Copyright American Psychological Association. Not for further distribution.

2

The Science of the Therapist Under Pressure

No pressure, no diamond.

—THOMAS CARLYLE

Therapy can present many moments of pressure for therapists: moments when a therapist feels confused, or frustrated, or stuck, and must wrestle with these feelings while trying to remain composed, attentive, and connected to a patient. For example, in a survey of psychologists, Pope and Tabachnick (1993) found that more than 80% reported experiencing a negative emotion like anxiety or anger toward their patients. In a study of 132 patients, Dalenberg (2004) found that more than 60% reported that their therapist had been angry with them. Therapists have to navigate the pressures of trying to help patients who are struggling with challenges such as suicidality, self-harm, addiction, trauma, and despair; they may find themselves working with patients who are ambivalent about or, in the case of court-mandated treatment, perhaps even opposed to the idea of being in therapy. In addition, many therapists face pressure from managed care or employers to take on increased workloads without a commensurate increase in support or compensation.

As we presented in Chapter 1, pressure can negatively impact performance. Pressure can lead us to become more rigid and narrow in our thinking and to overrely on heuristics and biases. This can negatively impact our abilities to do a thorough assessment and develop a comprehensive case conceptualization; to recognize when we need a consultation, supervision, or feedback; and to

http://dx.doi.org/10.1037/0000182-003
Therapist Performance Under Pressure: Negotiating Emotion, Difference, and Rupture,
by J. C. Muran and C. F. Eubanks
Copyright © 2020 by the American Psychological Association. All rights reserved.

choose and skillfully implement optimal interventions tailored to each patient. In addition, pressure can negatively impact our ability to build and maintain a strong relationship with our patients. Norcross and VandenBos (2018) suggested that the therapeutic relationship holds a unique place in clinical work: "It is, at once, the most significant source of pleasure and displeasure in psychotherapy" (p. 51). Given the importance of the therapeutic relationship across treatment modalities, we have chosen to focus our attention in this chapter on how pressure impacts the therapeutic relationship—more specifically, the alliance between therapist and patient.

Copyright American Psychological Association. Not for further distribution.

WHY DO WE NEED A STRONG ALLIANCE?

First, we need to establish why it is so important for therapists to navigate pressure in a clinical situation such that they maintain a strong alliance with their patients. The working or therapeutic alliance is usually defined in terms of the therapist's and patient's abilities to agree on the goals of therapy, collaborate on the tasks of therapy, and maintain an affective bond (Bordin, 1979). The importance of the alliance is one of the most reliable and consistent findings in the psychotherapy research literature. A recent meta-analysis of almost 300 studies involving more than 30,000 patients found that the quality of the alliance is positively associated with treatment outcome, with a moderate effect size (Flückiger, Del Re, Wampold, & Horvath, 2018). This finding remained robust across different alliance measures, different points of view (patient, therapist, or observer), different treatment approaches, different patient characteristics, and different countries.

Therapeutic approaches differ with respect to how much emphasis they place on the alliance, with some making it a central focus (e.g., Safran & Muran, 2000) and others regarding it as a necessary but insufficient condition that permits the use of therapeutic techniques that produce change (e.g., J. S. Beck, 2011). To the best of our knowledge, most (if not all) therapeutic approaches regard the alliance as important and a "good enough" alliance as essential: If there is no agreement, no collaboration, and no bond of mutual trust and respect, the work of therapy cannot take place.

WHAT GETS IN THE WAY OF A STRONG ALLIANCE?

Research literature points to some factors that can get in the way of building and maintaining a strong alliance and working effectively with patients. Undoubtedly, certain patients can be particularly challenging and create a higher level of stress for clinicians; prolonged occupational stress can result in the emotional exhaustion, cynicism, and reduced sense of accomplishment that characterize burnout (Maslach, Schaufeli, & Leiter, 2001). For example, using a large naturalistic data set of 119 therapists and more than 10,000 patients, Saxon and Barkham (2012) found that therapists with a

caseload including a higher percentage of patients at risk of harming themselves or others achieved poorer outcomes, not only with the at-risk patients but with all of their patients. The authors speculated that working with high-risk patients contributed to therapist burnout, which adversely impacted the therapists' ability to work effectively across their caseload. The researchers found support for the negative impact of therapist burnout in another study, based on a sample of 49 therapists and more than 2,000 patients (Delgadillo, Saxon, & Barkham, 2018): Delgadillo et al. (2018) found that higher therapist burnout was significantly associated with poorer patient outcomes on measures of anxiety and depression.

Stressful job situations can contribute to burnout and less effective performance, but so can issues in the therapist's personal life. In one study using a naturalistic outpatient sample, therapists' reports of feeling more burdened in their personal lives were negatively associated with patient-reported alliance development over time (Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013). Of interest, therapist burden was not related to therapists' ratings of the alliance, which may indicate that therapists were not aware of how their personal burdens were impacting their ability to collaborate and build a bond with their patients. As the authors observed, these findings suggest that it can be difficult for therapists to keep struggles in their personal lives from impacting their work in the therapy office. Patients may be particularly sensitive to therapists' experiences of distress, which therapists may unknowingly communicate to patients through the therapists' in-session behaviors.

HOW DO THERAPISTS' PERSONAL DIFFICULTIES CONTRIBUTE TO PROBLEMS IN THE ALLIANCE?

The idea that therapists' personal issues can affect their ability to work effectively with patients is not new. We are probably most familiar with thinking of this phenomenon in terms of countertransference. The field has defined countertransference in various ways, but increasingly, most empirical studies of countertransference have conceptualized the construct in terms of a therapist's unresolved conflicts being triggered by a characteristic of the patient (J. A. Hayes, Gelso, Goldberg, & Kivlighan, 2018). Therapist countertransference reactions can take the form of feeling anxious and avoiding and withdrawing from personally threatening patient material or meeting one's own needs by excessively nurturing patients. Therapists may have a distorted or inaccurate recall of what a patient said in a session, or they may experience somatic reactions such as sleepiness or headaches. A meta-analysis of the countertransference literature found that more frequent countertransference reactions are associated with worse patient outcome (J. A. Hayes et al., 2018).

