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Understanding and resolving ruptures in the therapeutic alliance: an introduction.

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Dr. Robert Watson, Clinical Psychologist, Accredited Cognitive Analytic Supervisor & Therapist,
Vice-Chair of the Association for Cognitive Analytic Therapy.

Robert_casab@hotmail.com
www.become-psychology-london-co.uk

Structure:

- What does the literature say about the challenges of training therapists in rupture resolution?
- What useful conclusions can be drawn from these findings?
- What are the implications for theory and practice?
- What are helpful and unhelpful therapist responses to alliance threats?

What is the therapeutic alliance?

- Edward Bordin (1979) developed a transtheoretical concept of the alliance consisting of three interdependent components:

- Tasks.
- Goals.
- Bond.

- Strength of the alliance determined by degree of agreement between patient and therapist about tasks and goals of therapy, and the quality of the relational bond.

- Suggests that explicit discussion and negotiation of goals and tasks of therapy have important roles in developing the alliance.

Key research findings.

- Alliance quality is consistently the strongest predictor of outcomes.
- Poor outcome cases show greater evidence of negative interpersonal process than good outcome cases.
- Negative process and alliance strains/ruptures are an inevitability.
- One of the most important therapist skills is dealing with and repairing ruptures to the alliance.

What do we mean by therapeutic rupture?

- Safran and Muran define rupture as
- *"...a breakdown in the collaborative process between therapist and patient, a poor quality of therapist-patient relatedness, deterioration in the communicative situation..."*
- Ruptures can vary in intensity, from minor tensions to major breakdowns in the relationship leading to premature termination of therapy.
- Anything from being late to the session to walking out of the session. One off events or repeated enactments over several sessions.
- Consensus that helpful part of process if managed well.

The challenges (1)

- Orlinsky et al. (1994) found that therapist assessment of the quality of the therapeutic alliance bore little relationship to the outcome of therapy.

- Therapists tended to rate the strength of the alliance as much higher than that of their clients.

The challenges (2)

- "In our study we failed to encounter a single instance in which a difficult patient's hostility and negativism were successfully confronted or resolved. Therapist's negative responses to patients are far more common and far more intractable than has been recognised."

- Vakoch & Strupp (2000). Vanderbilt II Study.

Vanderbilt II Study

1. Experienced therapists after enactment focused training of one year performed worse in session, even though performed better in supervision activities.

2. Ruptures/tensions always evident from the beginning and they were missed/not addressed in unsuccessful cases.

3. Those who adhered best to the manual, performed worst in terms of frequency of successful resolution of tensions.

Vanderbilt II Study

4. A significant relationship between therapist self-criticism and self-blame was observed.

5. The more self-critical and self-blaming the therapist, the more hostile and unsuccessful they were in resolving tensions.

6. They showed more complex communications – e.g. statements that were empathic and blaming simultaneously.

Challenges (3): rupture repair process.

- Bennett, D. & Parry, G. & Ryle, A (2006) assessed rupture repair and outcomes with Cognitive Analytic Therapists.
- They reported that in a fair number of cases:
- Therapists did not notice the rupture, even when the client commented directly on the relationship, or did not notice that their interventions triggered the client.
- Avoided addressing client's negative attitudes towards either therapist or therapy – described as "passive acceptance" by the authors. This was strongly associated with poor outcomes.

Challenges (3): process of rupture repair

- Closed exploration too early before the client had made an affective shift, perhaps in the face of angry feelings.

- There was lack of consensus, tentativeness, collaboration, and like in the Vanderbilt study, therapists became more rigid technically and were unable to shift gear in the face of a deteriorating alliance.

- Therapists assumed the rupture reflected a repeat of client's unhelpful relational schemas rather than first exploring the here and now of the therapeutic relationship i.e. subtly blaming.

