DRUG & ALCOHOL FINDINGS *Review analysis*

This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

▶ Alliance rupture repair: a meta-analysis.

Eubanks C.F., Muran J.C., Safran J.D.

Psychotherapy: 2018, 55(4), p. 508–519.

Amalgamation of research findings commissioned by the American Psychological Association raises the intriguing possibility that experiencing the resolution of breakdowns or tensions ('ruptures') in the therapist–client relationship promotes client welfare even more than relationships with no ruptures. Evidence-based tips are given to help therapists resolve ruptures.

SUMMARY [Though not specific to clients with drug and alcohol problems, the principles derived from this review of psychotherapy studies are likely to be applicable, partly because severe substance use problems generally form part of a complex of broader psychosocial problems. This review updates an earlier version also in the Effectiveness Bank.]

The featured review is one of several in a special issue of the journal *Psychotherapy* devoted to features of the therapist-client relationship related to effectiveness, based on the work of a task force established by the American Psychological Association. This particular review analysed findings relating psychotherapy outcomes to tensions or breakdowns in the alliance between client and therapist – known as 'alliance ruptures' – and restorations of this relationship, often termed 'repairs'. Ruptures can contribute to poor outcomes if unresolved, but to good outcomes if successfully repaired.

Key points
From summary and commentary

Commissioned by a task force of the American Psychological Association, this review amalgamated findings relating psychotherapy outcomes to tensions in the working relationship between client and therapist ('alliance ruptures') and restorations of this relationship ('repairs').

Breakdowns of the therapist–client relationship followed by its restoration were associated fairly strongly with better client outcomes compared to unresolved ruptures or no ruptures. Training therapists to restore ruptures was associated with improved outcomes but not to a statistically significant degree, possible due to the paucity of research.

Links between rupture-repair episodes and outcomes may or may not be causal. Nevertheless, the safest stance is for therapists to assume they are, and to remain alert to ruptures including subtle withdrawals from the therapeutic process and to seek to resolve them.

In greater detail, the alliance is composed of: agreement between patient and therapist on the goals of treatment; collaboration on the tasks of treatment; and an emotional bond between patient and therapist. Deterioration on any of these dimensions constitute 'ruptures' to the alliance – not necessarily reaching the dimensions of a breakdown, but including more subtle tensions and disharmonies. Patients may react to ruptures by disengaging from the therapist and the therapy, or by expressing anger or dissatisfaction or trying to pressure or control the therapist. A rupture is generally deemed 'repaired' when patient and therapist re-form a strong emotional bond and resume collaborating on the work of therapy. Strategies for resolving alliance ruptures may address it explicitly or without acknowledging its existence, and may seek an immediate repair or explore the rupture and underlying needs or concerns. Ruptures and repairs can be assessed by directly asking patient and/or therapist relevant questions (see panel for example), by

tracking fluctuations in the alliance measured by questionnaires completed by patient and/or therapist, or by observing what happens in sessions. Measures based on what patients and therapists say do not closely agree with observers' ratings.

Studies included in the review's analyses had to have been of psychotherapy, to have related patient progress to ruptures or repairs or training/supervision on handling ruptures, and to have been published (or in the pre-publication stages) in a peer-reviewed journal. Studies also had to have explicitly measured ruptures or repairs or tracked the alliance at least three times, enabling ruptures and repairs to be inferred from fluctuations in the alliance.

Alliance ruptures and repairs and outcomes

The first set of analyses amalgamated findings from 11 studies (sampling 1,314 patients) of the relationships between naturally occurring alliance ruptures and repairs on the one hand, and on the other, outcomes operationalised as patient progress from before to after therapy or therapy completion. All the studies related repairs to outcomes, sometimes by comparing outcomes for patients who experienced rupture-repair episodes to those who did not, or to those whose ruptures remained unrepaired.

The strength of the link between ruptures and repairs and outcomes was calculated as a correlation coefficient, an expression of the degree to which outcomes co-varied with the frequency of rupture-repairs. The chosen metric ranges from -1 (perfect negative co-variation meaning that as one side of the link gets larger the other diminishes) to +1 (perfect positive co-variation meaning that as one side of the link gets larger so does the other). Strength was also expressed as effect sizes. Effectively these metrics indicate how influential ruptures and repairs had been if causally linked to outcomes.

