CHAPTER 16

■   ■   ■   ■   ■

Developing Therapist Abilities to Negotiate Alliance Ruptures

J. Christopher Muran
Jeremy D. Safran
Catherine Eubanks-Carter

We developed our training protocol in the Beth Israel Psychotherapy Research Program (see Muran, 2002) primarily in response to a number of general findings in the research literature. First, outcome research has in sum demonstrated there is a good deal of room for improvement. Meta-analyses have suggested that 30–40% of patients fail to benefit (Lambert, 2004), and dropout rates average approximately 50% (Wierzbicki & Pekarik, 1993). Outcome research also has shown that patients with comorbid diagnoses (especially those with personality disorders or pathology) are especially challenging and resistant to treatment, resulting in more negative process, higher attrition rates, and greater treatment length (Benjamin & Karpiak, 2002; Clarkin & Levy, 2004; Westen & Morrison, 2001). This is particularly significant, given that comorbidity estimates of patients seeking treatment in our clinics and practices range from 40 to 70% (Kessler et al., 1994), with as many as 45% diagnosed with personality disorders (Zimmerman, Chelminski, & Young, 2008).

When it comes to considering how or where to improve the impact of our treatments, we have chosen to focus on therapist abilities to negotiate

the therapeutic alliance because of the consistent finding in the research literature that the quality of the alliance (and the interpersonal process between patient and therapist) is a robust predictor of outcome—in fact, stronger than most technical interventions (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Wampold, 2001). What has also influenced us in choosing this focus is the finding that therapists' individual differences strongly predict alliance quality and treatment success (see, for example, Baldwin, Wampold, & Imel, 2007; Luborsky et al., 1986; Nagavits & Strupp, 1994; Wampold, 2001). In this regard, the research suggests that some therapists are consistently more helpful than others and that these same therapists are better able to facilitate the development of the therapeutic alliance.

DEFINING RUPTURES IN THE THERAPEUTIC ALLIANCE

Our understanding of the therapeutic alliance has been organized around Bordin's conceptualization (1979), which has formed the basis for much of the research demonstrating the predictive validity of the concept. Bordin redefined the alliance as mutual agreement on the tasks and goals of treatment and the affective bond between patient and therapist. His definition suggested an inextricable relationship between the technical and the relational—that every intervention has relational meaning. It also suggested a more mutual and dynamic process of ongoing negotiation, which stands in contrast to previous conceptualizations that emphasized the therapist's support or the patient's identification with the therapist and acceptance of the therapist's values for the psychotherapy process (Muran & Safran, 1998).

We have developed this notion of negotiation to suggest that the alliance concept can include a view of the psychotherapy process as involving an ongoing push and pull of various patient and therapist affective states, underlying needs, and interpersonal behaviors (Safran & Muran, 2000, 2006). This conception is in part informed by the mother–infant research on affect regulation (Tronick, 1989) and the research on interpersonal complementarity (Kiesler, 1996). Our conceptualization suggests an *intersubjective negotiation* (Benjamin, 1990; Pizer, 1998) in which patient and therapist are seen as engaged in a struggle for *mutual recognition* regarding their respective subjectivities—a struggle that involves ongoing power plays and inevitable hostilities, accommodations, and refusals to accommodate. We have conceptualized this struggle as basic to every rupture in the therapeutic alliance.

Alliance ruptures have received increasing attention over the past 25 years in the research literature, with growing evidence that they are common

events (e.g., they are reported by patients in as much as 50% of sessions, they are observed by third-party raters in 70% of sessions), they predict premature termination and negative outcome, but when resolved they predict good outcomes (see Safran, Muran, Samstag, & Stevens, 2002; Eubanks-Carter, Muran, & Safran, Chapter 5, this volume). We have defined ruptures as (1) breakdowns in the negotiation of treatment tasks and goals and deterioration in the affective bond between patient and therapist; (2) markers of tension between the respective needs or desires of the patient and therapist as they continuously press against each other; and (3) indications of an enactment—a *relational matrix* of patient and therapist beliefs and action patterns, a vicious cycle involving the unwitting participation of both patient and therapist (Mitchell, 1988; Wachtel, 2007). This definition suggests that ruptures represent critical events and opportunities for awareness and change.