Challenges (4): Clin.Psych Training

- *An exploration of clinical psychologists' experiences of therapeutic relationship ruptures in the UK National Health Service: A grounded theory study.* (Reetta Newell, Robert Watson & Martin Baker, 2012).

- Only one participant remembered having explicit teaching on this topic during their clinical psychology doctorate training.

- *I think there was training but it's sort of the stuff you don't really focus on [...] So it's kind of there, but you aren't necessarily attuned to it because you are a bit heroic, "I'll never get as sort of feeble as that, or burnt out as that. Maybe they are not just CBT enough, or maybe they are just too CBT, and not systemic enough".* (John)

What conclusions can be drawn (1):

- We are human. Tensions between wanting to be a good helper and protecting the self (vulnerable) seem inevitable.
- Having to stay present and empathic when faced with responses that feel attacking can be challenging for therapists across all levels of experience.
- Understandably therapists want to do a good job, and this could lead to biases in their perceptions of the therapeutic alliance. Risk of missing tensions.
- Avoidance of ruptures observed. May reflect a training need, level of conceptualisation, or uncertainties of bringing self into the work.

What conclusions can be drawn (2):

- That our own patterns of relating with others and ourselves are important mediators of how training is internalised and how we respond.
- E.g. self-criticism could lead therapist to be overly focused on following the manual "correctly" and less attuned to the client emotionally.
- Seems that under pressure therapists can become less flexible and attempting to follow manualised approaches seems to make the task even more difficult.

What conclusions can be drawn (3):

- The therapist relationship with their own vulnerability is important.
- "Counter hostility" is a natural automatic response to hostility. On another level it may reflect the therapist's schemas or vulnerable side:
- E.g. Simpson et al (2019) found unrelenting standards and self-sacrifice schemas most predictive of burn out in a sample of 443 Psychologists.
- A client saying the therapy is "rubbish" could trigger a vulnerable feeling in the therapist : "feeling a failure". This could feel difficult for the therapist and could lead to criticising or blaming the client as a way of dealing with this vulnerable feeling.

Areas for development

1. Theory-practice: encourage a transtheoretical relational approach to the therapeutic alliance and broaden our conceptualisations.

2. Training: include an experiential component - conceptual and technical knowledge without the experiential seems to have been an issue.

3. Encouraging and facilitating therapists to know their own buttons, and to be appropriately vulnerable in their work.

4. Skills: incorporating meta communication as part of training.

A relational approach to the therapeutic alliance

- Interventions take place in a relational context and the quality of the bond will influence the extent to which agreement can be reached on goals and tasks, which in turn affects the quality of the bond.
- A client with agoraphobia needs to have sense of their therapist as knowledgeable and competent – before they attempt systematic desensitisation.
- A client disclosing details of sexual abuse needs to have a sense that they will be understood by their therapist.
- A relational approach to the alliance emphasises the interdependence of relational & technical factors in psychotherapy.

A relational approach to the therapeutic alliance

- The same relational style could be experienced differently depending on client's characteristic ways of relating to themselves and others.
- A therapist who provides minimal structure might be experienced as self-affirming by a client whose parents were stifling or withholding and abandoning by another whose parents rarely offered emotional support and guidance.
- Empathic reflection could be experienced as comforting or exposing of one's vulnerability as weak or contemptible. Interpretations as either insightful or patronising.
- Adapting where possible the relational stance depending on the needs of the client.

Interventions as relational acts.

- Similarly, different interventions place different demands on client's, and they may carry an implicit meaning at a relational level.
- Aim is for understanding/observing therapist in relation to an understood/empowered client.
- But how clients experience an intervention can depend on core relational themes even if it is well thought through.
- For example, a perfectionistic client may avoid a thought diary to avoid missing an internally imposed standard, or risking the therapist judging them negatively in some way. Or strive to do it perfectly leading to resentment with the task and then the therapist.

Interventions as relational acts.

- Not exploring this together might mean missing an opportunity to understand this pattern within a compassionate relationship.