Ruptures of the therapist–client relationship followed by its repair were associated fairly strongly with better client outcomes. Among clients who experienced ruptures, those whose ruptures were repaired or resolved on average experienced better outcomes, equating to a correlation of 0.29 and an effect size of 0.62 – a statistically significant, moderate-strength relationship, on the basis of which one could predict 8–9% of the variance in outcomes. Results were similar (correlation 0.24; effect size 0.50) when the comparison was between patients who experienced rupture-repair episodes and patients who experienced no ruptures of the alliance with their therapists.

However, the strengths of these links varied between studies more than would have been expected by chance. Among those tried, the only factor substantially related to variation in the strength of the link with outcomes was the phase of the study during which ruptures and repairs were assessed: the closer to the end of treatment, the stronger the link with outcomes, possibly because the assessments were nearer the time outcomes were also measured.

Unlike the previous version of the analyses, the link was not significantly different depending on the presence of diagnosed personality disorders among the sample in the study. Nor did it significantly differ for trainee versus experienced therapists, with the size

Measuring alliance rupture and repair

The Post-Session Questionnaire completed by patient and therapist after a session includes questions and statements indicative of ruptures and rupture repairs. Respondents respond by choosing options ranging from "Not at all" to "Very much". The relevant items are reproduced below:

"Did you experience any tension or problem, any misunderstanding, conflict, or disagreement, in your relationship with your [therapist or patient] during the session?"
"If yes, please rate how tense or upset you felt about this during the session."

"To what extent did you find yourself and your [therapist or patient] overly accommodating or overly protective of each other? Or to what extent did you feel you were making nice or smoothing things over? Or to what extent did you feel you were holding back or avoiding something?"
"If yes, please rate how tense or upset you felt about this during the session."

"To what extent was this problem addressed in this session?"

"To what degree do you feel this problem was resolved by the end of the session?"

of the therapist's caseload, or between studies where the therapy was versus was not based on cognitive-behavioural principles. Also not significantly accounting for the variation in the strength of the link was how ruptures and repairs were measured, or whether the study compared outcomes after rupture–repair episodes to those when no such episodes had occurred.

Rupture resolution training and patient outcome

Assuming the link between rupture-repairs and outcomes is a causal one opens up the possibility that training or supervising therapists to repair ruptures would improve outcomes. Another analysis addressed this possibility, drawing on the six studies of the impacts on patient outcomes of training or supervision with a specific focus on improving therapists' abilities to manage alliance ruptures. All six studies featured comparison therapists (or the same therapists before being trained or supervised) not offered rupture-repair training or supervision, benchmarking these inputs against a variety of alternatives, including no extra training or supervision.

Across the studies patients of therapists trained or supervised in rupture-repair progressed slightly better than patients of comparison therapists, equating to a correlation of 0.11 and an effect size of 0.22. However, these results were not statistically significant, meaning a chance finding could not be ruled out, and the strength and direction of the link between rupture-repairs and outcomes varied substantially between studies. The reviewers found several factors which might partly account for this variation. First was the proportion of personality disordered patients in the sample; the more there were, the less the training/supervision seemed to make a difference. Training/supervision significantly improved outcomes when the main therapy was cognitive-behavioural (equating to a correlation of 0.28), but not when it was based on psychodynamic principles. Additionally, the briefer the therapy, the stronger the apparent impact of training/supervision. However, the last two factors overlapped, since cognitive-behavioural therapies tended to be shorter, and it was unclear which (if any) led to training/supervision having a greater impact – the nature of the therapy, or its length.

Practice implications

The analyses conducted for this review demonstrate that alliance rupture-repair is associated with positive psychotherapy outcomes. Listed below are research-supported suggestions on how therapists can address and repair ruptures in the alliance:

• Be attuned to indications of rupture, including confrontation ruptures marked by expressions of dissatisfaction or hostility, and more subtle markers of withdrawal such as patients evading or appeasing the therapist to distance themselves from the therapist or from the therapy.

• Preferably acknowledge the rupture directly, and openly and non-defensively invite patients to explore their experience of the rupture. If the therapist-client bond is not strong enough for direct exploration or if this would divert from a priority therapeutic task, then address ruptures in an indirect, immediate manner, by changing the tasks or goals of therapy to satisfy the patient's concerns.