We have also defined ruptures in terms of two specific types of patient behaviors, communications or markers—withdrawal and confrontation. A *withdrawal* marker is a patient behavior indicating disengagement from an emotional state, from the therapist, or from some aspect of the treatment. It includes patient *movements away* from the therapist (away from the other); examples include silences, minimal responses, topic shifts, abstract talk, and storytelling; these are movements toward *autonomy and isolation*. Withdrawal also includes patient *movements toward* the therapist (away from self); examples include begrudgingly or too readily complying with a therapist, doing something with great anxiety or cynicism; these are movements marked by *compliance or appeasement*. A *confrontation* marker is most commonly a direct expression of anger or dissatisfaction by the patient about the therapist or some aspect of the treatment. It essentially involves patient *movements against* the therapist; these are movements marked by *aggression and control*; examples can also include coercions like being overly friendly or seductive.

Another way of understanding the distinction between withdrawal and confrontation draws on a theory of motivation that has received a great deal of transtheoretical attention in the psychotherapy literature since the 1980s (Blatt, 2008). Under this theory, withdrawal and confrontation markers can be understood as reflecting different ways of coping with the dialectical tension between two fundamental human motivations: *the need for agency versus the need for relatedness*. Ruptures mark a breakdown in the negotiation of these needs with another. Thus, a withdrawal rupture could be understood as the pursuit of *relatedness* at the expense of the need for *self-agency*, and a confrontation rupture the expression of *self-agency* at the expense of *relatedness*. Ruptures can be understood, then, as an opportunity to learn how to negotiate these needs with another.

A STAGE-PROCESS MODEL OF RUPTURE RESOLUTION

Our research program began as a study of rupture events and resolution processes with the specific aim of sensitizing clinicians to patterns that are likely to occur and to facilitate their abilities to intervene (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994; see also Eubanks-Carter, Muran, & Safran, Chapter 5, this volume). We have proposed a typology of rupture resolution strategies, both direct and indirect, that approaches ruptures at a surface and a depth level (see Safran & Muran, 2000, and Figure 16.1). For example, a direct surface approach can involve simple clarification of the treatment rationale or the misunderstanding between the therapist and patient, whereas an indirect surface approach can involve simply changing a treatment task or goal when there is disagreement. Similarly, a direct depth approach would involve exploring a core relational theme, while an indirect depth approach would involve providing a new relational experience, which can also be a consequence of any of the resolution strategy types.

Our research has concentrated on the study of a direct depth strategy that explores a core relational theme, and in this regard we developed two stage-process models for the resolution of withdrawal and confrontation ruptures. Each of the models begins with the therapist attending to the rupture marker. The critical task is for the therapist to recognize the rupture and invite an exploration of it. To progress, the therapist must facilitate a disembedding from the relational matrix or unhooking from the vicious cycle. The key principle in this regard is to establish communications about the communication process, or metacommunication (Kiesler, 1988, 1996). The typical progression in the withdrawal resolution process is from increasingly
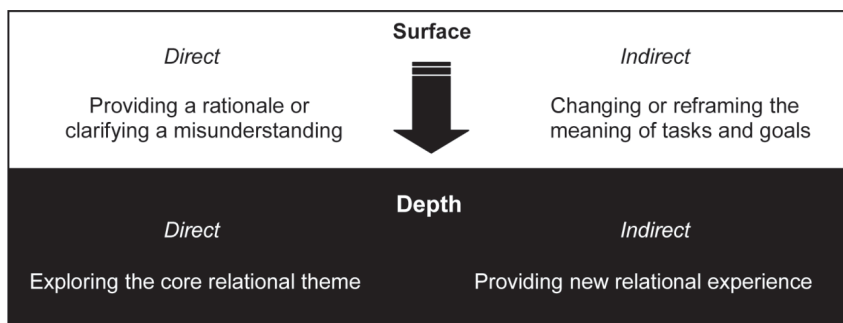

FIGURE 16.1. A typology of rupture resolution strategies. Adapted from Safran and Muran (2004). Adapted by permission. Copyright 2004 by The Guilford Press.

clearer expressions of negative sentiments to self-assertion. The typical progression in the confrontation resolution process is from expressions of anger to hurt and disappointment to vulnerability and contacting the need for nurturance. The essential task for the therapist to facilitate this movement is to empathize, to remain nondefensive, and to take responsibility where appropriate. Throughout such progressions, there are often shifts away, movements that reflect the patient's anxiety about expressions of assertion or vulnerability, which the therapist should explore.