Therapists' abilities to successfully manage their countertransference reactions have most commonly been operationalized with the Countertransference Factors Inventory (CFI; Van Wagoner, Gelso, Hayes, & Diemer, 1991),

Copyright American Psychological Association. Not for further distribution.

a supervisor-rated measure that focuses on therapist qualities of self-insight, self-integration (as manifested by recognition of interpersonal boundaries), empathy, anxiety management, and conceptualization ability. Research with the CFI has found that therapists' abilities to manage their countertransference reactions are associated with better treatment outcome (J. A. Hayes et al., 2018). This finding suggests that therapists who are aware of and able to understand their emotional reactions to a patient, to identify with the patient's experience, and to draw on theory to contextualize the patient's behavior are better able to help their patients make treatment gains.

Several studies have found that engaging in negative countertransference behavior may be a particular risk for therapists with insecure attachment styles (Ligiéro & Gelso, 2002; A. Martin, Buchheim, Berger, & Strauss, 2007; Mohr, Gelso, & Hill, 2005; Rubino, Barker, Roth, & Fearon, 2000). According to Bowlby's (1988) conceptualization of attachment theory, we develop inner working models of relationships based on early experiences with significant caregivers. These models inform our expectations for ourselves and others we relate to over the course of our lives. Individuals who develop secure attachment styles display cooperative behaviors and flexible coping strategies under stress, whereas individuals with insecure attachment styles may be distant and distrustful (dismissing attachment) or demanding and dependent (preoccupied attachment) in relationships (Strauss & Petrowski, 2017).

As one might expect, research suggests that therapists with secure attachment styles have better alliances with their patients (Schauenburg et al., 2010). Therapist security may be particularly important when working with more challenging patients: One study found that secure therapist attachment was associated with better outcome for patients who had higher levels of impairment (Schauenburg et al., 2010). Therapists with insecure attachment styles tend to have weaker alliances and report more problems in therapy (Black, Hardy, Turpin, & Parry, 2005; Dinger, Strack, Sachsse, & Schauenburg, 2009) and tend to display less attuned behaviors in session (Talia, Muzi, Lingiardi, & Taubner, 2018). Patients working with therapists with insecure attachments are more likely to describe their attachment to the therapist as insecure (Petrowski, Pokorny, Nowacki, & Buchheim, 2013). This finding suggests that insecurely attached therapists are vulnerable to the therapeutic situation activating their attachment-related concerns, which might hinder their ability to form a good working relationship with their patient (Strauss & Petrowski, 2017). For example, a therapist with a dismissing attachment style might maintain a cool distance from patients, whereas a therapist with a preoccupied attachment style might self-disclose excessively about his or her personal life. By contrast, a therapist with a secure attachment style might be better at flexibly negotiating distance and closeness based on the patient's needs, rather than the therapist's.

Countertransference reactions and attachment-related concerns can be thought of as therapist blind spots that can contribute to problems in our working relationships with our patients. There is a small but growing research

Copyright American Psychological Association. Not for further distribution.

Copyright American Psychological Association. Not for further distribution.

literature on another type of therapist blind spot: biases that lead therapists to commit microaggressions, conceptualized as direct and indirect disrespectful, insulting, dismissive communications about an individual's cultural group (Hook, Davis, Owen, & DeBlaere, 2017). Patient ratings of microaggressions related to patient gender (Owen, Tao, & Rodolfa, 2010) and race or ethnicity (Owen, Tao, Imel, Wampold, & Rodolfa, 2014) have been linked to lower alliance ratings. In a survey of lesbian, gay, and bisexual patients, 21% reported that their therapist was either dismissive of their sexual orientation or viewed it as a problem (Kelley, 2015). Microaggressions can range from explicitly prejudiced comments to invalidations, such as assuming that patients are heterosexual unless and until they tell you otherwise.

HOW DO THERAPISTS CONTRIBUTE TO NEGATIVE PROCESS?

We have identified evidence that therapists' own difficulties—in the form of problematic countertransference reactions, attachment insecurity, and biases—can negatively impact their abilities to work effectively with patients. In this section, we consider negative process.

In her review of qualitative studies, Clara Hill (2010) described qualitative efforts that have demonstrated the complexity of negative process, including patients' reluctance to disclose negative feelings; the difficulty for therapists to recognize these feelings; and, even if aware, the challenge for therapists to address these feelings (Fuller & Hill, 1985; Hill, Thompson, Cogar, & Denman, 1993; Hill et al., 2003; J. Martin, Martin, Meyer, & Slemon, 1986; J. Martin, Martin, & Slemon, 1987; Regan & Hill, 1992; Rennie, 1994). Here we examine research findings that shed light on how therapists can contribute to negative process, which increases the likelihood of poor treatment outcome.

Some of the most important studies on negative process in psychotherapy were the Vanderbilt studies conducted by Hans Strupp and colleagues (Strupp, 1998). With the first Vanderbilt study, Strupp and colleagues were interested in the role of specific therapeutic interventions versus common factors—that is, elements of healing relationships such as empathy that are presumed to be common across treatments. To investigate, Strupp compared professional therapists, who had training in specific interventions, with college professors, who were sought after for their advice and would presumably have access to only the common factors. Male college students who had difficulties with depression, anxiety, or shyness were randomly assigned to either a professional therapist or a professor and received two sessions each week, up to 25 sessions. The researchers found no significant differences in outcome between the two groups (Strupp & Hadley, 1979) and concluded that the question of specific versus common factors was the wrong question. To better understand what therapists do that contributes to outcome, Strupp and colleagues focused on the cases seen by professional therapists in the study. They conducted post hoc comparisons of good and poor outcome

patients who were seen by the same therapists (Strupp, 1980a, 1980b, 1980c, 1980d). They observed negative behaviors by the therapists that interfered with the therapists' ability to form a good working alliance, such as a lack of empathy when working with patients who were less motivated or less receptive to the therapist's approach. In his discussion of one such comparison, Strupp (1980d) concluded the following:

> Thus, major deterrents to the formation of a good working alliance are not only the patient's characterological distortions and maladaptive defenses but—at least equally important—the therapist's personal reactions. . . . Traditionally these reactions have been considered under the heading of countertransference. It is becoming increasingly clear, however, that this conception is too narrow. The plain fact is that *any therapist—indeed any human being—cannot remain immune from negative (angry) reactions to the suppressed and repressed rage regularly encountered in patients with moderate to severe disturbances*. (p. 953; italics in original)

Strupp (1980d) observed that therapists in his sample tended to respond to challenging patients with what he described as "counterhostility that not uncommonly took the form of coldness, distancing, and other forms of rejection" (p. 954). This hostility on the part of the therapist contributed to poor alliances, dropout from treatment, and poor treatment outcome. Strupp (1980d) emphasized that this phenomenon was not unique to a subset of "bad" therapists: "In our study we failed to encounter a single instance in which a difficult patient's hostility and negativism were successfully confronted or resolved" (p. 954).

