary by more than 30% to be considered important (e.g., 8 of 14 WD cases, or 57%, versus 3 of 13 of CF cases, or 23%, would be considered to be an important difference). We report first on findings for therapists and then for clients. Within perspective, we first describe categories that were similar across types of events

and then describe results that differed across types of events; we do not describe categories that occurred only variantly for one type of event but were not different across types of events (although these results can be found in the table).

In terms of the distribution of the 14 withdrawal and 13 confrontation events across the 8 cases, 2 cases had 2 WD and 2 CF events, 2 cases had 3 WD and 1 CF event, 1 case had 2 CF and 1 WD events, 2 cases had only 3 CF events , and 1 case had only 2 WD events. Dropout cases had more CF events than did continuers (61% versus 35%), and all the selected events occurred in the last sessions before the client abandoned treatment. In addition, in cases with both WD and CF, CF events occurred later in the treatment.

Cases with more WD events were in general cases with some histrionic features, including two clients with histrionic personality disorder. Cases with more CF events were in general cases with borderline and paranoid features. Although we have selected events from all the phases of the therapeutic process, most of the events occurred in the intermediate phase of treatment (from session 9^{th} to 15^{th}).

4.1 Therapists´ Experiences of Rupture Events

4.1.1 **Antecedents**

In terms of long-term background, in both type of events, therapists at least typically reported that a similar episode had occurred previously in both types of events. For example, one therapist (C)[9] said that the client had told her before that she was getting nothing from therapy and that her questions were repetitive. In terms of the immediate context before the event, therapist in both types of events had typically just

[9] The results of the different phases of the consensual qualitative analysis may be found in the Appendixes VI (domains and core ideas) and VII (categories). Cases are identified by letters from A to H, followed by the number of the episode. The examples of core ideas in this text include the identification of the case with the same letters.

tried a new intervention such as asking the client a question or challenging the client to a new perspective or behavior. One therapist (H) reported for instance: "*For the first time I confronted the client with the possibility of changing her needs instead of expecting others to change their behavior."* In addition, therapists in WD events more often than in CF events, reported that clients had been talking about painful topics. One therapist (F) said: "*We were exploring her life history, which was a hard thing for her…"*

In terms of their attributions about the cause of the event, therapists talked about recent life events in the clients' lives. More specifically, therapists in WD events more often than in CF events cited recent negative events with significant others in clients' lives. In one case (F) the therapist said that the event had been probably caused by an argument with the client´s mother; another (D) reported that the event was associated with the fact that in the day before the session, the client´s husband accused her of trying to be hospitalized as a way of getting the things she wanted. In both types of events, therapists variantly attributed the cause to a worsening of symptoms.

A second major category of attributions about the causes of the events referred to deficits in clients' personal characteristics. More specifically, in both types of events, therapists indicated at least typically that clients had dysfunctional interpersonal expectations such as a very low tolerance to any sign of incomprehension or rejection. Furthermore they variantly indicated that clients were critical or confrontational. In addition, therapists more often with WD than CF events attributed ruptures to clients' difficulty in processing and expressing negative emotions as well as in affirming self and confronting others. For example one therapist (F) said: "*The client has very intensive feelings but she´s not able to elaborate or process them.*

Table IV – 1. Therapist´s experience of WD (withdrawal) and CF (confrontation) rupture events

Domain and category	Frequency[10] WD	CF	Exemplary Core Idea
A. Precipitant of rupture event			
1.Previous background	general	typical	*The client had already told her that she was getting nothing from therapy and*
A similar episode had occurred before			*that her questions were repetitive*
2.Immediate context			
Therapist tried a new intervention/challenged the client for novelty	typical	typical	*For the first time she confronted the client with the possibility of changing her needs instead of expecting others to change their behavior.*
They were talking about a painful topic for the client	variant	-------	*They were exploring the client´s life history, which was a hard thing for her.*
3. Causes of the episode related to the client			
Client´s recent life events			
Incidents with significant others	typical	variant	*This was probably caused by an argument with her mother because this type of*
Worsening of symptoms			*episode always happened when something happened at home.*
	variant	variant	*Something that happened during the week made her become more depressed.*
Client´s personal characteristics			
Dysfunctional interpersonal expectations	typical	general	*The client had very high expectations from others, which could very easily go unmet*
Difficulty in processing and expressing negative emotions	typical	-------	*The client has very intensive feelings but she´s not able to elaborate or process them.*
Difficulty in affirming herself/confront others	variant	-------	*Client´s interpersonal pattern: she didn´t agree with the interpretation but she wasn´t able to tell her*
Critical/confrontational	variant	variant	*Client is critical, confrontational:other client would not say that even if he felt it*

[10] Categories marked with are the ones considered "different" in WD versus CF, that is, those that differ by 30% of the cases frequencies (e.g., 8 of 14 WD cases versus 3 of 13 of CF cases.)

B. Experience of the episode			
<u>Therapist´s experience of the episode</u>			
Did not know what to do in that moment	typical	typical	*Felt scared by not knowing what to do in that moment.*
Ambivalent/Confused	typical	typical	*Felt a dichotomy between the need of being a therapist and asking questions although it was painful for the client and the feeling that she could not hurt the client, didn´t want to lose her*
Guilty/ incompetent	variant	typical	*Was feeling angry with herself because she had hurt and disappointed the client.*
Tense, it was difficult to deal with that topic	variant	typical	*That was her own withdrawal strategy: she cut the conversation short, in order not to have to deal with that again.*
Feeling of risk by the newness of the intervention	typical	variant	*Was thinking that once that was something new she was running some risk.*
Angry/impatient about the client´s behavior	variant	variant	*Was feeling very irritated: the only thing she wanted was the client to move on to another topic, she thought: "ok, go on, we already gone over that part…"*
Focused on the client´s experience or the origins of the episode	variant	variant	*Was very curious about how those provocative questions related with client´s life outside therapy*
Comfortable/ close to the client	variant	--------	*Was feeling so close to the client that could even feel comfortable enough to laugh, things were going well and they were moving on.*
Less present in the interaction	-------	variant	*Doesn´t remember of what he felt because only half of his attention was focused on the client*
<u>Therapist´s perception of Client´s experience of the episode</u>			
Client was uncomfortable by having to expose him/herself	typical	variant	*The client changed the topic because it was being very difficult for her to deal with it*
Client felt angry/invalidated by something the therapist have done	variant	typical	*In this event the client confirmed her expectation that she shouldn´t trust the therapist, because he was not interested in her.*
Client wasn´t truly believing in what she was saying	variant	------	*The client did not really wanted to die, she only said that because she wanted the therapist to care for her*
C. How did the T dealt with the Rupture			
<u>T´s intention/intervention goal</u>			
To attend to what was happening/client´s immediate experience	typical	variant	*To understand what was going on for the client in that moment, what was she thinking*
To promote client´s understanding about her interpersonal patterns	typical	variant	*To bring to the session the previous episode in which she had felt that the client had brought to therapy her regular interpersonal pattern.*

Promote proximity and show therapy is a secure space	typical	variant	*Wanted the client to feel that she was still there despite the fact that what the client was telling her was distancing her*
Promote client´s contact with what she/he was avoiding	typical	--------	*Make the client realize that it was hard for her to talk about difficult moments of her childhood.*
To explore his/her contribution to the rupture event	--------	variant	*She tried to admit that she did not understand the client instead of accusing her of not allowing others to understand her.*
To get out of the episode/refocus the agenda on other topic	variant	variant	*When the client changed the topic, insisted on that because wanted to come back to where they were.*
<u>Professional variables that influenced the intervention</u>			
Influence of a client centered therapeutic stance	typical	variant	*The principle of the client as an expert: she listens to the client more than she intervenes.*
Influence of the supervision interpersonally oriented	variant	variant	*The supervision let her realize that her personal history and familiar problems were influencing her intervention.*
Lack of clinical experience	variant	variant	*The insecurity related to her lack of experience made her got from the episode a message that she wasn´t doing the right thing.*
Influence of the CBT approach	variant	variant	*Had a behavioral training, so he wanted to understand how client´s in session verbal expressions manifested the history of reinforcements outside therapy.*
Interest/focus on the therapeutic alliance	--------	variant	*She made research on the alliance on her masters, so she was more attuned with these questions.*
<u>Personal variables that influenced the intervention</u>			
Very careful in the interpersonal contact/ cares a lot about others	variant	variant	*Her need to apologize and validate what the client felt is related with her need to keep proximity and prevent others from feeling that she acted with bad intentions.*
Tendency to focus on the positive side of everything	variant	variant	*She tends to look at the positive side of everything that´s why she used the fact that the client ended up not committing suicide to reinforce her competencies.*
Perfectionist/needs others to appreciate him	--------	variant	*She needs everyone to like her even when she does not like the person: the client is not a person that she likes but she needed her to like her.*
Stubborn/persistent	--------	variant	*She´s a persistent person but admits that that might be felt by others as too much insistence.*
Personal characteristics influenced the event but can´t say how	variant variant	-------- variant	*The fact that she laughed when the client was interrupting her relates to a personal feature.* *Client´s behavior of complaining and asking for her daughter´s care, disturbed*

Influence of personal life experiences			*her because in the past she experienced exactly the same as a daughter.*
<u>Self evaluation of his own intervention</u>	typical	typical	*The intention of increasing client´s confidence in therapy was right, but the way he did it was not, because with that client the cognitive change was not the therapeutic goal.*
Didn´t implemented the intervention in the best way to reach the goals	variant	variant	*She disclosed and exposed herself in a safe way and never felt that they were threatened. Otherwise she would have changed the topic.*
Intervention was adequate	variant	variant	*She admits she did not take into account the alliance and the empathy.*
Was not empathic			
D. Impact of the episode			
<u>On the therapeutic alliance</u>			
Positive impact on the alliance	variant	variant	*Despite the risk it had a positive impact: both got more comfortable with the possible occurrence of similar situations of divergence in the future.*
Negative impact on the alliance	variant	variant	*As they only had one more session before the dropout, this may be related to the fact that the client quit therapy because it might have been too painful for her.*
Doesn´t know	variant	--------	*Does not know if the episode had on the client the impact she expected it to have.*
<u>On the client</u>			
<u>Immediate impact</u>			
Client processed and integrated the novelty the event brought	variant	-------	*The client may have felt better by realizing that everyone goes through difficult things in life and that the therapist could accept that she needed time to talk.*
Client felt uncomfortable for having explored a painful topic	variant	------	*During the week while taking care of her mother she remembered the difficult things she talked about during the episode and she didn´t knew how to deal with it: it was a difficult week for her.*
Client felt invalidated/rejected by the therapist	--------	variant	*The client was looking for evidence that nobody was interested in her and with this may have confirmed that belief.*
<u>Impact on the change process</u>			
Nothing changed due to the event	variant	typical	*Nothing changed for the client after this episode.*
Client became more aware of her functioning	variant	variant	*They reached an understanding about something the client had never thought about: the way her own patterns manifested in the therapeutic relationship.*
Client became less fearful of expressing negative emotions	variant	variant	*It may have been like a test for the client: she saw that people do not all react in the same way so there was no need for her to be afraid to say what she thinks*
The event promoted the changes that came next	variant	------	*There´s not enough information to talk about an explicit change but the episode could have opened doors, so that it comes in the future.*