• Empathise with patients' expressions of negative feelings about the therapist or the therapy. Validate them for broaching a difficult and potentially divisive topic in the session.

• Accept responsibility for your own part in the rupture; do not blame patients for misunderstanding or failing to comply with your wishes.

• To engage a patient unwilling focus on the rupture, consider linking ruptures to how the patient characteristically relates to people outside of therapy. At the same time be alert to the possibility that you – and your patients – may do this in order to escape painful exploration of how the therapist is disappointing the patient.

• Anticipate that for some therapists, ruptures can evoke feelings of confusion, ambivalence, incompetence and guilt. Develop your abilities to recognise, tolerate, validate, and empathically explore your own negative feelings, so that you can do the same for your patients.

COMMENTARY The practice recommendations advanced by the reviewers are based on the possibility of a causal link – that experiencing a problem

in the therapeutic relationship which is successfully resolved contributes to how well patients deal with the problems which brought them to therapy. Though causality has not been proven (▸ below), the review's findings, the plausibility of the proposition that repairing ruptures is a positive influence on outcomes, and the fact that this process is unlikely to damage outcomes (none of the studies found a negative relationship), suggest that therapists and their trainers and supervisors should assume a causal relationship, and prepare to repair ruptures when they happen.

In broad brush the findings were consistent with rupture-repairs promoting outcomes, but the detail too was important. It comes as no surprise that an unresolved difficulty is associated with worse outcomes than one resolved, but there was also evidence that experiencing a successful repair is associated with better outcomes than rupture-free therapy – as if the experience of being able to work through a relationship difficulty is more instructive or therapeutic than unbroken 'plain sailing'. Also reassuring is that the link between rupture-repairs and outcomes remained for different types of patients, different therapists, and different therapies, suggesting that this aspect of the client–therapist relationship is a 'common factor' (1 2) underpinning any effective psychosocial therapy.

Not *necessarily* causal

Though this account is plausible, and it would be prudent to assume a causal link, such a link could not be established by the types of studies included in the analyses. These noted when rupture-repair episodes happened in the natural course of therapy and related these experiences to outcomes. No study randomly allocated patients to therapies during which ruptures were deliberately generated and deliberately repaired or not, and to do so would almost certainly be considered unethical. But without such studies, the possibility cannot be ruled out that (for example) patients who were going to do well in any event were more likely to be able to collaborate in repairing a rupture, or that ruptures were less serious and/or easier to repair among patients who were already doing relatively well, or that therapists more capable of repairing ruptures are also more competent in other ways. In these scenarios, rupture-repairs would remain associated with better outcomes, but not because they helped *cause* them.

The review itself provided clues to the types of patients who might in any event do better or worse in therapy, and also experience fewer or more repaired ruptures, possibly creating the illusion that repairs affect outcomes. These characteristics include the patient's attachment style, having a personality disorder diagnosis, tendency to conflict in relationships, and ambivalence about change. From their own work, the reviewers suggested that patients "who are highly motivated for treatment and/or feel that they have a strong bond with the therapist are best suited to contribute to repairs". It seems very possible that these patients will also do better in therapy, but not because repairing ruptures contributes to their improvement. Supporting this interpretation is the non-significant impact of training/supervision in repairing ruptures – the closest the research comes to randomised trials in which repaired versus unrepaired ruptures are deliberately generated. However, this non-significant finding could simply be due to the paucity of research or the limitations of the training or supervision tested in the studies; it does not rule out a causal connection, but does lend weight to a non-proven verdict on repairing ruptures actually causing better outcomes.

The finding that the closer the rupture-repairs to the end of treatment, the stronger the link with outcomes, may signify a causal effect which wanes with time. But it would be just as plausible to suggest that the experience of being able to overcome a relationship difficulty early in treatment would help impel therapy on a positive trajectory, having a *greater* impact than later events. Also, the link between late rupture-repairs and outcomes may be stronger simply because successful restoration of the relationship is most likely when outcomes are also trending well for the client, and both were

being measured at about the same time.

As they are added to the Effectiveness Bank, listed below will be analyses of the remaining reviews commissioned by the American Psychological Association task force.

Cohesion in group therapy
Treatment outcome expectations
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Last revised 04 December 2018. First uploaded 28 November 2018

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