- It is always worthwhile enquiring about the experience of the previous session. Any hint of tension or difficulty might relate to a rupture marker requiring exploration.

- For instance, a client who feels embarrassed or ashamed in a session might come late to the next one as a way of managing this. If not addressed the client could prematurely end the therapy.

Conceptualising ruptures:

- Why do therapists not notice tension or difficulties in the therapy alliance?
- This might be because therapists more readily associate ruptures with confrontations or the expression of critical or angry feelings towards the therapist.
- Withdrawing rupture may be enacted in a multitude of ways which can be easier to overlook.
- Kyle et al. (2018) found therapists were less aware of withdrawal ruptures than confrontation ruptures and so intervened less often in these cases.

Conceptualising ruptures:

- Harper (1989) developed a framework for identifying markers of confrontation and withdrawal ruptures.

- Withdrawal = disengagement or withdrawal from therapeutic process.

E.g. short clipped answers, shifting the topic, being late.

- May present as a kind of pseudo alliance.

- Confrontation = complaints about therapist or therapy, or parameters e.g. time or location.

Conceptualising ruptures:

- Muran & Barber (2010) suggest therapists be alert to subtle markers of withdrawal as they argued that they were more likely to be missed or accepted at face value.
- Arriving late for a session or forgetting homework are two examples where therapists might interpret these markers as simply being human or be tempted to accept explanations at face value.
- Withdrawal ruptures may be as important in terms of impact upon therapy outcome.
- Helpful to consider as a withdrawal strategy from vulnerability.

An experiential approach to learning? A few ideas.

- Daily easy to do tasks that can facilitate noticing and using your emotional responses e.g. end of session emotions list.
- Routine rather than occasional use of audio and/or video recordings of sessions for supervision and self-reflection.
- Encourage personal growth and self-exploration: "I'm going to present a paper on narcissists" as if another species, versus "In what ways can you recognize a need to be admired. How does it play out in your work?"
- Routine use of role plays focused on reflection in action and awareness of thoughts and feelings in the moment. Ask trainees to focus and report feelings while watching a video, as opposed to speculate on the client's motivation.

How can we use vulnerability in our work?

- We need a thick skin and a thin skin (De Hann 2008). Use our emotional responses as important sources of information to be curious about.

- Invite dialogue about reactive responses to transform them into reflective responses. E.g. learning what triggered fear and helplessness in a session can aid self-exploration and help stay present enough next time to be curious.

- Supervisors modelling vulnerability and uncertainty. All knowing is not helpful. Opportunities for observation of supervisor's work.

- Normalise and convey the culture from the start e.g. at interview "What kind of clients press your buttons and why do you think that is"?

What are the tasks in rupture resolution?

- Preserve and strengthen the therapeutic relationship where possible.
- Possibly provide an experience where the client can understand better how they relate with others.
- Disconfirm unhelpful or limiting beliefs about others e.g. If I express my anger, people will reject me.
- Avoid where possible counter-productive responses and/or collusion with unhelpful or limiting relational patterns.

Strategies: guiding principle.

- Therapists can be guided by asking what a particular intervention might mean to the client at that moment – often influenced by core relational themes.

- Meaning addressing strains about tasks can be as important as addressing strains at the relational level, and both may need addressing.

E.g. client unclear about value of a reflective autobiography, and also feels controlled and put upon by the request – core relational theme. May need clarification of task rationale & exploration of experience of others as controlling/demanding.

Hierarchy of strategies for addressing ruptures.

- Interventions at the surface level affect the bond, just as relational focus can affect agreement on goals and tasks.

- In this sense, some ruptures may be addressed relatively simply by:

1. Clarifying therapy rationale & tasks.
2. Changing tasks & goals
3. Acknowledging and apologising for mistakes
4. Respecting client's wishes not to do a task.
5. Dealing with concerns or uncertainties directly.

Strategies for addressing alliance ruptures. (Murran & Barber).

