

Research on alliance ruptures: Clinical implications

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One of the most consistent findings in the field of psychotherapy research is that the quality of the therapeutic alliance predicts treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). There is also evidence that poor alliances are correlated with unilateral termination (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990; Tryon & Kane, 1993; Tryon & Kane, 1995). Research evidence also indicates that patterns of negative or hostile complementarity between therapists and patients are associated with poor outcome (Coady, 1991; Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993). There is also evidence that a pattern of deterioration in the alliance followed by an improvement over the course of treatment is associated with positive outcome (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006). Collectively, all of the above research suggests that the therapist's ability to constructively address patterns of negative therapist-patient complementarity and ruptures in the alliance may play an important role in improving therapeutic outcome. An alliance rupture can be defined as a breakdown in the collaborative process between therapist and patient, a poor quality of therapist-patient relatedness, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset (Safran & Muran, 2006). In fact, on the basis of available empirical evidence the Division 29 Task on Empirically Supported Relationships designated the repair of alliance ruptures as a "promising and probably effective" treatment principle (Norcross, 2002).

A number of studies examining the processes involved in repairing ruptured or strained alliances suggest that it can be valuable for therapists to keep in mind the following guidelines (Foreman & Marmar, 1985; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Hilliard, Henry, & Strupp, 2000; Lansford, 1986; Rhodes, Hill, Thompson, & Elliot, 1994; Safran, 1996; Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 2000; Safran, Muran, & Samstag, 1994; Safran, Muran, Samstag, & Stevens, 2002):

1. Therapists should be aware that patients often have negative feelings about the therapy or the therapeutic relationship which they are reluctant to broach for fear of the therapist's reactions. It is thus important for therapists to be attuned to subtle indications of ruptures in the alliance and to take the initiative in exploring what is transpiring in the therapeutic relationship when they suspect that a rupture has occurred.
2. It appears to be important for patients to have the experience of expressing negative feelings about the therapy to the therapist should they emerge or to assert their perspective on what is going on when it differs from the therapist's.
3. When this take place, it is important for therapists to attempt to respond in an open or nondefensive fashion, and to accept responsibility for their contribution to the interaction.
4. There is some evidence to suggest that the process of exploring patient fears and expectations that make it difficult for them to assert their negative feelings about the treatment may contribute to the process of resolving the alliance rupture.

Preliminary evidence is also beginning to emerge indicating that therapists' attitudes towards the self mediate the process of dealing with negative therapeutic process. Both Henry, Schacht, and Strupp (1986) and Hilliard, Henry, and Strupp (2000) found that therapists with

negative introjects (i.e., who have internalized hostile attitudes towards the self), are more likely to exhibit patterns of hostile interpersonal process in the relationship with their patients.

Nelson (2002) found that therapists who have interpersonal schemas predicting hostile response from their own fathers (but interestingly not their mothers), are more likely to act hostile towards their patients during ruptures in the alliance. Also, Fox and Safran (2004) found that therapists with interpersonal schemas predicting friendly responses from their own mothers (but not their fathers) were better able to establish alliances with their patients, whereas therapists expecting friendly responses from their fathers (but not their mothers) were better at resolving ruptured alliances (at least from the patient's perspective). Findings of this type provide preliminary evidence suggesting that training approaches that help to promote greater therapist self-acceptance may facilitate the process of working constructively with alliance ruptures. It is consistent with clinical theory that suggests that the capacity for self-acceptance plays a critical role in allowing therapists to use their countertransference experience as a source of important information rather than acting it out (Safran & Muran, 2000).

Finally, there is also preliminary evidence emerging regarding the effectiveness of brief relational therapy (BRT) as an approach that is particularly helpful for decreasing patient dropout and for working with patients with whom it is difficult to establish a therapeutic alliance (Muran, Safran, Samstag, & Winston, 2005). BRT (Safran, 2002) incorporates the therapist guidelines described above and emphasizes the use of therapeutic metacommunication (i.e. the process of working collaboratively with the patients to explore and disembed from negative patterns of complementarity that are emerging between them). It also, incorporates mindfulness practice in the training of therapists in order to help them increase their capacity to attend to their countertransference in a nonjudgmental fashion and use it as an important source of information.

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