4.1.2 Experience of the Event

Therapists had a number of internal experiences of the ruptures. Therapists in both types of events typically or variantly reported many negative feelings: not knowing what to do in that moment (e.g., "*I was focused on how I would close that intervention; I did not know where to go from there…"* (G)), feeling ambivalent and confused (*e.g., "I felt a dichotomy between the need of asking questions although it was painful for the client and the feeling that I could not hurt the client because I didn´t want to lose her"(*E)), feeling guilty and incompetent *(e.g., "I was feeling angry with myself because I had hurt and disappointed the client"* (C))., feeling tense because of the difficulty of dealing with the topic (e.g. "*That was my own withdrawal strategy: I cut the conversation short, in order not to have to deal with that again*"(F))., feeling that it was risky to intervene in a new way (e.g., "*It was the first time I did it and was thinking about what the result of the intervention would be*."(G)),, and feeling angry or impatient with the client (e.g., "I *was feeling very irritated: the only thing I wanted was the client to move on to another subject"*(F)). In addition, they variantly focused on the clients' experiences or the origins of the events *(e.g., "I thought that in that moment, it was being hard for the client to think about that*."(H))

A variant reported only for the WD was feeling comfortable/close to the client, whereas a variant reported only for the CF was feeling less present in the interaction. The therapist´s feeling of guilt and incompetence was more frequent in CF ruptures than it was in WD

Therapists also discussed their perceptions of their clients' experiences during the rupture events. More often in WD than in CF events, therapists perceived that their clients were uncomfortable being vulnerable and talking about painful topics (e.g., (F) "*The client changed the topic because it was being very hard for her to deal with that*

it"). In contrast, more often in CF than in WD, they perceived that clients felt angry and invalidated by something the therapist did. (e.g., (A) *The client felt I was not there for her and I was judging her and thinking she was not a good mother.)*

In addition, therapists in the WD rupture events variantly perceived that clients did not truly believe what themselves were saying, whereas therapists never perceived this in the CF events. As an example, in one WD event the therapist said: "*The client did not really wanted to die, she only said that because she wanted me to care for her* (F)."

4.1.3 How Therapists Dealt with Rupture Events

In describing their intentions or goals for dealing with the ruptures, therapists in both types of events at least variantly reported that they wanted to attend to what was happening immediately for the clients in terms of their experiences and needs (e.g, *"I wanted to understand what was going on for the client in that immediate moment, what was she thinking of* (G).) , promote clients' understanding about their interpersonal patterns (e.g., *"I wanted the client to understand that her incoherence was a part of her need to protect herself* (C)" *),* provide support and reassure clients that therapy is a secure space *(e.g., "I wanted the client to feel that she was still there despite the fact that what the client was telling her was distancing her (*C*)"),* and refocus the client on a different topic (e.g., "*When the client changed the topic, I insisted on that because wanted to come back to where they were (*D)".) The first two therapist´s intentions were more frequently reported in WD than in CF.

In addition, therapists reported more frequently in WD than CF events that they were trying to promote the clients' contact with what they were avoiding. For instance, one therapist (C) said she wanted the client to be aware that due to the incoherence of her message she was not able to understand what she was saying. In contrast, in CF as

opposed to WD events, therapists tried to explore their own contributions to the events. For instance, one therapist (G) said tried to admit that she did not understand the client instead of accusing her of not allowing others to understand her.

Therapists also described the professional variables that influenced how they intervened with clients. In both types of events, it was at least variant for therapists to talk about the influence of having a client-centered therapeutic stance (e.g., one therapist (F) said he was influenced by the idea of the client as an expert), of interpersonally-oriented supervision (e.g., one therapist (C) said the supervision was focused on the client´s basic needs, so she was looking for the client´s fears), of a lack of clinical experience (e.g., one therapist said she was in the early stages of her career (B)), and of cognitive-behavioral therapy (e.g., one therapist said she was influenced by her CBT training, because whenever she does not know what to do she goes back to that, because that´s the model she knows better (F)).The influence of a client-centered therapeutic stance was more frequently reported in WD.

Therapists also described personal variables that influenced their interventions. For both types of events, therapists reported variantly their tendency to be careful in the interpersonal contact as a way of maintaining proximity and preventing others from getting disappointed as well as their tendency to look at only positive aspects and run away from difficult topics. As an illustration one therapist (A) said she was influenced by her tendency to try to soften things and run away from what is central and more difficult.

Therapist´s characteristics such as stubbornness and perfectionism/need to be admired by everyone, were cited variantly as influential in CF events but not at all in WD events. As an example one therapist (D) said that the fact that he did not talked in an open way about his fault had to do with the fact he does not like to fail in front of other people.

Finally, therapists in WD events variantly recognized that personal characteristics were influential but were not able to identify specifics, whereas this category did not emerge in CF events. .

In terms of self-evaluation of the interventions, therapists in both types of events typically evaluated their own interventions negatively, indicating that their interventions were not the best for achieving their goals. For instance, some therapists said they would do things differently if they could redo the event, either giving more time to the client or transmitting a clearer message. Variantly, however, therapists in both types of events felt that their interventions were adequate. Another variant that occurred with both types of events was therapists reporting they were not empathic as they should (e.g., *I was not empathic with the client because I was too much focused on her daughter*. (A)

4.1.4 Impact of the Event

Regarding the impact of the events on the alliance, therapists in both types of events variantly reported positive effects (e.g., more openness on the client´s part to talk). They also variantly reported negative effects (e.g., deterioration of the dyad´s emotional bond).

In terms of the immediate impact of the event on the client, therapists more often in WD than in CF events reported that the client seemed to integrate the novelty of the rupture event (e.g., one therapist (E) said that the client may have felt better by realizing that everyone goes through difficult things in life and that she could understand that she needed time to talk), and that the clients left the session feeling uncomfortable for having explored a painful topic (e.g., one therapist (G) said that the painful topics that they explored in the session were re-activated during the week when the client was

taking care of her sick mother). In contrast, therapists more often in CF than in WD events perceived that clients left the session feeling invalidated or rejected by the therapist (e.g., one therapist (A) said that the client may have felt this event as a judgment).

In terms of therapeutic gains, therapists in both types of events at least variantly perceived that nothing changed as a result of the rupture event. However, therapists variantly in both types of events indicated that clients became more aware of their functioning (e.g., *"The client made an insight about the way her own patterns manifested in the therapeutic relationship* (H)), or that the client became less fearful of expressing negative emotions (e.g., *This may have worked like a test for the client so that she could understand that people do not all react in the same way and that there was no need for her to be afraid to say what she thinks (*G)). In addition, therapists more often in WD than CF events perceived that the event facilitated subsequent changes, whereas in CF episodes, most of the therapists said that nothing has changed for the client.

4.2 Client's Experiences of Rupture Events

4.2.1 Antecedents

In terms of long-term background for the event, clients for both types of events variantly reported the presence of a strong alliance. In contrast, other clients variantly reported a weak alliance. Furthermore, clients more often in CF than in WD events reported that a similar episode of dissatisfaction had occurred previously (e.g., one client (C) said that in the previous session they had been involved in a repetitive cycle, and so in the current session she came anticipating that the same waste of time would occur).

In terms of the immediate context before the event, clients in both types of events variantly reported that they were talking about a painful topic (e.g., *We were talking about some topics that made me feel nervous and I wasn´t able to control my reactions* (E). In addition, clients in both types of events variantly indicated that they were feeling upset or unmotivated about coming to the session (e.g., one client (A) said that in that day she was very upset and not feeling like coming into the session). Finally, clients in both types of events variantly mentioned that the therapist had done something the client did not like or agree with (e.g., one client (D) said that the therapist had behaved in a way that made her feel he was not interested on her).

Clients reported two attributions about the causes of the event. First, therapists more often in WD than in CF events reported that the episode was related to incidents involving significant others, usually their parents. In addition, clients for both types of events variantly made attributions related to personal characteristics. More specifically, they referred to having difficulty processing negative emotions (e.g., one client (F) said she knows very well how to hide her emotions: she uses to speak about painful things laughing although she feels like crying) and also to their negative interpersonal expectations (e.g., one client (C) said she did not know how to manage her expectations, so she preferred not expecting anything rather than expecting something and not getting it)

Table IV - 2 Client´s experience of WD (withdrawal) and CF (confrontation) rupture events

Domain and category	Frequency WD (n=14)	Frequency CF (n=13)	Exemplary Core Idea
A. Precipitant of rupture event			
1.Previous background			*She came to therapy hoping she could take something from itbut wasn´t getting the help she needed*
Previous alliance was not strong	variant	variant	*She had a very positive relationship with the therapist and trusted her very much.*
Previous alliance was strong	variant	variant	*In the previous session they had been involved in a repetitive cycle, so in the current session she came anticipating that the same waste of time would occur.*
A similar episode had occurred before	-------	variant	
2.Immediate context			
They were talking about a painful topic for the client	variant	variant	*They´re talking about some topics that made her feel nervous and she wasn´t able to control this reaction.*
Was unmotivated or upset right before coming to the session	variant	variant	*In that day she was very upset and not feeling like coming to the session.*
The therapist had done something (challenged the client for new perspective)	variant	variant	*The therapist brought to the session painful things she never attributed importance.*
3. Causes of the episode related to the client			
Client´s recent life events			
Incidents with significant others	variant	-------	*She had had a terrible week with her parents.*
Client´s personal characteristics			
Difficulty in processing and expressing negative emotions	variant	variant	*She knows very well how to hide her emotions: she speaks about painful things laughing although she feels like crying.*
Dysfunctional interpersonal expectations	variant	variant	*She doesn´t know how to manage her expectations: so she prefers not expecting anything rather than expecting something and not getting it*
B. Experience of the episode			
Sad/ Helplessness	typical	variant	*She was so depressed and hopeless that absolutely nothing the therapist might have said would matter. She didn´t even wanted to have been born.*
Felt she was being abandoned/criticized by the therapist	--------	typical	*She felt very angry when the therapist suggested she did different activities because the therapist knew all the problems she had at home: it was like telling a paraplegic to walk*