A more recent research study on therapist reactions supports Strupp's contention that the problem of negative therapist reactions to patients is widespread and important. Westra, Aviram, Connors, Kertes, and Ahmed (2012) examined therapists' reactions to patients in a sample of 30 patients receiving eight sessions of cognitive behavior therapy (CBT) for generalized anxiety disorder. They found that when therapists had certain negative reactions to patients early in treatment, such as the therapist feeling that he or she was in a power struggle with the patient or feeling drained, helpless, guilty, and frustrated, patients were likely to display higher levels of resistance behaviors (such as ignoring or disagreeing with the therapist) later in treatment. By contrast, when therapists reported positive reactions such as liking, enjoying, and feeling attached to patients, their patients had lower levels of resistance at midtreatment and evidenced reductions in resistance across the early stage of treatment. These findings suggest that therapists' own personal reactions to patients may impact their ability to respond effectively to patient resistance and that negative therapist reactions may worsen patient resistance.

The clinical importance of these findings is underscored by another study from the same data set: Button, Westra, Hara, and Aviram (2015) found that patient resistance was a significant predictor of poor treatment outcome. Of additional concern is the possibility that therapists may not only have difficulty managing patient resistance but also lack awareness of it. In another study

Copyright American Psychological Association. Not for further distribution.

drawing on a different sample of patients with generalized anxiety disorder receiving CBT, Westra and colleagues (Hara et al., 2015) found that observers appeared to be better than therapists at detecting resistant behaviors that impacted clinical outcomes. Compared with therapist ratings, observer ratings were more predictive of patient perceptions of the therapeutic alliance, patient compliance with homework assignments, and treatment outcome. The tunnel vision and the self-focus that can arise under pressure may interfere with therapists' abilities to remain sensitively attuned to their patients' experience in therapy.

Based on the findings of the first Vanderbilt study, Strupp and colleagues sought to address therapists' difficulties with responding effectively to negative patient reactions by developing a treatment manual and a training program (Strupp & Binder, 1984). In the Vanderbilt II study, they examined the impact of the training on treatment process and outcome in a sample of 16 experienced therapists who each treated several patients (Strupp, 1993). Strupp and colleagues found that contrary to their hopes, the training did not improve therapists' abilities to manage interpersonal processes within the therapeutic relationship. Rather, they found an *increase* in negative process, specifically an increase in therapist hostility and in complex communications in which the therapist conveyed mixed messages (e.g., communicating both friendliness and hostility or both approach and avoidance; Henry, Strupp, Butler, Schacht, & Binder, 1993). The researchers also found that negative process was related to worse treatment outcome (Najavits & Strupp, 1994).

Why didn't the training work? One possible explanation is suggested by a series of analyses that Strupp and his colleagues conducted using therapists' ratings of how they treated themselves (Henry, Schacht, Strupp, Butler, & Binder, 1993). Therapists who reported that they treated themselves in negative ways (e.g., self-indicting and oppressing) demonstrated the greatest adherence to the training and were linked to the increases in negative process that resulted from the training. By contrast, therapists who treated themselves in a more positive and nurturing way showed decreases in negative process after training. These findings are consistent with the research findings on performance under pressure: Judgment and decision making under stress often become more rigid and narrow. When therapists experience pressure in a clinical situation—which could be generated or exacerbated by their own inner critic—they may become more adherent to a treatment protocol in a way that ends up being unhelpful for the patient. Additional research offers more support for this idea. Studies of both cognitive therapy (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996) and psychodynamic therapy (W. E. Piper, Azim, Joyce, & McCallum, 1991; W. E. Piper et al., 1999; Schut et al., 2005) have found evidence that some therapists respond to a difficult interaction with a patient by increasing their adherence to their theoretical model—for example, cognitive therapists increase their challenging of the patient's distorted cognitions, and psychodynamic therapists make more transference

Copyright American Psychological Association. Not for further distribution.

interpretations—and this type of arguably rigid adherence in the context of a strained patient–therapist relationship has been linked with poor outcome and dropout from therapy. It is not hard to imagine how frustrating it would be for a patient who is feeling misunderstood by the therapist or dissatisfied with the treatment to realize that the therapist's response is to double down on their approach instead of pausing and creating space to hear the patient's concerns.

Therapists differed in their response to the training offered in the Vanderbilt II study, which points to how therapists' personal characteristics can moderate therapists' responses to challenging clinical situations. This observation contributed to a line of research on therapist facilitative interpersonal skills. Drawing on case examples from the Vanderbilt studies, Anderson, Patterson, and Weis (2007) developed a performance task (Facilitative Interpersonal Skills) to measure therapists' abilities to respond to challenging interpersonal situations in therapy. With this task, therapists respond verbally to brief video clips based on patients from the Vanderbilt studies. Therapists' responses are recorded and then coded using an observer-based measure of skills such as empathy, warmth, verbal fluency, and the ability to build and maintain a strong alliance. This task can be stressful for therapists: Not only are they asked to respond to a difficult clinical situation, but they are under pressure to quickly come up with a response that they know will be recorded and evaluated. Hence, to perform well on the task, therapists must not only possess good interpersonal skills but also be able to demonstrate these skills under pressure.

