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▶ Evidence-based psychotherapy relationships: Repairing alliance ruptures.

Safran J.D., Muran J.C., Eubanks-Carter C. Request reprint

Psychotherapy: 2011, 48(1), p. 80–87.

This meta-analytic review commissioned by the American Psychological Association finds that repairing breakdowns in the alliance between therapist and client improves outcomes, and that 'rupture repair' training makes a difference, especially in the cognitive-behavioural approaches commonly used in addiction treatment.

Summary *Editor's note: Though not specific to patients with drug and alcohol problems, many of the studies in the analyses described below will have included such patients, and the principles are likely to be applicable to these disorders among others, not least because substance use problems generally form part of a complex of broader psychosocial problems.*

This review is one of several in a special issue of the journal *Psychotherapy* devoted to evidence-based, effective therapist-client relationships. It reports on two research synthesis related to tensions or breakdowns in the relationship between client and therapist – know as 'alliance ruptures' – and restorations of this relationship, often termed 'repairs'. All the included studies had to have been published in English in a peer-reviewed journal and measured how well patients were at the beginning and end of treatment.

The first analysis concerned the relationship between outcomes and the natural occurrence of alliance ruptures and repairs during therapy. In practice, the three studies found by the analysts identified rupture-repair episodes through substantial downs then ups in therapeutic alliance measures taken in adjacent sessions. ('Alliance' has been variously defined as a bond between the client and therapist which holds the client in therapy or as a collaborative working relationship. The concept has been reviewed in other papers in this special issue in relation to individual adult therapy, child and adolescent therapy, couple and family therapy, and group therapy.)

The second analysis was of the eight studies which provided usable data on the impact of efforts to help therapists avoid and repair ruptures. These took the form of therapist training or supervision with a specific focus on improving therapists' abilities to manage alliance ruptures or problems in the therapeutic relationship with adult patients in individual, in-person psychotherapy. Seven of these eight rupture resolution studies featured some kind of control group of patients whose therapists had not been trained or supervised in rupture resolution, or in one study patients waiting for treatment.

Both analyses used meta-analytic techniques to synthesise results from the relevant studies. The aim was to provide estimates of the overall strength of the link between patient progress and alliance rupture-resolution episodes or related training/supervision, and to be able to probe for influences on the strength of those links. Strength was expressed as effect sizes using the 'r' metric, which can be squared to calculate how much of the difference in outcomes can be attributed to differences in the therapy dimension being investigated. The assumption was made that there is no single, true strength of the link between outcomes and these factors which appears to vary only because of methodological differences, but that instead the strength really might vary across the studies included in the analyses.

Main findings

Across the three relevant studies, the greater the number of rupture-resolution episodes identified by alliance fluctuations, the greater the average progress made by clients. This link equates to an effect size of 0.24, a statistically significant, moderate-strength relationship, which accounts for about 6% of the variance in outcomes. Given the subjects of these studies, the results indicate that depressed clients or those with personality disorders have gained greater symptom relief and improvement in wellbeing when difficulties with their therapists have occurred, but largely been overcome by the next session of therapy, rather than continuing to sour the relationship, impede progress or cause patients to drop out.

These findings open up the possibility that training or supervising therapists to repair ruptures could improve outcomes. Across all eight studies which tested this possibility, there was indeed substantial patient improvement associated with rupture repair training or supervision. However, some studies had no control group of patients against which to benchmark whether the training or supervision led to *extra* gains over and above that from usual therapy. Seven studies did have control groups, but in one (which recorded unusually strong benefits from rupture resolution training) this consisted of untreated patients on a waiting list. Across the remaining seven studies, there remained a small but statistically significant extra patient improvement gained by training or supervision which equated to an effect size of 0.11, a difference which accounted only for about 1% of the variance in outcomes. The greatest extra gains were noted with relatively brief cognitive-behavioural treatments of anxious or depressed patients, equating to an effect size of 0.22. In contrast, patients in longer, dynamic and relational treatments for personality disorder experienced negligible extra benefit from their therapists being trained/ supervised in rupture repair.

Given the subjects of these studies, these results mean that seriously depressed or anxious adult patients in individual, face-to-face (usually cognitive-behavioural) psychotherapy, have tended to gain greater symptom relief and improvement in

wellbeing when their therapists have been specifically trained in how to manage client-therapist relationship difficulties. The practical implication of this finding is obscured somewhat by the fact that the training or supervision the therapists received was not always limited to repairing ruptures, but included this along with other instruction intended to improve performance. What it was in the training or supervision which led to small extra gains for patients is unclear, and so too is how it did so – whether, for example, it really was by promoting rupture repair.

Practice recommendations

Be aware that patients often have yet withhold negative feelings about the psychotherapy or the therapeutic relationship. It is important for therapists to be attuned to subtle indications of these feelings and to take the initiative in exploring what is happening in the relationship.

It probably helps if patients express any negative feelings about the therapy to the therapist or assert any differing views about what is going on.

When this happens, it is important for therapists to respond in an open and non-defensive fashion, and to accept responsibility for their side of the interaction as opposed to blaming the patient.

It also proves important for therapists to empathise with their patients' experiences and to validate them for broaching a potentially divisive topic.

In some forms of treatment, the primary intervention may consist of the therapist changing the tasks or goals of treatment without necessarily explicitly addressing the rupture with the patient. In others, resolving alliance ruptures may involve in-depth explorations of the patient's experience and what is happening between them and the therapist.

For some therapeutic approaches, there is also suggestive evidence that it can help if the therapist explicitly links a rupture event to the patient's characteristic ways of relating. This evidence should be interpreted cautiously, given growing evidence that frequent interpretations of this kind can be counterproductive. The quality (as opposed to quantity) of the interpretation and its relational meaning in the context of the therapeutic relationship appear to make the difference between a positive and negative impact.

FINDINGS This article was in a special issue of the journal *Psychotherapy* devoted to effective therapist-client relationships. For other Findings entries from this issue see:

- Evidence-based psychotherapy relationships: Psychotherapy relationships that work II
- Evidence-based psychotherapy relationships: Alliance in individual psychotherapy
- Evidence-based psychotherapy relationships: The alliance in child and adolescent psychotherapy
- Evidence-based psychotherapy relationships: Alliance in couple and family therapy
- Evidence-based psychotherapy relationships: Cohesion in group therapy
- Evidence-based psychotherapy relationships: Empathy
- Evidence-based psychotherapy relationships: Goal consensus and collaboration
- Evidence-based psychotherapy relationships: Positive regard
- Evidence-based psychotherapy relationships: Congruence/genuineness

- Evidence-based psychotherapy relationships: Collecting client feedback
- Evidence-based psychotherapy relationships: Managing countertransference
- Evidence-based psychotherapy relationships: Research conclusions and clinical practices

The special issue which contained the article featured above was the second from the task force. The first was a special issue of the *Journal of Clinical Psychology*. While the second aimed to identify elements of effective therapist-client relationships ('What works in general'), the first aimed to identify effective ways of adapting or tailoring psychotherapy to the individual patient ('What works in particular'). For Findings entries from this first special issue see this bulletin. Both bodies of work have also been summarised in this freely available document from the US government's registry of evidence-based mental health and substance abuse interventions.

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