Ambivalent/Confused	variant typical	*When the therapist suggested they do something different she got confused: it was very hard to see things in a way she never saw it before. It seemed she was losing her identity.*
Anguish/desperate	variant ------	*Her heart was beating very fast and she was feeling very disturbed, she was afraid of losing control.*
Didn´t wanted to talk about that topic/ be with those emotions	variant variant	*She didn´t wanted to answer to those questions so she was looking for a way of changing the topic, that´s why she asked the therapist about the mirror in the room.*
Felt she was not getting help	-------- variant	*She felt there was nothing she could get from therapy.*
Was thinking about what the therapist might be thinking.	variant variant	*When the therapist said she could be protecting her,she thought the therapist was thinking she was hiding something from her and she got afraid that their intimacy could change*
In revolt/disgusted about significant figures in her life.	variant -------	*She felt that it was not fair that her mother told her that if she could she would have had an abortion when she was pregnant from her.*
C. How did the Therapist dealt with the Rupture		
<u>Useful aspects of the Therapist´s response</u>		
Nothing was useful/doesn´t remember	typical variant	*There was nothing new that had helped her.*
Therapist explored her immediate experience	variant variant	*It was good that the therapist asked her about the reasons of her smile which led her to explain that also in therapy she felt like she had to protect herself.*
Therapist validated / showed her she was not alone	variant variant	*The therapist told her that everyone has good and bad moments and she shouldn't feel bad because of that.*
<u>What did she expect from the Therapist</u>		
Nothing	general variant	*There was nothing the therapist could do to be able to help her because that was just the way she is*
The therapist to give up on what he was doing	variant typical	*Expected the therapist to recognize that what she was suggesting was impossible given the client´s difficulties.*
More guidance	variant ------	*She expected the therapist to be more firm and to tell her what to do in a more concrete way*
The therapist to show he was interested on her/greater proximity	variant variant	*She would prefer that the therapist speak with her not as a doctor but more as a friend, even though she knew there was a distance between them.*
The therapist was absent or unable to perceive her needs	variant variant	*The therapist was unable to perceive the client´s dissatisfaction in the last sessions: it took three bad sessions until they talked about it.*

D. Impact of the episode		
<u>On the therapeutic alliance</u>		
Negative impact on the alliance	variant typical	*She was already losing her motivation to go to the sessions and after that incident she completely lost her interest on therapy.*
Positive impact on the alliance	variant variant	*From the moment she became more exposed that was a greater proximity and she got more open in therapy*
<u>On the client</u>		
<u>Immediate impact</u>		
Left the session feeling more vulnerable/tired	typical -------	*She dealt with such painful topics that felt even more upset and helpless when she left*
Left the session feeling angry/disappointed with the therapist	------ variant	*She left the session feeling indignant about what the therapist had told her. If she could she would go back to the session and ask the therapist why she had said what she did.*
Positive immediate impact	variant ------	*She left the session with the feeling that she was not such a bad person. The therapist´s answers calmed her a little bit.*
<u>Impact on the change process</u>		
None	typical variant	*It was an interesting moment but it wasn´t important because she didn´t learn anything new about herself*
Became more aware of her functioning	variant variant	*She was able to see the way she tended to protect herself.*
Her dysfunctional behaviors or beliefs became more flexible	variant variant	*She didn´t change completely but there were changes: there was an episode in which she was assertive as the circumstances required her to be, whereas before she probably would have submitted to other people.*
E. Similarities between the rupture event and Client´s personal life		
Shifts from difficult topics or hides her emotions	general variant	*Also outside therapy she often changes the topic on purpose to end the conversation quickly because people bother her with questions.*
Can´t trust relationships/it´s hard to communicate with others	variant typical	*There is one similarity: the feeling that others are there for her but suddenly they´re not there anymore and normally when she perceives that she moves away from others.*
Gets angry when others normalize her feelings	-------- variant	*Everyone in her life tells her that everything is normal which really bothers her and even the therapist did the same thing. She always gets indignant with that because for her things are not normal at all.*
No similarities/Has a different behavior in therapy	variant variant	*It´s different because in her external life she normally does not allow for things to reach this point, but this was her therapist and she felt she had to talk.*
There are no similarities	variant variant	*There were no similarities.*

4.2.2 Experience of the Event

Clients reported only about their own experiences of the event (and not about their perceptions of therapists' experiences). Clients in both types of events reported at least variantly feeling sad or helpless (e.g., *"I was so depressed and hopeless that absolutely nothing the therapist might have said would matter. I didn´t even want to have been born"*(F)., ambivalent or confused (e.g., "*When the therapist suggested to do something different, I got confused. It was very hard to see things in a way I never saw before. It seemed she was losing her identity"* (H), not wanting to talk about their emotions (e.g.,*"I didn´t wanted to answer to those questions so I was looking for a way of changing the topic, that´s why I asked the T about the mirror in the room*. (D), and thinking about what the therapist might be thinking (e.g., "*When the therapist said I could be protecting her, I thought the therapist was thinking I was hiding something from her"(*H).

Clients more frequently in the CF than WD events reported feeling abandoned/criticized by the therapist (e.g., *"I felt very angry when the therapist suggested I do different activities because the therapist knew all the problems I had at home. So it was like telling a paraplegic to walk* (F"). In contrast, clients more often in WD than CF events reported feeling desperate (e.g., "*My heart was beating very fast and I was feeling very disturbed, I was afraid of losing control (D).)*

4.2.3 How Therapists Dealt with Rupture Events

Clients talked first about helpful aspects of their therapists´ responses to rupture events. For both WD and CF events, clients variantly reported that therapists facilitated exploration of their immediate experiencing, and that therapists validated their feelings.

More often in WD than in CF events, however, clients said that nothing was helpful or were unable to identify helpful aspects of the therapist´s intervention.

Clients then talked about what their expectations were for therapists during rupture events. In both types of events, clients variantly expected therapists to show that they were interested in them (e.g., one client (D) said she would prefer that the therapist speak with her not as a doctor but more as a friend, even though she knew there was a distance between them), and that therapists were absent or unable to perceive their needs (e.g., one client (C) said that the therapist was unable to perceive her dissatisfaction, it took three bad sessions until they talked about it). In WD more often than CF events, however, clients were not able to identify expectations regarding the therapist´s response (including cases in which the client said they expected nothing because there was nothing the T could do, either because the client would never change or because that was a professional relationship). In contrast, in CF more often than WD events, clients reported they had expected therapists to change strategies and do something different (e.g., one client (F) said the therapist should have recognized that what the therapist was suggesting was impossible given the client´s difficulties).

4.2.4 Impact of the event

Clients talked first about the impact of the event on the therapeutic alliance. Across both types of events, clients variantly reported positive impacts (e,g., the fact that a similar problem didn´t occurred again). More often in CF than WD events, however, clients reported that the event had a negative impact (including cases in which the event led to a dropout or to a loss of confidence in the therapist or in the possibility of getting help from therapy). As an example, one client (C) said she was already losing

her motivation to go to the sessions and after that incident she completely lost her interest on therapy.

Clients also described the immediate impact of the event. In WD more often than in CF events clients said they felt vulnerable (e.g., even more upset, tired or depressed after the session from having talked about painful topics and that the negative impact persisted all day or week after the session), and that there was a positive impact (e.g., one client (D) said she left the session feeling that she was not such a bad person). In contrast, in CF as compared to WD events, clients more often reported having felt angry or disappointed with the therapist. For instance, one client (A) said that on her way home from the session she felt indignant about what the therapist had told her, and added that if she could she would go back to the session and ask the therapist why she had said what she did.

Regarding the therapeutic gains, clients in both types of events reported becoming more aware of their functioning and being able to change/challenge their dysfunctional behaviors or beliefs. For example, one client (H) said that whereas before she probably would have submitted to other people, she now felt more assertive when circumstances required her to be. In addition, clients more often in WD as compared with CF events reported that nothing had changed (some clients simply said nothing changed, whereas others explained that nothing changed because that is just the way they are or because they had too many problems at home that compromised what they learned from therapy).

4.2.5 Similarities between the Rupture Event and the Client´s Life

Across both types of events, clients variantly reported no similarities between the rupture event and outside life. They attributed this lack of similarity to the

idiosyncratic characteristics of the therapeutic relationship, such as confidentiality and the fact that it is a professional relationship in which they expected specific helpful skills from the therapist. Because therapy is different, they reacted in a different way, allowing for things that they normally do not allow for in their relationships.

More often in WD than CF events, however, clients reported that they generally tend to shift away from difficult topics and hide their negative emotions. As an example, one client (G) said that in both therapy and in outside relationships she often changes the topic on purpose to end the conversation quickly because people bother her with questions. In contrast, clients in CF as compared with WD reported more often that they are not able to trust or communicate with other people because they anticipate that others may not be there for them when needed. For instance, one client (D) said: "*There´s one similarity: the feeling that others are there for me but suddenly they´re not there anymore, and normally when I perceive that I move away*".

5. DISCUSSION

This study sought to explore the therapists and clients´ perspectives about different dimensions of alliance ruptures.

The precipitants of the rupture events were one of the aspects we wanted to explore. The fact that in WD and CF ruptures, other events of the same type had occurred in the previous sessions, suggests that ruptures typically involve an ongoing history of problems in the therapeutic relationship. Similar results had been found by Hill et al. in 1996. Interestingly the clients only reported the previous occurrence of other events in CF, which may suggest that, compared with the therapists, clients are less able to recall the occurrence of previous WD events, maybe because CF events are more salient and thus easier to detect.

The therapist´s attempt to challenge the client to a new perspective or behavior immediately preceded the rupture, thus, the event seemed to be associated with the therapist trying something new that the client was not adequately prepared for. Similarly Hill et al. (2003) found that hostile anger events were less likely to be resolved when they involved the therapist challenging client´s problematic behaviors. This suggests that therapist´s interventions that challenge client´s cognitive or emotional schemas, more than the client is able to tolerate at any given time, may contribute to the emergence of alliance ruptures (Ribeiro, 2009).