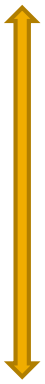
Surface level: disagreements on Tasks/Goals

Direct

- Outlining rationale & demonstrating therapy tasks
- Negotiating tasks and goals

Indirect

- Reframing the meaning of tasks & goals
- Changing tasks & goals



Bidirectional influence

Relational level: problems associated with the relational bond

Direct

- Exploring core relational themes

Indirect

- Allying with the resistance

Consensus: helpful therapist responses.

- Establish space for the rupture and/or its markers. Try to slow things down. Remain curious. Let it sail until the wind stops.
- Successful resolution only occurs when client can be involved in acknowledging something was adrift.
- Therapist showing vulnerability. Helps to let go of a power struggle, and models that vulnerability is helpful.
- Avoiding pulls to justify, criticise or gain a one up position.
- Allying with "resistance" – as reflections of how client sees self and others.
- Attempting to make the tension a focus of collaborative dialogue.

Allying with resistance.

- Sometimes it may be more useful to validate rather than address directly a relational style you might hypothesise to be associated with a rupture/block.

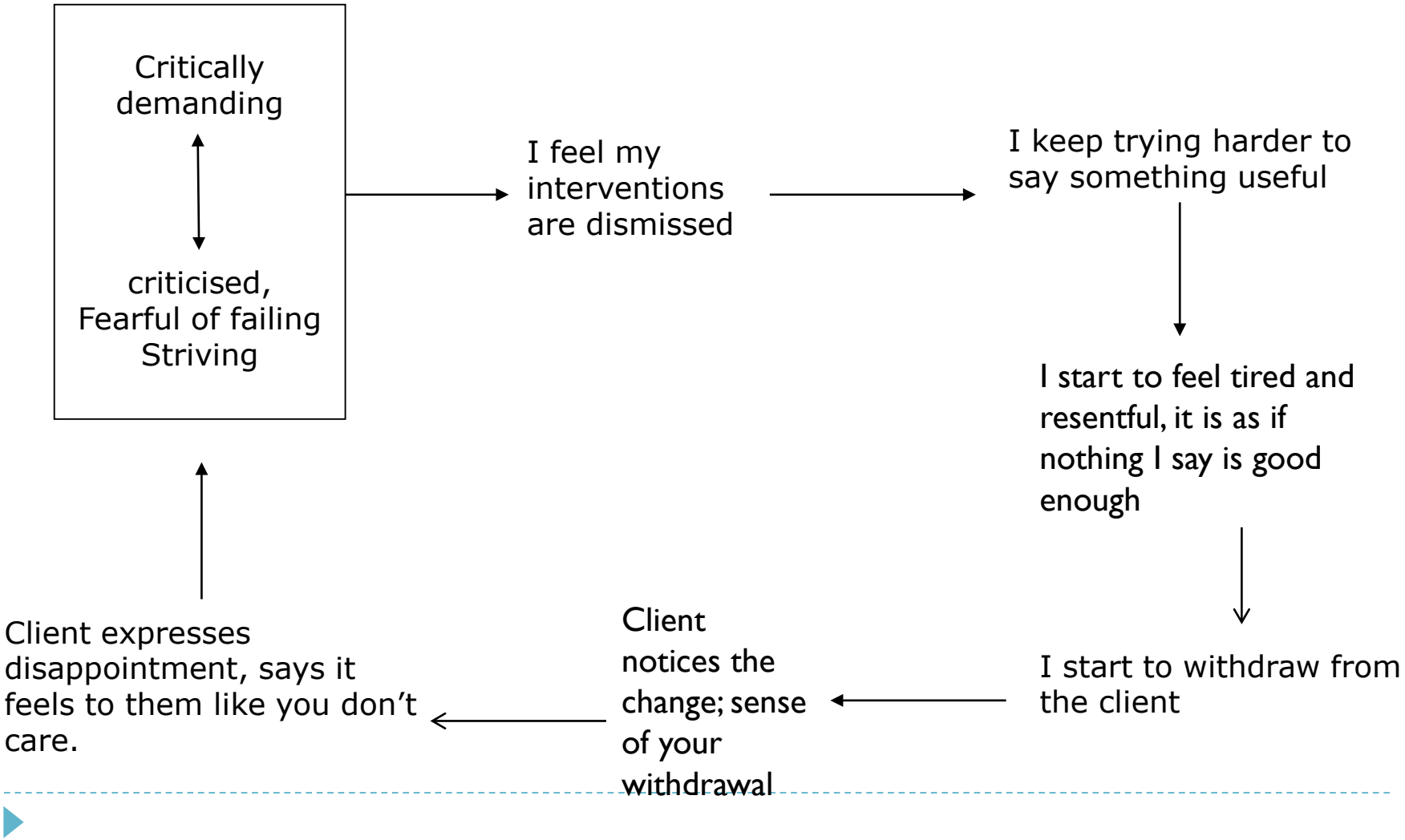
- E.g. behind a client's "angry" insistence not to explore something, maybe a strong mistrust component or feeling of shame. In this case, it may be more transformative to stand alongside the shamed or mistrusting part.