Studies using the Facilitative Interpersonal Skills task have found links between performance on the task and treatment outcome (Anderson, McClintock, Himawan, Song, & Patterson, 2016; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). One particularly striking finding is from a study that was partly modeled after the Vanderbilt I study comparing therapists and college professors: Participants were randomly assigned to attend seven sessions with either psychology graduate student therapists or graduate students in other disciplines who had not received therapy training (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016). The researchers found that therapists' facilitative interpersonal skills predicted alliance ratings and change on most outcome measures. There were no significant differences between the psychology students and the students from other disciplines. This finding suggests that what mattered was not whether a therapist had received training in psychotherapy but rather whether the therapist could respond empathically and skillfully to challenging clinical situations.

Findings from another study provide more support for this idea of the importance of therapists' skills under pressure. Schöttke, Flückiger, Goldberg, Eversmann, and Lange (2017) showed therapy trainees a 15-minute film clip of a provocative therapy intervention and then observed the trainees as they engaged in a group discussion. The researchers found that trainees' abilities to communicate in the discussion with clarity, respect, warmth, and empathy predicted their outcome with their patients over a 5-year period.

Copyright American Psychological Association. Not for further distribution.

WHAT ARE ALLIANCE RUPTURES?

The literatures on therapists' personal difficulties and on negative process point to ways in which therapists can struggle to build and maintain good working alliances with their patients, particularly in challenging clinical situations. We now turn to a literature that directly focuses on moments of tension and strain in the therapeutic relationship: the literature on alliance ruptures.

Drawing on Bordin's (1979) tripartite conceptualization of the alliance, ruptures can be characterized as disagreements between patients and therapists on the goals of treatment, failure to collaborate on the tasks of treatment, and/or a strain in the emotional bond. Although the word *rupture* connotes a sudden or dramatic break, we have found it useful to also view subtle tensions and misattunements as markers of rupture and to draw on related constructs such as countertransference to inform our understanding of ruptures. By paying close attention to early signs of potential rupture, clinicians can find opportunities to intervene before the therapeutic relationship reaches a breaking point. Research on ruptures suggests that this is important; for example, one study found that experiencing more intense ruptures, as reported by both patients and therapists, was associated with a worse outcome on measures of patients' interpersonal functioning and that a failure to resolve these ruptures predicted premature dropout from treatment (Muran et al., 2009). Research also suggests that ruptures are not a clinical problem that is solely the concern of mediocre therapists or particularly challenging patients: In the study just cited, around 33% of patients and 50% of therapists reported that they experienced difficulties in the therapeutic relationship early in treatment (Muran et al., 2009). Studies using observer-based measures of ruptures often report even higher frequencies—from 33% to 100% of sessions (see Eubanks, Muran, & Safran, 2018, 2019).

In our work, we have found it useful to distinguish between two types of ruptures: withdrawal and confrontation ruptures (Safran & Muran, 2000; Samstag, Muran, & Safran, 2004; see Exhibit 2.1). We have defined withdrawal ruptures as movements *away* from an other, including efforts toward isolation

Copyright American Psychological Association. Not for further distribution.

EXHIBIT 2.1

Alliance Ruptures

Withdrawal ruptures

- Movements away from other or self
- Efforts toward *isolation* or *appeasement*
- Pursuits of *communion* at the expense of *agency*

Confrontation ruptures

- Movements against other
- Efforts toward *aggression* or *control*
- Pursuits of *agency* at the expense of *communion*

---

or attempts to deny an aspect of the self—such as stifling a desire—in order to appease the other. These movements away are efforts to protect an attachment: Take the example of the child who learns to be quiet around a domineering parent in order to maintain some connection and avoid rejection. We have defined confrontation ruptures as movements *against* an other, including movements toward aggression or control. Another way of thinking about withdrawal and confrontation is in terms of the ongoing negotiation between the patient and therapist in terms of what they wish for or need from each other. In a withdrawal rupture, the patient sacrifices or compromises his or her need for *agency* in an effort to maintain a relationship (the need for *communion*) with the therapist. For example, the patient may disagree with what the therapist is saying, but rather than state this directly, the patient changes the topic for fear that direct expression would endanger the therapeutic relationship. In a confrontation rupture, the patient is trying to preserve or defend his or her agency by moving against the therapist, at the expense of communion and collaborating well with the therapist. We should also note that ruptures can present as complex combinations of both withdrawal and confrontation markers, as patients wrestle with their own ambivalence or concerns about their needs and fears around agency and communion.

In describing types of withdrawal and confrontation ruptures, we draw on an observer-based measure of ruptures that we have developed—the Rupture Resolution Rating System (3RS)—to provide specific examples (Eubanks, Lubitz, Muran, & Safran, 2019; Eubanks, Muran, & Safran, 2015; see also the appendix). In confrontation ruptures, the patient moves against the therapist and/or the work of therapy. This could take the form of behaviors such as criticizing or complaining about the therapist, the activities or parameters of the treatment, or the patient's lack of progress. Additional examples of confrontation ruptures include rejecting the therapist's efforts to intervene, defending oneself against perceived criticism by the therapist, or attempting to control or pressure the therapist. In withdrawal ruptures, the patient moves away from the therapist or the work of therapy. This could take the form of avoidant behaviors such as the patient denying his or her true feelings about how treatment is going, giving minimal responses to the therapist's questions, shifting the topic or telling stories in an effort to avoid the topic at hand, speaking in a vague or intellectualized manner, being overly appeasing and deferential, or pulling away from the therapist via a self-critical and hopeless stance. Additional descriptions and examples of these markers of ruptures are provided in Table 2.1. In a recent study using the 3RS to code ruptures in early sessions of CBT, we found that the frequency of confrontation ruptures predicted premature dropout from treatment (Eubanks, Lubitz, et al., 2019).

In this discussion of withdrawal and confrontation ruptures, we are describing ruptures in terms of patient behaviors. However, we believe that ruptures are dyadic phenomena that are coconstructed by both patient and therapist (Safran & Muran, 2000), and we have long emphasized the importance of therapists attending to their internal experience during ruptures (see Chapter 3). Therapists' contributions to ruptures have been recognized in some

Copyright American Psychological Association. Not for further distribution.