Another aspect we wanted to explore was the participant´s experience during the event. The therapists´ report of felling lost without knowing what to do and confused or ambivalent, supports Safran and Muran´s (2000) suggestion that when dealing with ruptures, therapists often feel a kind of internal collapse of the therapeutic strategy and may need to recover their internal space before proceeding the intervention. According to the authors the therapists may need to metacomunicate about these feelings so that they can regain the ability to focus on the client´s experience. It seems that rupture events challenge both elements of the dyad to something new, in that clients also reported they felt confused or ambivalent. When a rupture marker emerges during the session, the relational configuration suddenly changes, and the negotiation process between the therapist and the client, which is always taking place, moves into the foreground (Safran, Muran, Samstag, & Stevens, 2002). Both participants are then required to negotiate the needs of the self versus the needs of the other, which may explain the experience of internal contradiction between different needs that both therapists and clients reported.

We found some relevant differences between WD and CF events, that we would like to discuss.

One difference has to do with the way the therapists dealt with the rupture event. They seemed to be more capable of implementing resolution interventions such as attending to what was happening in the interaction and promoting client´s understanding about his/her interpersonal patterns in WD events than they were in CF. This was consistent with the client´s report that the most helpful therapist´s interventions such as therapist´s attending and validating client´s immediate experience, were more frequent in WD and the therapist´s report that they were more often influenced by a client centered therapeutic approach in WD events than in CF.

These findings suggest that it may have been more difficult for therapists to empathize with the client´s experience in CF events, which has already been found by previous studies. Hill (2003) found that in hostile events, therapists seldom encouraged their clients to process and express their feelings. Also Binder and Strupp (1997) have shown that therapists may respond with avoidance or counter hostility when the client´s anger is directed toward them.

The therapist´s difficulty empathizing with the client´s experience in CF events may have led to the negative impact on the alliance, including the contribution to the dropout that most clients reported in these events. The association between the presence of non-resolved ruptures and the occurrence of dropout has been supported by several studies (e.g., Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995).

Not surprisingly most clients reported that in CF ruptures they were expecting the therapist to give up on what he was doing and change the strategy. In a way, clients seemed to be expecting the therapist to be more flexible, which is an important therapeutic skill when it comes to rupture resolution. Other studies have shown that therapists tend to do more of the same when they have to deal with an alliance rupture

(Piper, Azim, Joyce, & McCallum, 1991; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

The following question arises: why were these therapists less able to empathize with their client´s experience and respond them a flexible way, in CF ruptures? The answer to this question may be found when we look at the therapist´s experience of these rupture events.

CF events seemed to have provoked more intensive negative feelings in both participants. The therapist´s feelings of guilt and incompetence were more frequent in CF events, which may also explain the fact that only in CF did the therapists reported that they tried to explore their own contribution to the marker. Furthermore no therapist has reported the feelings of comfort and closeness to the client that some therapists in WD ruptures reported. This is not surprising given the fact that in CF events the clients tend to express their dissatisfaction in a direct and even hostile way, which may likely be felt by the therapists as an attack on their professional or personal abilities. CF also seems to activate more negative experiences in the client, such as feeling angry and abandoned or criticized by the therapist.

Therefore the client´s and therapist´s reports about their experiences of alliance ruptures, seem to validate Safran and Muran (2000) distinction between CF and WD events. In CF events the client moves against the therapist by expressing his/her anger or dissatisfaction, whereas in WD, the client tends to move away from his/her own experience of the therapeutic relationship. The idea that in WD events, the client partially disengages from his or her emotions or needs, was supported by the fact that in WD markers, most clients were unable to identify the helpful aspects of the therapist´s intervention as well as their expectations regarding the therapist´s response. In other words, in WD the client seemed to be less aware of what could have been helpful for

them, which may be related with them being less aware of their own needs. The idea that WD ruptures are characterized by any kind of avoidance of client´s internal experiences was also supported by the fact that the client´s difficulty processing negative emotions and affirming themselves were more frequently reported by the therapists, as general causes, in WD.

According to Safran and Muran´s (2000) the two types of ruptures reflect the client´s different ways of dealing with threats to the interpersonal relatedness. While in WD the client strives to maintain the proximity with others at the cost of their needs for self-affirmation, in CF the client moves against others expressing his dissatisfaction in a hostile way. This distinction was also validated by the clients´ reports when we asked them about the similarities between the therapeutic interaction during the rupture event and their outside life. In WD events, clients reported that also in their personal life they tend to hide their emotions, while in CF they reported they also have difficulty trusting others and they tend to get angry when others tell them what to do or normalize their feeling.

It is important to stress that some clients said there was no similarities between the therapeutic interaction and their outside life, due to the special qualities of the therapeutic relationship. This finding is a very interesting one, and is consistent with the idea that such unique features of the therapeutic relationship, such as the co-existence of a strong intimacy with very well defined professional boundaries, are what make this relationship so powerful. If the strong intimacy of this relationship allows for the possibility of sharing emotional experiences and have them reflected in the response of another human being with whom the client is interacting, the openness to the human encounter with the therapist in only possible due to the security that stems from the very specific professional boundaries of the relationship. This paradox that is inherent to the

therapeutic relationship, has been referred by relational psychoanalysts such as Greenson (1972) and Hoffman (1991) as the balance between the real and the transferential dimensions of the therapeutic relationship.

6. Conclusion and Implications for practice

With this study we were able to achieve a broader understanding of alliance ruptures in personality disorder clients, according to both participants' perspectives.

The first main finding is that rupture events seem to involve the previous occurrence of other rupture events, which stresses the importance of addressing problems in the negotiation of the alliance since the first time they emerge. This does not mean that if the therapist does not deal with a rupture when it first comes, the client won´t come back anymore. Actually this finding suggests that even severe personality disordered clients can keep coming to therapy after a negative incident occurred, although therapists and supervisors must keep in mind that the alliance does not survive to intense and repeated rupture episodes.

Apparently, the rupture emergence was associated with the client not being yet prepared to adhere to the therapist's intervention or to assimilate the therapist´s challenge for novelty. This should alert therapists to the need of properly assessing the timing of more challenging interventions, so that they work within the therapeutic zone of proximal development, a concept adapted from Vigostsky´s model to therapy by Leiman and Stiles (2001) and E. Ribeiro, (Ribeiro, Azevedo, Oliveira & Gonçalves, 2010).

We also found that the experience of confusion or ambivalence was frequent for both the therapist and the client, which suggests that ruptures probably activate some

kind of sense of surprise which makes it very important to explore and communicate about both element´s immediate internal experience, before they are able to move on.

According to our data, confrontation events seem to activate more intense and negative feelings in both therapists and clients. Therapists felt guilt or incompetent, while clients felt rejected or abandoned by the therapist. This can make us think that in CF events it may be particularly important for therapists and supervisors to offer their clients and supervisees support and validation interventions.

The fact that some therapists reported they lacked the clinical experience to deal with this type of therapeutic events, suggests that we need to include in therapist´s training programs more alliance focused interventions, independently on the training program´s theoretical approach. Moreover most of the categories concerning the influence of therapist´s personal variables to the way they dealt with the event, were variant, suggesting that the therapists are not very used to reflect on the way their own issues and internal states contribute to the therapeutic interaction.

We believe that training and supervision programs must optimize therapist's capacity to engage in a process of self-exploration, by encouraging them develop the capacity to attend to their immediate experience of the interaction with the client and use it to guide their intervention. This experiential focus in supervision may help therapists intervene in a beneficial way before cases end in unilateral termination.

7.Strengths and Limitations

Like any other study that relies on participants´ retrospective recollection of an event to assess their subjective experiences, our findings may be limited to what each interviewee was aware of and willing to disclose. Besides, there is some controversy regarding the conscious versus unconscious nature of the psychological processes

underlying alliance ruptures (Horvath, 2008), which can lead us to question the possibility of assessing participants' internal experience of rupture events, using introspective methods. However, we think that by having the participants answering our questions shortly after the session and immediately after they watched the video of the episode, we may have partially controlled the limitations of the introspective reports.

We can´t generalize these findings to other samples, because although we had a satisfactory number of rupture events, they all came from the same eight therapeutic dyads. Additionally both the therapists and the clients were mostly female and the therapeutic approach was mostly CBT oriented. Thus, future studies should replicate our findings with larger samples of therapists from different theoretical orientations, as well as male therapists and clients with different diagnosis. It could be interesting to see if some categories are more frequent in a sample of therapists that received a relational training, for example. Finally, some of the results may be related with the specific biases of this team of qualitative researchers.

The main strength of our study is the fact that for each rupture event we were able to capture the perspective of both the therapist and the client, which is something that the great majority of previous studies had not yet done. Other authors like Rhodes et al. (1994) have argued that therapists and clients generally view impasses very differently, so it´s important to compare both perspectives within the same cases. The analysis of the consistencies and discrepancies between therapists' and client´s perspectives is even more relevant according to an interpersonal approach, in which we must always take into account both element´s experiencing of the interaction.

8. References

Binder J.L., & Strupp, H.H. (1997). Negative process: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology Science and Practice, 4,* 121-139.

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J., & Hayes, A.M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497-504.

Greenson, R.R. (1972). Beyond transference and interpretation. *The International Journal of Psychoanalysis, 53,* 213-217.

Elkind, S.N. (1992). *Resolving impasses in therapeutic relationships.* New York: Guilford.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9,* 443-467.

Farber, B.A. (1983). Psychotherapists' perceptions of stressful patient behavior. *Professional Psychology: Research and Practice, 14,* 697–705.

Hill C.E., Kellems I. S., Kolchakian M.R., Wonnell T.L., Davis, T.L., Nakayama E.Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13,* 475–491.

Hill, C.E., Nutt-Williams, E., Heaton, K.J., Thompson, B.J., & Rhodes, R.H. (1996). Therapist retrospective recall of impasses in long term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43,* 207–217

Hill, C.E., Thompson, B.J., & Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517–572.

Horvath A.O. (2008). *Tacit assumptions about the therapeutic relationship: A conceptual analysis of the literature on the "rupture-repair" cycle.* Paper presented at the international meeting of the Society for Psychotherapy Research, Barcelona, Spain.

Hoffman, I.Z. (1991). Discussion: Toward a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues, 1,* 74-105.

Leiman, M., & Stiles W.B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*, 311–330.

Matsakis, A. (1998). *Managing client anger: What to do when a client is angry at you*. Oakland, CA: New Harbinger Publications.

Mitchell, S.A. (1988). *Relational Concepts in Psychoanalysis*. Cambridge, MA: Harvard University Press.

Newman, C.F. (1997). Maintaining professionalism in the face of emotional abuse from clients. *Cognitive and Behavioral Practice, 4*, 1.