"I completely understand given what you have told me about your life why you don't yet feel like you can trust me enough to open up about some things in your life. I think trust needs to be earned and built up over time, and I haven't earned your trust yet".

Skills: Therapeutic Metacommunication.

- It is an attempt to notice and understand the relational pattern taking place between you and your client in a given moment.
- It is an attempt to step outside of this enactment and focus on the pattern through collaborative dialogue.
- It is an attempt to communicate on the meanings and positions held by both therapist and client during the enactment.
- So that awareness can be brought into the room.

Striving trap



Critically demanding

Criticised, anxious of failure,

striving therapist role.

"I'm aware of feeling as if I'm trying hard to solve all your problems right now but worried that what I am saying isn't feeling useful which I imagine is frustrating. I'm not sure how this might relate to us, but if its okay with you, could we explore this more?"

Critical – therapist role

Criticised – client role.

"It might be nothing, but I notice I'm choosing my words carefully as if something I say could sound critical. Has anything I've said sounded a bit off?"

Exercise.

- Think of a recent clinical encounter which felt difficult or challenging because you felt admired, criticised, controlled or intimidated (doesn't matter which), but you did not comment directly about it.

- With your partner, discuss what you think might have stopped you from attempting a dialogue?

Conclusions.

- Self-compassion & personal growth.
- Modelling: ask yourself – "In what ways do I model and encourage vulnerability as a supervisor, therapist?"
- Incorporating a relational approach to supervision and training, that respects the experiential as well as the conceptual.
- Asking for the supervision and training resources you need to do your job well.
- Appreciation that this is a life-long area of professional development.

Further reading.

- Brown, Brene. (2013). "Daring Greatly: how the courage to be vulnerable transforms the way we live, love, parent and lead". Penguin Books.

- Bennett, D. & Parry, G. & Ryle, A (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder.: a task analysis. *Psychology & Psychotherapy: Theory, Research and Practice, 79, 395-418.*

- Kathryn V. Kline, Clara E. Hill, Taylor Morris, Seini O'Connor, Ryan Sappington, Collin Vernay, Gabriela Arrazola, Michelle Dagne & Hide Okuno (2018). Ruptures in psychotherapy: Experiences of therapist trainees. *Psychotherapy Research*, Vol. 10.

- Murran, C. & Barber, J. (eds.) (2010). *The therapeutic alliance: an evidence-based guide to practice. Guilford Press.*

- Vakoch, D. & Strupp. H. (2000). The evolution of psychotherapy training: reflections on manual based learning and future alternatives. *Journal of Clinical Psychology*, Vol 56(3), 309-318.