TABLE 2.1. Alliance Rupture Markers From the Rupture Resolution Rating System

Withdrawal rupture markers and examples	
Denial	The patient withdraws from the therapist and/or the work of therapy by denying a feeling state that is manifestly evident, or denying the importance of interpersonal relationships or events that seem important and relevant to the work of therapy. Therapist: Are you OK? You look upset. Patient: It's nothing, I'm fine.
Minimal response	The patient withdraws from the therapist and/or the work of therapy by going silent or by giving minimal responses to questions or statements that are intended to initiate or continue discussion. Therapist: That sounds really difficult. How did it make you feel? Patient: *(Shrugs)*
Abstract communication	The patient avoids the therapist and/or the work of therapy by using vague or abstract language. Therapist: How did you feel when she turned you down? Patient: It really made me reflect on how my relationship with her is an example of the rise of transactional interactions in society today. I think she and I are both really impacted by that.
Avoidant storytelling and/or shifting topic	The patient tells stories and/or shifts the topic in a manner that functions to avoid the therapist and/or the work of therapy. Therapist: I think we really need to talk about our goals. I'm concerned that we aren't really on the same page. Would you be willing to talk about this? Patient: You know, that reminds me of something that happened at work the other day. We were working on this project—oh, I have to tell you about this project, it's really interesting . . .
Deferential and appeasing	The patient withdraws from the therapist and/or the work of therapy by being overly compliant and submitting to the therapist in a deferential manner. Therapist: I think for homework you should focus on tracking your thoughts and feelings around asking your boss for a raise. Patient *(Sitting very stiffly, looking uncomfortable)*: That sounds like a good idea. Yes, absolutely.
Content/affect split	The patient withdraws from the therapist and/or the work of therapy by exhibiting affect that does not match the content of his or her narrative. Therapist: It's hard for you to tell me about those sad feelings. Patient *(A bright, forced smile)*: Yes, it's not easy to talk about. *(Patient chuckles nervously.)*

(*continues*)

Copyright American Psychological Association. Not for further distribution.

TABLE 2.1. Alliance Rupture Markers From the Rupture Resolution Rating System (*Continued*)

	Withdrawal rupture markers and examples
Self-criticism and/or hopelessness	The patient withdraws from the therapist and/or the work of therapy by becoming absorbed in a depressive process of self-criticism and/or hopelessness that seems to shut out the therapist and to close off any possibility that the therapist or the treatment can help the patient. Therapist: That sounds important. Can you tell me more about that? Patient: *(Sighs)* What's the point? It's not going to make me feel better.
	Confrontation rupture markers and examples
Complaints/concerns about the therapist	The patient expresses negative feelings or concerns about the therapist. Patient: I can see I'm not going to get anything useful out of you.
Patient rejects therapist intervention	The patient rejects or dismisses the therapist's intervention. Therapist: When did your insomnia begin? Patient: What difference does that make? That's irrelevant.
Complaints/concerns about the activities of therapy	The patient expresses dissatisfaction, discomfort, or disagreement with specific tasks of therapy such as homework assignments, empty chair exercises, or exposure. Patient: I really don't understand what you're asking me to do on these thought records. I don't see the point of them at all.
Complaints/concerns about the parameters of therapy	The patient expresses complaints or concerns about the parameters of treatment, such as appointment times, session length, or frequency, or about completing questionnaires. Patient: Once a week is not enough time to address all my problems!
Complaints/concerns about progress in therapy	The patient expresses complaints, concerns, or doubts about the progress that can be made or has been made in therapy. Patient: I've been coming here for four weeks now, and I really can't think of anything that has changed. Maybe this has all been a waste of time.
Patient defends self against therapist	The patient defends their own thoughts, feelings, or behavior against what they perceive to be the therapist's criticism or judgment. Therapist: A lot of things have changed for you. Patient: But I think it's normal for people to change. I'm going through a transitional period. It doesn't mean that I'm unstable!
Efforts to control/pressure therapist	The patient attempts to control the therapist and/or the session, or the patient puts pressure on the therapist to fix the patient's problems quickly. Patient: I want to know how this therapy works. Tell me how it's going to help me with my problems. And none of that fancy therapist talk; I want a direct answer.

Note. Data from Eubanks, Muran, and Safran (2015).

Copyright American Psychological Association. Not for further distribution.

research on alliance ruptures, such as the Collaborative Interactions Scale (Colli & Lingiardi, 2009), an observer-based measure that assesses both patients' and therapists' positive and negative contributions to the alliance, as well as the System for Observing Family Therapy Alliances (Friedlander et al., 2006), which includes negative alliance-related behaviors of both patients and therapists in family therapy. In our own research program, we are interested in drawing more attention to how therapists contribute to the development and maintenance of ruptures by engaging in withdrawal and confrontation behaviors themselves (see Eubanks, 2019, for an example of applying 3RS markers to both patient and therapist behaviors). For example, therapists may withdraw by becoming passive in the session or by engaging in intellectualized digressions that move away from the patient's presenting concerns. Or therapists may engage in confrontation ruptures by criticizing the patient or being overly controlling of the session. Our preliminary efforts to examine the therapist's role suggest that therapist contributions to ruptures in an early therapy session, as rated by observers, predict premature dropout from therapy (Eubanks, Lubitz, et al., 2019).

WHAT DO WE KNOW ABOUT RUPTURE REPAIR?

Although alliance ruptures can contribute to poor patient outcome or dropout, a meta-analytic review of 11 studies found that repair or resolution of ruptures were quite prevalent (from 15% to 80% of cases) and significantly predictive of improved patient outcome (see Eubanks et al., 2018; Eubanks, Muran, & Safran, 2019). These studies included treatments from various orientations. A striking example from this literature is a study of 79 patients who received either CBT or psychodynamic-interpersonal therapy for depression (Stiles et al., 2004). The researchers found that patients with repaired ruptures—identified based on changes in patients' self-reported alliance scores—attained, on average, greater improvement in therapy than patients who did not experience ruptures. This is a provocative finding: Ruptures may spell doom for a case if they are not adequately addressed, but if they are handled well, they can contribute to patient improvement. What can therapists do to facilitate this kind of rupture resolution? How can therapists respond to the pressure of a rupture in a way that contributes to better outcome rather than making the rupture worse?