Paulson, B.L., Truscott, D. & Stuart J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology, 46,* 317-324.

Piper, W.E., Azim, H.F. A., Joyce, A.S. & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short term individual psychotherapy. *Archives of General Psychiatry, 48,* 946-953.

Rhodes, R., Hill, C.E., Thompson, B.J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counselling Psychology, 41*, 473-483.

Ribeiro E. (2009). A aliança terapêutica reconsiderada: colaboração terapêutica me zonas de mudança proximal. In E. Ribeiro (Ed.), *Aliança Terapêutica: Da Teoria à Prática Clínica* (pp.169-181). Braga: Psiquilíbrios Edições.

Ribeiro, E. Ribeiro, A.P., Azevedo, H., Oliveira, S., & Gonçalves, M. Therapeutic *Alliance as therapist and clients' actions coordination*. Paper presented at the international meeting of the Society for Psychotherapy Research, Asilomar, CA

Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice & Research, 7,* 126–143.

Safran, J.D., & Muran, J.C. (2000) *Negotiating the therapeutic alliance: A relational treatment guide.* Guilford.

Safran, J.D.; Muran, J.C.; Samstag, L. W., & Stevens, C. (2002). Repairing Alliance Ruptures. In Norcross (Ed.), *Psychotherapy Relationships That Work*, (pp. 235-254). Oxford University Press.

Safran, J.D., & Segal, Z.V. (1990). Interpersonal process in cognitive therapy. New York: Basic.

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

CONCLUSION

"To Rupture is Human…

To Repair is Therapy."

(Adam Horvath, 2008)

CONCLUSION

The findings of the papers included in this dissertation, as a whole, allowed us to broaden our understanding about some dimensions of the clinical phenomena of ruptures in the therapeutic alliance, namely in what concerns its resolution processes, its impact on the therapeutic process, and the way they are experienced by the therapist and the client. In what follows we´ll try to articulate some of the main findings of the different studies, and reflect on its major implications for clinical practice and future research.

In terms of the impact of alliance ruptures on the therapeutic process several studies that we had reviewed in the theoretical paper of this dissertation had shown that unresolved ruptures may have a negative impact on the therapeutic process, (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995). This was one of the main findings consistently replicated in the three empirical papers of the dissertation, with data coming from qualitative and quantitative methods.

In the first empirical study we found that in dropout and unsuccessful cases there was an increase in both withdrawal and confrontation rupture markers right before the client left treatment, whereas that did not occur in successful cases.

In this paper we also found that after an initial increase in the alliance that was present for all the thirty-five cases, the fifth session emerged as a turning point from which the variability between individuals increased, as if it was a first filter of those cases that "survived" with success to the period of alliance formation. After the turning point of session five, successful cases kept the pattern of high and increasing alliance, which is consistent with the literature in this area that has shown that either the pattern of linear growth or the V pattern, in which the alliance decreases and increases again,

may be associated with good outcome (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). The fact that only the linear model emerged, that is, we found no statistical evidence for a quadratic model to fit into this data, may be partially explained by the fact that ruptures were not adequately resolved having led to the dropout as the decrease in the WAI and the increase in confrontation and withdrawal scores immediately before the patient abandoned therapy, suggest. This again confirms the potential negative impact of alliance ruptures in the alliance.

Another aspect that the previous study allowed us to explore relates to the development of the alliance in personality disorders.

In the theoretical paper we had already presented the argument derived from an interpersonal approach, that people´s internal models of the self and the world lead them to engage in interpersonal transactions that confirm them through the dynamics of interpersonal complementarity (Kiesler, 1983). The more rigid those internal models are, the more restricted will be the set of behaviours from others that will be able to confirm the individual´s self-image. Patients with personality disorders are characterized by this type of rigid interpersonal functioning which makes it more likely that the therapists encounter ruptures in the alliance with these patients as others had already pointed out (e.g., Benjamin & Karpiak, 2001; Muran, Segal, Samstag, & Crawford, 1994).

This was supported by the results of the first empirical paper, in that, we found that personality disordered patients started therapy with lower WAI scores that decreased across time, whereas patients with axis I disorders started therapy with a higher score that increased across time. Moreover we found that personality disorders had higher levels of withdrawal and confrontation. This, thus, confirms the fact, well

know by clinicians, that these clients are more challenging when it comes to the process of alliance formation.

The last finding of this paper that we would like to highlight is the coherence observed between the self-report measure of the alliance and the observational systems of ruptures detection. This coherence suggests that researchers and clinicians may rely on both measures to assess the dynamics of the alliance. However the WAI can only detect ruptures through the analysis of the fluctuations on the alliance from session to session, while observational systems such as the 3RS are located at a micro-level of analysis. Thus the WAI fluctuations capture global changes in the quality of the alliance, whereas the 3RS is able to capture discrete negative alliance events that may compromise the relationship. This may explain the fact that the measure that seemed to better discriminate dropout from non-dropout cases, was the confrontation score, suggesting that confrontation ruptures, may have a more salient negative effect on the alliance, if not efficiently addressed.

We were able to analyze at a microscopic level, the effect of confrontation ruptures on the therapeutic process, in the case of Laura presented in the third paper. This case study illustrated how the therapist and the client, when dealing with alliance ruptures, may get caught up in negative interpersonal cycles, which prevent them from solving the problems in the alliance. In this case, a series of unresolved ruptures related to a disagreement around therapeutic tasks, that started on session five, ended up leading to premature treatment termination. The case of Laura replicated the pattern of high and stable alliance followed by a decrease in the fifth session that had been found in the first empirical paper. The therapist and the client adopted complementary interpersonal positions, in that the more the client refused the therapist´s suggestion to look for psychiatric help, the more the therapist insisted on that task, which in turn led

to an intensification of the client´s reluctance about the therapist suggestion. The process of mutual recognition, that is, the therapist´s and client´s ability to recognize each other as a separate subject with his own needs and desires, which is an achievement that therapy should foster, (Benjamim, 1990 as cited in Safran & Muran, 2000) ended up not occurring. This prevented the dyad from negotiating the therapeutic agenda in a way that would solve the impasse.

Finally this case study may also have contributed to the validation of Safran et al.´s Ruptures Resolution Models. According to this model, we expect that therapist´s interventions such as drawing patient's attention to a problem in the relationship; changing tasks or goals in response to the patient's complaints and linking the rupture to larger interpersonal patterns between them, will be frequently adopted by the therapist in cases of resolved ruptures, while in unresolved cases we expect those interventions not to occur. In their verification study, Safran and Muran have been assessing their model for its ability to distinguish resolved from unresolved rupture events. Once this was a poor outcome case, with several unresolved events, in which most of the resolution strategies prescribed by Safran and Muran´s resolution model were not implemented by the therapist, this case study may, somehow, contribute to the validation of the model.

The fact that the therapist ("Dr S.") seemed to have an adapted functioning regarding dimensions such as attachment organization and interpersonal schemas, prevented us from finding in that sort of personal variables, the causes for her inability to deal more effectively with the rupture markers. The reasons why she got involved in a negative interpersonal cycle during the therapeutic interaction, seemed to rely instead in more dynamic internal variables such as the type of cognitive and emotional processes she was involved in during rupture events.

These internal processes were, in turn, influenced by the level of clinical experience of this novice therapist. According to Ronnestad and Skovholt (2003), the early stages of therapist´s career development may be lived with anxiety and a high sensitivity to negative feedback from clients and supervisors. Novice therapists may question their own competence and be more focused on themselves and on their own performance, which may make them less present in the relationship with the client. The lack of confidence and the subsequent tendency to depend on external sources of security such as the supervisor, can make novice therapists more prone to adhere to treatment manuals in a rigid fashion. This may explain Dr S.´ insistence on implementing a specific therapeutic agenda, regardless of the client´s reluctance. Thus therapist´s internal processes, influenced by variables such as the level of clinical experience, may contribute to the therapist´s involvement in negative interactive cycles during rupture events.

As we said before, the second paper of this dissertation suggested that confrontation ruptures may be better able to predict therapeutic early unilateral termination and the third paper illustrated the effect of a series of unresolved confrontation markers in a particular case. The fourth study, in turn, offered a possible explanation for that.

It showed that the stronger negative effect of confrontation ruptures on the alliance, may be due to the fact that they activate more negative feelings in both the therapist and the client. When talking about confrontation events, most therapists reported they felt guilt and incompetent and tense or having difficulty in dealing with the situation. The clients, in turn, reported they felt abandoned or criticized by the therapist, that is, that the therapist did not respect his/her feelings or needs.

The stronger negative feelings experienced by therapists during confrontation events may explain the fact that they were less capable of implementing alliance repair interventions in confrontation than they were in withdrawal. The therapist´s difficulty in responding in a therapeutic way when the client expresses hostility in a direct way had already been found in other studies (Hill, 2003; Strupp, 1997; Piper, Azim, Joyce, & McCallum, 1991; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

The distinction between withdrawal and confrontational events is an important one and was generally supported by our last study. Most clients reported that the withdrawal event was similar to their personal life, in that also they tend to shift from difficult topics or hide their negative emotions, in their outside relationships. On the contrary, in confrontation events, most clients reported that outside therapy, they usually have the same feeling of not being able to trust others because they anticipate they may not be there for them when they need. In addition they said they tend to get angry when people try to normalize their problems or suggest them to do something. Thus this validates, Safran and Muran´s (2000) assumption that the two types of rupture markers reflect client´s different ways of dealing with threats to the interpersonal relatedness. While in WD the client strives to maintain the proximity with others even if that implies an avoidance of their own needs, in confrontation the client moves against others expressing his dissatisfaction in a hostile way.

Maybe this is way confrontation ruptures may more easily lead to the dropout as we already saw. This may be so because in confrontation ruptures, whenever his own needs are different from the therapist´s needs, the client tends to favor his needs for self-definition and individuation. In other words, the client may prefer giving up on the interpersonal proximity, even if that implies to abandon therapy, rather than accommodate to the therapist´s needs.

From what we said until now, unresolved ruptures, particularly confrontational ruptures, have a negative impact on the therapeutic alliance and this relationship seems to be mediated by client´s variables, such as the presence of personality disorder traits, and therapist´s variables such as their internal processes during the rupture episodes.

In what follows we will argue that it is possible to establish some connections between interpersonal models such as Harry Stack Sullivan´s Theory of the Interpersonal Introjection, which strongly influenced Safran and Muran´s conceptualization of alliance ruptures and the Assimilation Model developed by Bill Stiles (Stiles, 2002, Stiles et al., 2006).