From a series of studies (Safran & Muran, 1996), we provided confirmatory evidence for a generic model of rupture resolution, which represents the general process in the more specific resolution models described above (see Figure 16.2 for an illustration). It depicts the different pathways of intervention that therapists should pursue in response to various patient states or positions, including attending to the rupture marker, exploring the rupture experience, clarifying any mixed expressions (e.g., qualified assertions or angry expressions of hurt), exploring any avoidant movement away from communicating about the rupture, and finally recognizing the patient's expression of an underlying wish or need—whether it be the need to assert or the wish for nurturance. It is important to note that our research suggests that resolution or productive process does not require progression through all these pathways and reaching all these patient states, especially within any given session (see Safran & Muran, 1996, 2000). Instead, any exploration of a rupture or avoidance in and of itself can be experienced by patients as very meaningful.

DEVELOPING AN ALLIANCE-FOCUSED TREATMENT

Based on this research, we developed an alliance-focused treatment and training model with support from a grant awarded by the National Institute of Mental Health in the early 1990s (Muran & Safran, 2002; Safran, 2002; Safran & Muran, 2000). The alliance-focused treatment has been alternatively called *brief relational therapy* (BRT). In this grant study, we compared the treatment efficacy of BRT to two traditional time-limited treatments (a short-term dynamic psychotherapy and a cognitive-behavioral therapy approach) and found it to be at least equally effective in the treatment of patients presenting with a personality disorder, with a lower attrition rate (Muran, Safran, Samstag, & Winston, 2005). We also found preliminary evidence to suggest that BRT may be more effective with patients determined to be at risk for treatment failure based on having difficulty establishing an alliance with a previous therapist (Safran, Muran, Samstag, & Winston, 2005).

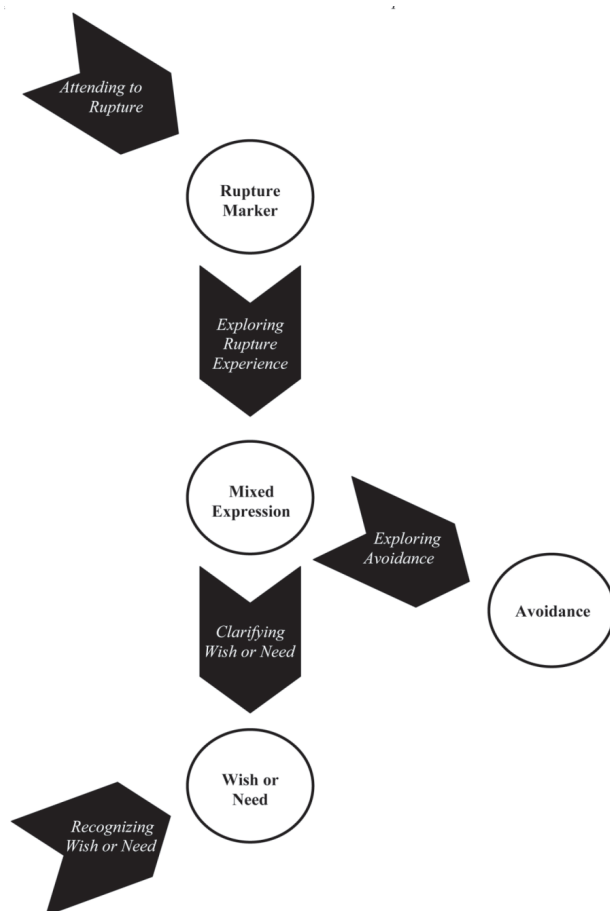BRT is organized around several key principles: (1) it assumes a two-

FIGURE 16.2. Therapist intervention pathways to critical patient states in the rupture resolution model.

person psychology and a social constructivist epistemology; (2) there is an intensive focus on the here and now of the therapeutic relationship; (3) there is an ongoing collaborative exploration of both patients' and therapists' contributions to the interaction; (4) it emphasizes in-depth exploration of the patients' experience in the context of unfolding interactions; (5) it makes use of therapist self-disclosure; (6) it emphasizes the subjectivity of the therapist's perceptions; and (7) it assumes that the relational meaning of interventions is critical. BRT generally involves the following protocol:

Establishing the Collaboration

The beginning of treatment in BRT is marked by defining the tasks and goals of treatment, even though this relational model remains relatively less structured or directive than other short-term dynamic models (and especially so, compared to cognitive-behavioral treatments).