In our research program, our efforts to better understand the resolution process were grounded in a series of task analyses, studies in which a model of rupture resolution was constructed and then progressively refined based on empirical data (Safran & Muran, 1996; Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Samstag, 1994). Safran and Muran (1996) developed a four-part stage-process model of rupture resolution with the aim of sensitizing therapists to the critical processes and pathways involved. In Stage 1, the therapist recognizes and addresses the rupture by drawing the patient's attention to it. In Stage 2, the patient and therapist collaboratively explore the

Copyright American Psychological Association. Not for further distribution.

negative feelings associated with the rupture. This process can become uncomfortable for the patient, who may try to avoid further exploration. If this happens, the therapist pivots to Stage 3, in which he or she draws the patient's attention to the patient's avoidance maneuvers and explores them. In the final stage, the therapist and patient focus on clarifying the patient's core relational need that underlies the initial rupture. Figure 2.1 provides an illustration of this stage-process model.

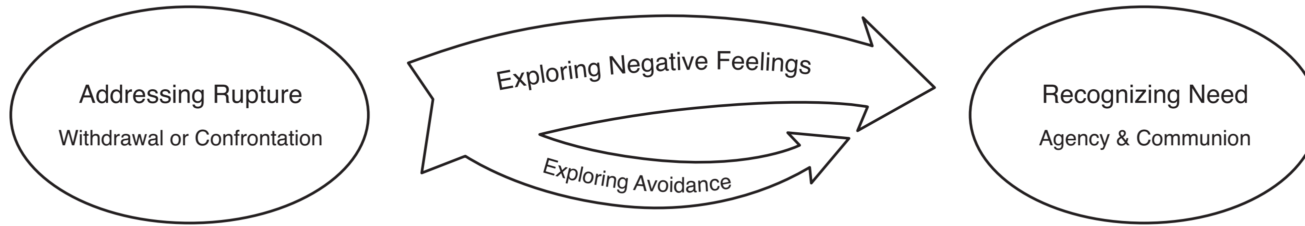
In withdrawal ruptures, the process usually involves moving from exploring the patient's efforts to avoid directly engaging with the therapist to recognizing and helping the patient more clearly assert what the patient really needs from the therapist: a progression to *agency*. In confrontation ruptures, the process of exploring the rupture would typically involve moving from exploring the patient's expressed anger toward the therapist to identifying feelings of disappointment with the therapist and then to contacting the patient's underlying vulnerability and recognizing the need to be nurtured: a progression to *communion*. The four stages of the rupture resolution model should be understood as a heuristic that facilitates the development of a *mental representation* of rupture resolution. In reality, repairing a rupture often involves cycling between these stages multiple times, and the process may extend across multiple therapy sessions. Efforts to resolve one rupture may lead to another rupture; for example, a therapist's initial attempt to draw attention to a rupture (e.g., "I feel that there is some distance between us") may cause the patient to feel criticized (e.g., "Are you saying that I'm doing something wrong?"), and the therapist will need to recognize and address this new rupture. It is important that the therapist move flexibly to where the patient is rather than rigidly adhere to one resolution strategy or plan (Safran & Muran, 2000). If the therapist is focused on repairing an initial rupture, while the patient is actually upset about a subsequent rupture, the therapist's misdirected efforts at repair may only serve to strengthen the patient's sense of being misunderstood or disconnected from the therapist.

The hope is that this exploration will not only help the dyad to work together toward a greater understanding of the rupture but also shed light on how the patient understands and experiences themselves in relationships. In other words, by exploring this particular relational event, the patient will gain greater awareness of how the patient navigates other relationships as well (Safran & Muran, 2000). By exploring a patient's complaints about the therapist, a therapist may help a highly critical patient become more aware of how their hostility pushes others away, leaving them alone in their contempt. By encouraging a patient to directly assert what is needed, a therapist may help a deferential patient recognize how the patient's prior efforts at appeasement successfully kept the peace, but at the price of the patient's needs for true recognition and intimacy. The therapist may make such links explicit by pointing out parallels between the therapeutic interaction and patterns in the patient's interpersonal relationships. However, it is important that therapists not move too quickly to make these links. As we noted, therapists can focus too much on transference interpretations, particularly when feeling

Copyright American Psychological Association. Not for further distribution.

Copyright American Psychological Association. Not for further distribution.

FIGURE 2.1. Safran and Muran's (1996) Stage-Process Model of Rupture Resolution



Note. Version designed by Rachel Small, 2019.

Copyright American Psychological Association. Not for further distribution.

anxious (e.g., W. E. Piper et al., 1991, 1999). Moving away from exploring the patient's experience in the here and now—perhaps because of the therapist's own anxiety—can lead the therapist to miss the opportunity for a richer understanding of the patient's experience and a more powerful, in vivo exploration of the patient's relational schemas. It is much more impactful to become aware of how one is moving away or against the therapist *in this very moment* than to make those connections about relationships in the past or outside of the room.