According to Sullivan, certain personal characteristics are experienced by us as belonging to the self trough the appraisals of others, that is, we´re able to fully articulate the characteristics in our sense of self to the extent that they do not represent a potential disruption in interpersonal relationships with significant others. Those characteristics that were valued by significant others come to be integrated in our sense of self, constituting the "good me" in Sullivan terms, whereas those characteristics that represented a challenge to interpersonal relatedness with important others do not become cognitively integrated as part of the self, constituting the "not me" (Sullivan, 1953, as cited in Safran and Segal, 1990). It is not difficult to see the connections between Sullivan´s ideas and that from Stiles and Leiman: "What makes a voice problematic to the person does not reside within the voice itself but in how it positions the person with regard to self and others" (Stiles et al., 2006, p.409)

Let´s come back to the case of Laura to see how the participant´s experience of the rupture episodes may be understood in light of the Assimilation Model.

In this case the therapist had difficulty integrating the need to implement a specific therapeutic task and the need to empathize with the client´s experience. As we

already said according to the assimilation model, the personality is seen as a community of voices that represent significant people, experiences and events. Voices of problematic experiences may remain separate from the rest of the person´s experience (Stiles, 2002; Stiles, Osatuke, Glick, & Mackay, 2004), because they can be frightening from the perspective of the dominant voice. Recent developments of the assimilation model (Leiman, 2004) argue that a self position is problematic when it is incompatible with positions of the person currently acceptable sense of self.

Once this young therapist was very committed with the implementation of the *manual*, which, as we said before, may be related to her stage of career development, she was not able to assimilate in her dominant sense of self the experience of empathy for the client´s concerns. Thus this experience was warded off or dissociated from a dominant voice of a technical and responsible therapist, which led to Dr. S.´s reported feeling of internal contradiction.

As Dr. S. had difficulty acknowledging all the aspects of her own experience within the therapeutic relationship, she also had difficulty accepting and validating her client´s experience. This prevented her from inviting the patient to directly express her negative sentiments or vulnerability with respect to the therapy. The absence of mutual recognition eventually led to the dropout as the Laura´s words illustrate: *"I was not respected as a decision maker. I needed a therapy that was with me, with whom I really am..."*

We saw how a rupture event may constitute a reaction to a problematic experience for the therapist, according to the Assimilation Model. This is equally true for the client as the results of the last paper on therapist´s and client´s experience of ruptures seem to indicate.

Both the therapist and the client associate the origin of the rupture event to any sort of therapeutic intervention that the client was not yet prepared to accept or integrate. In one case of a suicidal histrionic patient the therapist reported that the rupture emerged right after: "*The therapist tried to explore the reasons why she did not follow through the suicide attempt, so that they could look at the positive side of the client´s life*". The therapist intervention was trying to activate the client´s non-dominant voice of someone who wants to live. In this case the client´s sense of self was dominated by a voice of self-punishment and self-destruction.

In another case of a client who had unacknowledged negative feelings towards her daughter, the client reported that right before the rupture emerged*: "The therapist had transmitted the idea that she was complaining about her mother but also her daughter had reasons to complain about her"* In this case the therapist was trying to give voice to the client´s negative feelings towards her daughter, so that they could be integrated in her acceptable sense of self.

According to the Assimilation model, the work of therapy involves gaining useful access to formerly problematic experiences and turning them into resources. However the assimilation process involves the progression through different stages or levels, that range from a total dissociation of the problematic content to its fully integration in the person´s sense of self. The therapist must then assess the level of the problem´s assimilation the client is at, in any given time of the process, before he can promote movement to the next level. (Leiman & Stiles, 2001). This should alert therapists work within the therapeutic zone of proximal development, a concept adapted from Vigostsky´s model to therapy by Leiman and Stiles (2001) and Ribeiro et al. (2010). Thus the therapist´s attempt to promote contact with experiences that are still in

the early stages of the assimilation sequence may lead to the emergence of rupture markers, as the reports of both therapists and clients suggested.

The client´s difficulty in working within the level the therapist is proposing may be reflected in the client´s reported feelings of ambivalence or internal contradiction, like A P. Ribeiro, Loura, Gonçaves and Ribeiro (2010) have also shown. The client´s negative reaction may, in turn, activate in the therapist the same feelings of ambivalence. Actually both the elements of the dyad reported feelings of being lost by not knowing what to do and feelings of ambivalence.

Safran and Muran (2000) described this experience as a collapse of the therapist´s internal space, and argued that metacommunication is a possible way of reestablishing the internal space, before both elements can continue the exploratory movement. To quote Safran and Muran (2000): "*Metacommunication consists of an attempt to step outside of the relational cycle that is currently being enacted by treating it as the focus of the collaborative exploration: that is communicating about the transaction or the implicit communication that is taking place"* (p.108). This process allows for the exploration of the patient´s construal of the therapeutic interaction. The patient may then be able to process his/her own disowned feelings of aggression or vulnerability regarding the therapist. The assimilation and acceptance of their own negative feelings regarding the therapist may facilitate the assimilation of other warded off problematic experiences.

Therefore, we believe that metacommunication may contribute to the construction of what Stiles (2002) described as "*meaning bridges".* According to the author, meaning bridges can represent and link previously separated voices so that a new configuration is formed. Similarly through metacommunication, a docile,

peacemaking voice that dominates the client's sense of self may then be able to communicate and empathize with the client´s enraged voice towards the therapist.

If we move our perspective from the individual point of view, that implies looking at the therapist´s and the client´s individual assimilation processes, to a relational point of view, we are able to see that the dyad itself goes through a similar assimilation process. Through metacommunication, a new relational configuration emerges, one that allows for the new configuration within each element´s internal community of voices. Ruptures pose a great challenge to the alliance: from a dominant voice of agreement, synchrony and collaboration, the alliance evolves to a more differentiated and complex voice, one that is also able to accommodate the experience of disagreement, mismatch and non collaboration. We don´t know weather is the more differentiated sense of self of each element of the dyad (now able to integrate previously dissociated aspects), that allows for a more differentiated view of the relationship, or the other way around. However, the relational models´ assumption that all human processes have an interpersonal root, will make us assume the primacy of the relationship, that is, the individual´s change is only possible through the relational change.

We cannot conclude this dissertation without reflecting on the way our research work evolved throughout this PhD project.

In these studies we used methods as diverse as the longitudinal statistical analysis, the case study analysis and the consensual qualitative analysis, which was very enriching as it allowed us to experience the strengths and weaknesses of different ways of doing science. This methodological diversity did not seem to have compromised the internal consistency of the different papers. Rather it allowed us to broaden our comprehension about alliance ruptures throughout the different studies.

We think that the studies we presented here ended up being more focused on the *"negative side"* of the alliance ruptures: in the first paper we explored the effect of unresolved ruptures in the alliance, in the second one we analyzed a dropout case in which several confrontation ruptures had not been adequately addressed and in the last one we explored the therapist´s and the client´s experience of unresolved ruptures. Other studies focused on rupture´s resolution and its positive impact on the process would have complemented this work. As an example, the analysis of our case study could have been improved with the inclusion of a contrasting good outcome case in which ruptures were resolved. This would allowed us to see how things work when the alliance strains are repaired and ruptures can constitute a learning experience for the client by breaking the interpersonal cycles that maintain his/her dysfunction.

However, this apparent bias for the study of unresolved ruptures, had to do with characteristics of our sample, in which we could not observe a lot of resolution processes. Most of the therapists that composed this sample had never had any training in relational models and alliance focused interventions. In fact several therapists that we interviewed in the last paper reported that they did not have enough clinical training and experience with this type of therapeutic events.

Therefore we strongly believe that we need to include in the therapist´s training programs more alliance focused interventions. We must train our therapist in the implementation of very specific techniques that are tied to the different therapeutic orientations, but we must also help them to develop the capacity for self-acceptance that will allow them to be open to explore the client´s and their own immediate experience at each moment of the session. That´s the only way the therapeutic dialogue can end up being therapeutic.

Looking at the research work we made and to its main findings, we easily recognize that they have a more confirmatory nature of most of the assumptions of Safran and Muran´s work. We replicated findings from other studies, such as the negative impact of unresolved ruptures and the importance of specific rupture resolution interventions, such as the ones that fail to occur in Laura case.

However we believe that we made some novel contributions for the research in this area, namely in terms of methodological options. For example the study of the alliance development described in the second chapter, may be distinguished from similar previous studies by the inclusion of therapeutic cases with different types of termination and treatment length. Most of the studies exclude those cases that do not end the treatment protocol or the pre-defined number of sessions. Our design increased the ecological validity of a study that aimed to analyze the process of alliance development as it naturally occurs.

Moreover although the negative impact of unresolved ruptures is not a new finding in the literature, studies like the case study and the last study on the participants´ experiences allowed for a comprehensive look on the impact of ruptures.

The studies we presented here opened the door for future ones. ´

Future studies on the alliance development for example, should also include the therapist´s perspective, in order to compare both the client´s and the therapist´s evaluation of the alliance across time with observational systems like the 3RS.

We believe an important research line for the future is the study of alliance ruptures in different theoretical approaches. Due to the circumstances of our data collection we mainly worked with cases from cognitive therapy, but we believe that the type of ruptures that typically emerge, as well as the most adequate strategies to resolve them, differ from one treatment model to another. For example, resolution strategies

such as providing a rationale for the task and disclosing the therapist´s internal experience of the relationship won´t be implemented as often by a CBT therapist and an experiential therapist. Also some models will make it more likely that some specific types of rupture markers will emerge.

However, regardless of the therapeutic approach one is working with, alliance ruptures will always constitute an inevitable and fascinating clinical phenomena that can help us better understand our clients and ourselves.

REFERENCES

REFERENCES

Ackerman, S.J., & Hilsenroth, M.J (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy Practice and Research, 38*(2), 171-185.

Ackerman, S.J., & Hilsenroth, M.J (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*, 1–33.

Agnew, R.M., Harper, H., Shapiro, D.A., & Barkham M. (1994). Resolving a challenge to the therapeutic relationship: A single case study. *British Journal of Medical Psychology, 67*, 155-70.

Alexander, F., & French, T. M. (1946) *Psychoanalytic Therapy.* New York: Ronald Press

Aspland H., Llewelyn S., Hardy G., Barkham M., & Stiles W.B. (2008). Alliance Ruptures and Rupture Resolution in Cognitive Behavior Therapy: A Task Analysis. *Psychotherapy Research*, *18*(6), 699-710.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: a qualitative analysis. *Journal of Counseling Psychology*, *42*(3), 323–337.

Baptista, A. (2009). Escala de regulação do afecto: estudo para a adaptação portuguesa (unpublished master's thesis). Universidade do Minho, Braga.

Barber, J.P., Conolly, M.B., Crits-Christoph, P., Gladis, L. & Siqueland, L. (2000) *Alliance Predicts Patients' Outocome Beyond In-Treatment Change in Symtoms.* Journal of Consulting and Clinical Psychology, *68*, 1027-1032.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychology, 4*, 53-63.

Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology, 7*, 33-46.

Benjamin, L.S., & Karpiak, C.P. (2001). Personality disorders. *Psychotherapy, 38,* 487–491.

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy. *Psychology and Psychotherapy, 79,* 395-418.

Binder J.L., & Strupp, H.H. (1997). Negative process: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults". *Clinical Psychology Science and Practice, 4*, 121-139.

Blatt, S.J., & Blass, R.B. (1992). Relatedness and self-definition: Two primary dimensions in personality development, psychopathology and psychotherapy. In J. Barron, M. Eagle, & D. Wolitsky (eds.), Interface of psychoanalysis and psychology (399-428). Washington, DC: American Psychological Association Books.

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

Bordin, E. (1994). Theory and Research in the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (eds), *The Working alliance: Theory, research and practice* (pp. 13-37). New York: Wiley.

Bowlby, J. (1969) *Attachment and loss. Vol I. Attachment* New York: Basics.

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J., & Hayes, A M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factores. *Journal of Consulting and Clinical Psychology*, *64*, 497-504.

Colli A., & Lingiardi V. (2009). The collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research, 19*(6), 718- 734.

Corbella, S., & Botella, L. (2003). La alianza terapéutica: historia, investigación y evaluación. *Anales de Psicologia, 19*(2), 205-221.

Coutinho, J., Fernandes E., & Safran J. (2008). Versão Portuguesa da Escala de Auto-Avaliação de Sabedoria Pessoal. *Actas da XIII Conferência Internacional "Avaliação Psicológica: Formas e Contextos". Braga.*

de Roten, Y., Fisher, M., Drapeau, M., Beretta, V., Kramer, U., Fravre, N., & Despland, J. (2004). Is one assessment enough? Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy*, *11*, 324-331.

Derogatis, L.R. (1993). *Brief Symptom Inventory: Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Diggle P.J., Heagerty P., Liang K.Y. & Zeger S.L. (2002). *Analysis of Longitudinal Data*. (2nd ed.) Oxford: Statistical Science Series.

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*(4), 421 – 434.

Elkind, S.N. (1992). *Resolving impasses in therapeutic relationships.* New York: Guilford.

Elliot, R., Slatick, E., & Urman, M. (2001). Qualitative Process Research on Psychotherapy: Alternative Strategies. In J. Frommer, & D.L. Rennie (Eds.), *Qualitative Psychotherapy Research: Methods and Methodology*. Lengerisch: Pabst Science Publishers.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9,* 443-467.

Elliott, R., & Shapiro, D.A. (1988) Brief Structured Recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology*, *61*, 141-153.

Eubanks-Carter, C., Mitchell, A., Muran, J.C, & Safran, J.D. (2009). Rupture resolution rating system (3RS): Manual. Unpublished manuscript.

Fairbairn, W.R D. (1952) *Psychoanalytic studies of the personality*. London: Tavistock.

Farber, B. A. (1983). Psychotherapists' perceptions of stressful patient behavior. *Professional Psychology: Research and Practice, 14,* 697–705.

Fassnacht, D, & Machado, P.P. (in preparation). The Outcome Questionnaire (OQ-45.2) in a Portuguese population: Psychometric properties, norms and confirmatory analysis.

First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B.W. (1995). *Structured Clinical Interview for DSM– IV.* New York: Biometrics Research Department, New York Psychiatric Institute.

Foreman, S.A., & Marmar, C.R. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry*, *142*(8), 922-926.

Freud, S. (1912/1958). The dynamics of transference. In standard edition (Vol.12, pp. 97-108) London: Horgarth Press.

Fuller, F., & Hill, C.E. (1985). Counselor and helpee perceptions of conselor intentions in relation to outcome in a single counselling session. *Journal of Counselling Psychology*, *32*, 329-338.

Garfield, S.L. (1994). Research on client variables in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). New York: Wiley.

Gelso, C.J., & Carter, J.A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296-306.

George, C., Kaplan, N., & Main, M. (1985) Attachment interview for adults. Unpublished manuscript. University of California at Berkeley.

Ghent (2002) http://www.iarpp.org/library/download/enews1pdf

Golden, B.R., & Robbins, S B. (1990) The working alliance within time-limited therapy: A case analysis. *Professional Psychology: Research and Practice, 21*(6), 476-481.

Goldman, G.A. (2005). *Quality of object relations, security of attachment, and interpersonal style as predictors of the early therapeutic alliance.*. Unpublished doctoral dissertation, Ohio University, Athens.

Gonçalves, A. (2009). Compreensão da mudança terapêutica a partir da co-construção de episódios terapêuticos significativos, Unpublished Dissertation. University of Minho. Braga.

Gouveia, J.P., Cunha M., Robalo, M. (1997). Avaliação de Esquemas Interpessoais: A versão portuguesa do Questionário de Esquemas Interpessoais de Safran e Hill. *Psychologica, 17*, 105-127.

Gratz, K.L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioural Assessment, 26*(1), 41-54.

Greenson, R. (1971). The real relationship between the patient and the psychoanalyst. In M. Kanzer (ed), *The unconscious today* (pp.213-232). New York: International Universities Press.

Greenson, R.R. (1972). Beyond transference and interpretation. *The International Journal of Psychoanalysis, 53*, 213-217.

Harper, H. (1989a). *Coding Guide I: Identification of Confrontation Challenges in exploratory therapy*. Unpublished manuscript, University of Sheffield.

Harper, H. (1989a). *Coding Guide II: Identification and classification of therapist markers and withdrawal challenges.* Unpublished manuscript, University of Sheffield.

Hastie, T. & Tibshirani, R. (1990). *Generalized additive models, Volume 43 of Monographs on statistics and applied probability*. London: Chapman & Hall.

Henry, W.P., Strupp, H.H., Butler, S.F., Schacht, T.E., & Binder, S.L. (1993) Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 441-447.

Hill C.E., Kellems I.S., Kolchakian M.R., Wonnell T.L., Davis, T.L., Nakayama E.Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13*, 475–491.

Hill, C.E., Nutt-Williams, E., Heaton, K.J., Thompson, B.J., & Rhodes, R.H. (1996). Therapist retrospective recall of impasses in long term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207–217.

Hill, C.E., Thompson, B.J., & Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517–572.

Hill, C., & Safran, J. (1994). Assessing interpersonal schemas: Anticipated responses of significant others. *Journal of Social and Clinical Psychology, 13,* 366-379.

Hoffman, I.Z. (1991). Discussion: Toward a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues, 1*, 74-105.

Horowitz, L, Rosenberg, S., Baer, B., Ureiio, G., & Villasefior, V.S. (1988). The Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885-892.

Horvath A.O. (2008). *Tacit assumptions about the therapeutic relationship: A conceptual analysis of the literature on the "rupture-repair" cycle.* Paper presented at the international meeting of the Society for Psychotherapy Research, Barcelona, Spain.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology, 38,* 139-149.

Horvath, A.O., & Greenberg, L.S. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford Press.

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

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139–149.

Huppert, J.D., Bufka, L.F., Barlow, D.H., Gorman, J.M., Shear, M.K., & Woods, S.W. (2001). Therapists, therapist variables, and cognitive– behavioral therapy outcomes in a multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology, 69,* 747–755.

Infante, C.A. (2009). Rupture episodes not reported by the client in high therapeutic alliance sessions. Unpublished Dissertation. University of Minho Portugal.

Keele L. (2008). *Semiparametric regression for the social sciences*. London: John Wiley & Sons.

Kiesler, D.J. (1983). The 1982 Interpersonal Circle: A taxonomy for complementarity in Human transactions. *Psychological Review, 90,* 185 – 214

Kiesler, D.J. (1996) *Contemporary interpersonal theory and research: Personality, Psychopathology and Psychotherapy*. New York Wiley.

Kivlighan, D.M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counselling Psychology, 47,* 362-371.

Kivlighan, D.M., Clements, L., Blake, C., Arnez, A., & Brady, L. (1993). Counselor sex role orientation, flexibility, and working alliance formation. *Journal of Counseling and Development, 72,* 95–100.

Klein, M.H., Mathieu, P.L., Gendlin, E.T., & Kiesler, D.J. (1969). *The Experiencing Scale: A research and training manual.* Madison, WI: Wisconsin Psychiatric Institute.

Klein, M.H., Mathieu-Coughlan, P., & Kiesler, D.J. (1986). The experiencing scales. In L. Greenberg & W. Pinsof (Eds.), *Psychotherapeutic process* (pp. 21–71). New York: Guilford.

Kobak, R. (1993) *The attachment Q-sort.* Unpublished manuscript University of Delaware.

Kokovic, A., & Tracey, T. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology*, *37*(1), 16-21.

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

Kramer U., De Roten, Y., Beretta V., Michel, L., & Despland J. (2009). Alliance patterns over the course of short dynamic psychotherapy: The shape of productive relationships. *Psychotherapy Research*, *19*(6), 699-706.

Lambert, M.J., Burlingame, G.L., Umphress, V.J., Hansen, N.B., Vermeersch, D., Clouse, G., & Yanchar, S. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3,* 106-116.

Lambert, M.J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., Huefner, J.C., & Reisinger, C.W. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ 45.2).* Wilmington, DE: American Professional Credentialing Services.

Lansford, E. (1986). Weakenings and Repairs of the Working Alliance in Short-Term Psychotherapy, *Professional Psychology, Research and Practice, 17*(4), 364-366.

Leiman, M. (2004). Dialogical sequence analysis. In H.H. Hermans & G. Dimaggio (Eds), The dialogical self in psychotherapy (pp. 255- 269). London: Brunner-Routledge.

Leiman, M., Stiles W.B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11,* 311–330.

Little R., & Rubin D. (1987). *Statistical Analysis with Missing Data*. London: John Wiley & Sons.

Loewald, H.W. (1972). Freud's Conception of the Negative Therapeutic Reaction, with coments on instinct theory. *Journal of the. American. Psychoanalytic. Association*. *20*, 235-245.