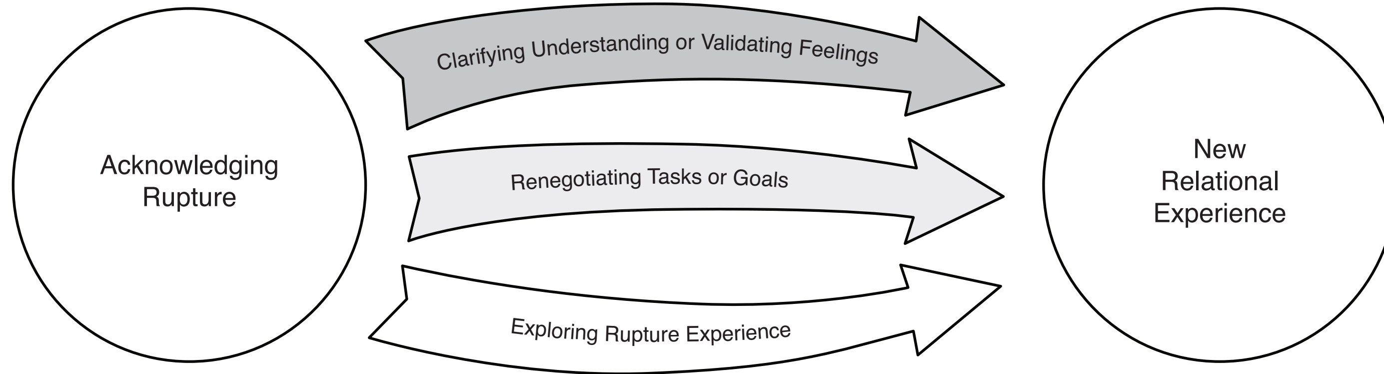
Several other research groups have also developed models of rupture resolution based on task analyses. Similar to the model just described, some of these models regard the starting point of rupture resolution as the therapist acknowledging the rupture and exploring it collaboratively with the patient; these include studies of rupture repair in interpersonal psychodynamic therapy with patients who are depressed (Agnew, Harper, Shapiro, & Barkham, 1994), cognitive analytic therapy with patients with borderline personality disorder (Bennett, Parry, & Ryle, 2006; Daly, Llewelyn, McDougall, & Chanen, 2010), and emotion-focused therapy with couples (Swank & Wittenborn, 2013). However, task analyses of CBT for depression (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008) and CBT for borderline personality disorder (Cash, Hardy, Kellett, & Parry, 2014) concluded that therapists did not need to explicitly acknowledge a rupture. Rather, they described how therapists can resolve ruptures by changing the topic of discussion or the task in which the patient and therapist were engaged in a way that is responsive to the patient's needs or concerns.

Whether or not a therapist explicitly acknowledges a rupture, it seems important for the therapist to have some internal recognition that a rupture is occurring in order to be best positioned to address it. Several research studies found evidence suggesting that therapist recognition of a rupture is related to subsequent improvements in alliance or outcome (e.g., Atzil-Slonim et al., 2015; Chen, Atzil-Slonim, Bar-Kalifa, Hasson-Ohayon, & Refaeli, 2018; Rubel, Zilcha-Mano, Feils-Klaus, & Lutz, 2018; Zilcha-Mano, Snyder, & Silberschatz, 2017).

Once a therapist recognizes that a rupture is occurring, the therapist has multiple response options. First and foremost, we argue that part of building and maintaining a good alliance is the therapist consistently approaching the patient with empathy, validation, and curiosity. The therapist never presumes that he or she has all the answers; the therapist respects the patient's unique perspective and appreciates that the work of therapy always involves a collaboration between patient and therapist. The therapist brings a "skillful tentativeness" (see Safran & Muran, 2000; see also Muran, Safran, & Eubanks-Carter, 2010) to interactions with the patient; the therapist is seeking greater understanding and clarification of the patient's experience. As this should always be taking place, with some ruptures, the therapist may simply maintain this position, continue to validate the patient, and try to understand their concerns, and that may suffice to repair the rupture. This is represented as the first potential path in Figure 2.2.

Copyright American Psychological Association. Not for further distribution.

FIGURE 2.2. Strategies for Alliance-Building and Rupture Repair or Resolution



Note. Version designed by Rachel Small, 2019.

The second and third potential paths in Figure 2.2 represent what we have described as *immediate* and *exploratory* resolution strategies (Eubanks et al., 2018). Immediate strategies are efforts to promptly address a rupture and get treatment back on track, such as strategies involving renegotiating tasks or goals, as indicated in the second path in Figure 2.2. For example, if a patient objects to a therapy task, the therapist might address the patient's concerns by offering more explanation of the rationale for the task, or the therapist could change the task, as suggested by the task analytic studies of CBT. A therapist might choose an immediate strategy if it is very early in treatment and they do not feel the bond is strong enough yet for an in-depth exploration of the rupture. A therapist might try to initiate an exploration of a rupture and find that the patient is not willing to collaborate on such a discussion at this point; shifting the topic from the rupture back to the patient's presenting concerns might be an effective way to keep the patient engaged until a more propitious moment for exploration arises. Or if the patient is in great distress, the therapist might choose an immediate strategy to prioritize getting back to specific therapy techniques aimed at alleviating the patient's symptoms.

Exploratory strategies involve shifting the focus of the session toward exploring the rupture experience (the third path in Figure 2.2), consistent with the type of exploration described in Safran and Muran's (1996) stage-process model. For example, the therapist could invite the patient to share his or her thoughts and feelings about the impasse. The therapist could disclose his or her own experience of the therapeutic relationship and acknowledge how he or she has contributed to the difficulties they are experiencing. A therapist might choose to use exploratory strategies when they reach an impasse so great that it is impossible to move forward with therapy without taking time to fully address the alliance rupture. A therapist might also choose an exploratory approach if he or she has a sense that what is unfolding between the therapist and patient is related to the patient's key interpersonal difficulties and is therefore important to explore further.

Although our research program has focused on the exploratory approach to rupture resolution, it is important to emphasize that both immediate and exploratory approaches can be useful and that even the "simplest" approach can have a powerful impact on a patient, providing a new relational experience. We have noted how the process of exploring a rupture can be a powerful corrective experience for patients (Christian, Safran, & Muran, 2012). A patient might find it a unique opportunity to talk about and work through an interpersonal conflict with an empathic person; this may be in stark contrast to the patient's other interpersonal experiences and provide a powerful challenge to the patient's assumptions about what is possible in an interpersonal relationship. Other forms of resolving ruptures can also provide a corrective experience. For example, a patient complains about a homework assignment, and the therapist agrees to change the assignment in a flexible and nondefensive manner. The therapist may not link this directly to the patient's underlying interpersonal problems, but nevertheless it may be profoundly impactful for a patient who is not accustomed to being heard and validated.

Copyright American Psychological Association. Not for further distribution.

Copyright American Psychological Association. Not for further distribution.