Luborsky (1994) *Therapeutic Alliances as Predictors of Psychotherapy Outcomes: Factors Explaining the Predicitve Sucess*, In: Horvath A. & Greenberg (Eds), The Working Alliance: Theory, Research and Practice (pp. 51-84) New York: Wiley.

Luborsky, L. 1984 Principles of Psychoanalytic Psychotherapy: *A Manual for Supportive-Expressive (SE) Treatment* New York: Basic Books.

Luborsky, L., McLellan, A.T., Woody, G.E., O'Brien, C.P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42,* 602-611.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes?" *Archives of General Psychiatry, 32,* 995–1008.

Machado P.P., & Horvath A. (1999). Inventário da Aliança Terapêutica – W.A.I. In M. R. Simões, M. M. Gonçalves & L. S. Almeida (Eds.), *Testes e Provas Psicológicas em Portugal* (Vol.2, pp.87-94). Braga: APPORT/SHO.

Mallinckrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. *Journal of Counseling Psychology, 38,* 401–409.

Mann, J. (1973).*Time-limited psychotherapy*. Cambridge, MA: Harvard University Press.

Marmar, C.R., Weiss, D.S., & Gaston, L. (1989). Towards the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 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 Consulting and Clinical Psychology , 68*(3), 438-45.

Martin, J., Martin, W., & Slemon, A. (1987). Cognitive Mediation in person-centered and rational-emotive therapy. *Journal of Counselling Psychology*, *34*, 251-260.

Matsakis, A. (1998). *Managing client anger: What to do when a client is angry at you*. Oakland, CA: New Harbinger Publications.

Mead, G. H. (1934). *Mind self and society*. Chicago: University of Chicago Press.

Mitchell, S.A. (1988). *Relational Concepts in Psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S.A. (1993). *Hope and dread in psychoanalysis.* New York: Basis Books.

Mitchell, S.A., & Aron, L. (Eds.), (1999). Relational Psychoanalysis: The emergence of a tradition. New York: Analytic Press.

Muran, J.C., Safran, J.D., Gorman, B.S., Eubanks- Carter, C., & Banthin, D. (2008, June). *Identifying ruptures & their resolution from postsession self-report measures.* Paper presented at the annual meeting of the Society for Psychotherapy Research, Barcelona, Spain.

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*(2), 233–248.

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

Muran, J.C., Segal, Z.V., Samstag, L.W., & Cawford, C. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 62,* 185–190.

Nagy, J., Safran, J.D., Muran, J.C. & Winston, A. (1998). *A comparative analysis of treatment process and therapeutic ruptures.* Paper presented at the international meeting of the Society for Psychotherapy Research, Snowbird, UT.

Newman, C.F. (1997). Maintaining professionalism in the face of emotional abuse from clients. *Cognitive and Behavioral Practice, 4*, 1.

Orlinsky, D.E., & Howard, K.I. (1975). *Varieties of psychotherapeutic experience.* New York: Teachers College Press.

Patton, M.J., Kivlighan, D.M.,Jr., & Multon, K.D. (1997). The Missouri Psychoanalytic Counselling Research Project: Relations of changes in counselling process to client outcomes. *Journal of Counselling Psychology, 44*, 189–208.

Paulson, B.L., Truscott, D., & Stuart J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology*, *46*, 317-324.

Piper, W.E.M., Azim, H.F.A., Joyce, A.S., & McCallum, M. (1991). Transference Interpretations, therapeutic alliance and outcome in short term individual psychotherapy. *Archives of General Psychiatry, 48*, 946-953.

Piper, W.E., Joyce, A.S., Rosie, J.S., Ogrodniczuk, J.S., Mccallum, M., O'Kelly, J.G., & Steinberg, R.I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy, 36(*2) 114-122.

Podsakoff, P.M., MacKenzie, S.B., Lee, J., & Podsakoff, N.P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879-903.

Regan, A.M., & Hill, C.E. (1992). Investigation of what clients and counsellors do not say in brief therapy. *Journal of Counselling Psychology*, *39*, 186-174.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst´s irreducible subjectivity. *Psychoanalytic Quarterly, 62*, 466-495.

Rennie, D.L. (1994). Client's deference in psychotherapy. *Journal of Counselling Psychology*, *41*(4), 427-437.

Rhodes, R.H., Hill, C.E., Thompson, B. J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counselling Psychology, 41*(4), 473-483.

Ronnestad, M.H., & Skovholt, T.M. (2003). The journey of the counselor and the therapist: research findings and perspectives on professional development. *Journal of career development, 30*(1), 5-44.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. A*merican Journal of Orthopsychiatry, 6,* 412–415.

Ribeiro E. (2009). A aliança terapêutica reconsiderada: colaboração terapêutica me zonas de mudança proximal. In E. Ribeiro (Ed.), *Aliança Terapêutica: Da Teoria à Prática Clínica* (pp.169-181). Braga: Psiquilíbrios Edições.

Ribeiro, A.P., Loura, J., Gonçalves, M.M., & Ribeiro, E. (2010). *A micro-analytic look at therapeutic interaction in ambivalence episodes.* Paper presented at the international meeting of the Society for Psychotherapy Research, Asilomar, CA.

Ribeiro, E., Ribeiro, A.P., Azevedo, H., Oliveira, S., & Gonçalves, M. (2010). Therapeutic *Alliance as therapist and clients' actions coordination*. Paper presented at the international meeting of the Society for Psychotherapy Research, Asilomar, CA.

Safran, J.D. (1993). Breaches in the therapeutic alliance: An arena for negotiating authentic relatedness. *Psychotherapy: Theory, Research, & Practice, 30,* 11–24.

Safran, J.D., & Segal Z. (1990), *Interpersonal Process in Cognitive Therapy.* Aronson London.

Safran, J.D. & Muran, J.C. (1996) The Resolution of Ruptures in the Therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, *64*, 447-458.

Safran, J.D. & Muran, J.C. (2000) *Negotiating the Therapeutic Alliance, A Relational Treatment Guide*. The Guilford Press.

Safran, J.D., & Muran, J.C. (2006) Has the Concept of the Therapeutic Alliance Outlived its Usefulness? *Psychotherapy: Theory, Research, Practice, 43*(3), 286–291.

Safran, J.D., Muran, J.C., Samstag, L.W., &Stevens, C. (2002). Repairing Alliance Ruptures. In Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*, (pp. 235-254). New York: Oxford University Press.

Safran, J.D., Muran, J.C., Samstag, L.W., & Stevens, C. (2001) Repairing Alliance Ruptures, *Psychotherapy*, *38*, 406-412.

Safran, J.D., Muran, J.C., & Samstag, L.W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath and L. S. Greenberg (Eds.) *The Working alliance: Theory, research and practice* (pp. 225-255), New York: Wiley.

Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice & Research, 7,* 126–143.

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 & Research, 5,* 126-143.

Schacht T.E., Binder J.L., & Strupp H.H. (1984). The dynamic focus. In H.H. Strupp & J.L. Binder (Eds.), *Psychotherapy in a New Key* (pp. 65-109). New York: Basic Books.

Shaffer, C. (1993). *The role of Adult Attachment in the Experience and Regulation of Affect* Unpublished doctoral dissertation, Yale University, New Haven

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 evaluations. *Psychotherapy Research, 18,* 377–388.

Sroufe, L.A., Egelend, B., Carlson, E., & Collins W. A. (2005) *The development of the person: The Minnesota study of risk and adaptation from Birth to Adulthood*. New York. Guilford Publications.

Stern, D.N. (1985). *The interpersonal world of infant.* New York: Basic

Stiles, W.B. (2002). Assimilation of problematic experiences. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357-365). New York: Oxford University Press.

Stiles, W.B., Glick, M.J, Osatuke, K., Hardy, G.E., Shapiro, D.A., Agnew-Davies, R., Rees, A., & Barkham M. (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.

Stiles, W.B., Leiman, M., Shapiro, D.A., Hardy, G.E. , Barkhanm, M., Detert, N.B., & Llewelyn, S.P (2006). What does the first exchange tell? Dialogical sequence analysis and assimilation in very brief therapy. *Psychotherapy Research, 16*(4), 408-421.

Stiles, W.B., Osatuke, K., Glick, M.J., & Mackay, H.C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H.H. Hermans & G. Dimaggio (Eds), The dialogical self in psychotherapy (pp. 91-107). London: Brunner-Routledge.

Stiles, W.B., Shapiro, D.A., & Elliott, R. (1986). "Are all psychotherapies equivalent?" *American Psychologist, 41*, 165–180.

Strauss, J.L., Hayes, A.M., Johnson, S.L., Newman, C.F., Brown, G.K., Barber, J., Laurenceau, J., & Beck, A.T. (2006). Early 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*(2), 337–345.

Strupp, H.H., Butler, S.F., & Rosser, C.L. (1988). Training in Psychodynamic Therapy. *Journal of Consulting and Clinical Psychology*, *56*, 669-689.

Strupp, H.H., & Anderson, T. (1997). On the limitations of treatment manuals. *Clinical Psychology: Science and Practice, 4*, 76 – 82.

Sullivan, H.S. (1953) *The Interpersonal Theory of Psychiatry*. New York: NortonTryon, G. S., & Kane, A.S. (1995). Client involvement, working alliance and type of therapy termination. *Psychotherapy Research, 5*, 189-198.

Tracey, T.J., & Kokotovic, A.M., (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 50*(1), 207-210.

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

Villard K.L., & Whipple, L.J. (1976) *Beginnings in Relational Communication*. New York: John Wiley & Sons Inc.

Wallerstein, R.S. (1990). The Corrective Emotional Experience: Is Reconsideration Due?. *Psychoanalytic Inquire, 10*, 288-324.

Wampold, B.E. & Brown, G.S. (2005). Estimating Variability in Outcomes Attributable to Therapists: A Naturalistic Study of Outcomes in Managed Care. *Journal of Consulting and Clinical Psychology, 73*(5), 914–923.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Waters, E., Weinfield, N., & Hamilton, C. (2000). The stability of attachment security from infancy to adolescence and early adulthood: General Discussion. *Child Development, 71*(3), 703-706.

Webster, J.D. (2007). Measuring the character strength of wisdom. *International journal of aging & human development, 65*(2), 163-183.

Winnicott, D.W. (1969). The Use of an object. *International Journal of Psychoanalysis, 50,* 711-716.

Zetzel, E.R. (1956). Current Concepts of Transference. *International Journal of Psycho-Analysis, 37,* 369-375.