CASE EXAMPLE: IMMEDIATE AND EXPLORATORY RESOLUTION APPROACHES

To further illustrate how a therapist might employ immediate and exploratory resolution approaches, I (CFE) present an experience with one of my patients. We had been working together for a while, and I had become accustomed to her tendency to tell and retell the story of her life—revisiting why she had made certain life decisions and trying to understand how she had ended up in an unsatisfying marriage and a dead-end job. Initially I had listened with the assumption that she was telling me this story to communicate content that I needed to know and understand. However, as I realized she was telling the same story over and over, with no change or movement in the narrative, and I could not see how it was benefitting our work, I began to shift my focus to the process. I started interrupting her when she began her story and asked her why she was telling me this story again at this moment. Sometimes she agreed that she was going off on a ruminative tangent (like the 3RS withdrawal rupture marker of avoidant storytelling) and thanked me for refocusing her (the immediate resolution strategy of redirecting the patient). Other times she told me that there was a reason she was telling me the story now and would note a new detail and explain why she felt this was important. This would shift my view of her story from an effort to withdraw to an effort to engage and enrich our work.

But then came a session when she spoke about relationships with various people in her life, and I heard the familiar complaints differently: as an endless string of one "poor me" after another, blaming everyone in her life for all her problems. I experienced her as more intense than usual, as aggrieved and indignant. I don't know if the increase in intensity lay in how she expressed herself or in how I received it that particular day—or most likely an interaction between the two—but I found myself trying to interject more with questions and observations, anything to break up the tired narrative. As she continued, I became acutely aware that nothing that I was saying was penetrating, as if we were speaking different languages. When she complained about a request her boss had made of her—something that I perceived as appropriate and part of her job description—and she said that her boss was being "cruel," I suddenly had the overwhelming sense that I could not complete this session. The session was infuriatingly pointless because she was not listening to me and was not open to anything I was saying. Either I would have to walk out of the room, or I would have to ask her to leave.

I was taken aback by my visceral reaction. I knew that I had to say something to tolerate staying in my chair: "I feel like we are having two separate conversations here. There is a wall between us, and we aren't really communicating with each other."

My effort to draw attention to what was happening between us (the exploratory strategy of disclosing my internal experience of the patient–therapist interaction) got her attention. She stopped her narrative and asked me what I meant. I shared my reaction to her calling her boss "cruel"—my sense that she

was being unfair to him, that he was asking something reasonable. I revealed my thought that one reason she had been having so many problems at work was that she thought the job was beneath her.

I was blunt and forthright, and she responded in kind: "You are being so direct with me right now. You're usually so gentle. We've been talking about my work problems for a long time. Why didn't you say this before?"

Now I felt both defensive and self-critical: Why had I been holding back so much for so long? At the same time, was *I* now being cruel? I tried to continue exploring what was happening between us by disclosing more of my experience: "I think I didn't really put it all together until just now. I think when we started working together, I couldn't figure out what was going on for you at work, and it took time for me to form an opinion." A moment from our prior session suddenly came to my mind: "I'm remembering right now something you said in our last session, that you are a grown woman and you can take it. I have to take responsibility for the fact that I haven't been treating you like a grown woman. I've been holding back, feeling like I need to protect you, and to protect us. But you *are* a grown woman, and I need to show you that respect and be honest with you." She was looking closely at me with an intense focus, and I was concerned about how she was receiving my effort to acknowledge my contribution to the rupture. I returned to a focus on what was happening between us in this moment (the exploratory strategy of inviting the patient to discuss thoughts or feelings about the therapist or therapy): "How is this, to hear me say this?"

Her face softened, and her response surprised me: "It reminds me of my mother. She would do this sometimes; she would give me a kick in the seat of the pants when I needed it. Thank you for being honest with me. It means a lot."

By exploring what was happening between us, we were able to change what I experienced as a moment of profound disconnection into a moment in which we were genuine with each other, and I think we both felt seen and heard by the other. This does not mean that our interpersonal difficulties were completely resolved. My patient continued to be prone to avoidant storytelling, and speaking honestly about what was going on between us was not easy. For example, in the next session, she spoke more about her mother than usual and expressed some criticism of her mother, and I used the exploratory strategy of linking the rupture to larger interpersonal patterns in the patient's other relationships to try to explore how her criticism of her mother might be related to her concerns about me and my ability to help her. In that session, through a mixture of moving against (confrontation markers such as *patient rejects therapist intervention*) and moving away (withdrawal markers such as *denial, shifting topic, avoidant storytelling* and being *deferential and appeasing*), she adeptly outmaneuvered my attempts to facilitate an exploration of what she wanted and needed from me. The challenge for me was to keep moving with her: to stay close to the process and my experience of it, remembering what I had learned about my tendency to be overprotective of her and the potential value of being more direct, without becoming rigidly fixed in that

Copyright American Psychological Association. Not for further distribution.

position. Our rupture resolution process was not one moment in time but rather an ongoing negotiation between both our desires to protect our connection while respecting our needs to be heard and seen by each other.

CODA

Challenges Therapists Face in the Alliance

Therapists can have difficulty building and maintaining strong working alliances with patients when the therapist is under pressure. The stress of working with high-risk patients, issues in the therapist's personal life, struggles with countertransference and insecure attachment, or therapist bias can all hinder therapists' effectiveness. Particularly when working with challenging patients, therapists can be vulnerable to engaging in forms of negative process, such as hostile responses to patient hostility, or overly rigid adherence to therapy protocols.

Alliance Rupture

Based on a meta-analysis of 11 studies, the research indicates that ruptures are quite prevalent: Patients report them approximately one third of the time (early in treatment), therapists half the time, and observers in as much 100% of cases. They are also a demonstrated risk factor for premature termination or poor outcome. We presented an operational definition of rupture distinguishing between withdrawal and confrontation markers (specific patient communications or interpersonal behaviors), furthered by the observer-based 3RS and supported by other measures.

Rupture Repair

Based on the cited meta-analysis, the research indicates that rupture repair is also quite prevalent (up to approximately 80% of cases, per patient report) and significantly predictive of treatment success. Rupture repair or resolution has been defined in different ways; we highlighted both immediate and exploratory strategies. We noted the importance of therapists' abilities to recognize alliance ruptures and to respond nondefensively with curiosity and flexibility. No matter which specific strategy a therapist employs, by maintaining such a stance in the face of a rupture, a therapist can facilitate a new relational or corrective emotional experience for a patient.

Copyright American Psychological Association. Not for further distribution.