Establishing the Rationale for Treatment Tasks

The process of explicitly establishing a rationale for treatment is one that is often neglected in more insight-oriented therapies. This omission fails to recognize the critical role that agreement about tasks and goals plays in creating an alliance. We typically give the patient concise reading material at the beginning of therapy and spend time early in treatment discussing how therapy works, with particular attention paid to the role of awareness and the use of the therapeutic relationship. It is critical to convey a rationale for such therapeutic tasks as becoming aware of emotional experience, exploring perceptions and beliefs, and examining what takes place in the therapeutic relationship.

Demonstrating the Task of Mindfulness

In light of the importance of establishing agreement on tasks, we also recommend the use of a mindfulness exercise to experientially demonstrate the notion of bare or nonjudgmental attention. For example, one might ask patients to close their eyes and focus on their breath and each breathing cycle, paying attention to where their mind goes and then redirecting their attention back to their breath. The purpose here is to sensitize patients to attending in an accepting manner to an emerging and ongoing process, much in the same way that they will be asked to attend to their feelings.

Clarifying Expectations Regarding Treatment Goals

When conveying the rationale at the beginning of therapy for a short-term and time-limited therapy, it is important to begin the process of trying to establish reasonable expectations about what can take place in such a framework. Our time-limited treatment is conceptualized for patients as a process of providing them a new experience, which involves primarily cultivating a new skill of attention and awareness as well as shining a beam of light on some core relational themes, such that patients can continue to grow and develop after the end of treatment.

Navigating the Treatment Course

The course of BRT involves many tasks and challenges for the therapist. Here, we outline some of the more important ones.

Oscillating between Content and Process

A major task for therapists in this model involves oscillating their attention between the *content* and *process* of communication. As communication theorists maintain, there are always report and command aspects to any communication. The report aspect of the communication is the specific content of the communication. The command aspect of the communication is the interpersonal statement or the statement about the current relationship that is being conveyed by the patient's communication. The therapist should always be monitoring both the content of *what* the patient says and the process of *how* the patient says it.

Observing the Interpersonal Field

Relatedly, the therapist should always be monitoring the current interpersonal field as it shifts over time. A cue of critical importance about the interpersonal field consists of the therapists' sense of interpersonal contact or engagement with the patient. Therapists should always be monitoring how related, connected to, or disconnected from the patient they are feeling at any given moment. Moments of disconnectedness provide the therapists with very important information about what is presently transpiring.

Exploring the Patient's Experience

In tracking patient experience, therapists should pay particular attention to not only emotionally salient experiential states in the patient but also transitions in patient experience, the seams between one self-state and another. These may reflect important underlying processes that should be explored and clarified. Often it is the case that these transitions indicate an avoidance of or a defensive operation against an experience. And often therapists find themselves losing contact with the patient as a result of this movement away. The task is to help the patient become aware of avoiding or defending against that experience, including the reasons for and ways of doing it.

Exploring Self-Experience

At the same time as tracking patient experience, therapists should track their own inner experience as well. Here it is critical to go beyond simply

identifying a feeling such as sadness or anger at a more gross somatic level and to articulate the nature of one's inner experience in a more differentiated way. The process of articulating one's own inner experience involves a movement back and forth between the level of feelings grounded in bodily felt experience and a conceptual elaboration of those feelings. This parallels the task in which we invite patients to engage.

Oscillating between the Self and Other Experience

Implicit in what is being said already is that therapists are always directing their attention back and forth or alternating their attention between the patient's inner experience and therapist's own inner experience. One of the primary points of orientation for therapists is their experience of contact with the patient's inner experience. So long as therapists experience empathic contact, they are naturally inclined to establish the kind of therapeutic environment in which their patient can grow. Over the course of any session, however, it is common for therapists' experience of empathic contact to shift back and forth. Whenever the therapist experiences a lack of contact with the patient's inner experience, the key task then becomes to recognize the shift, explore it, and the let reconnection follow as a natural consequence.

The Ongoing Process of Embedding and Disembedding

The course of treatment in the best of cases invariably involves an ongoing process of embedding and disembedding from various relational matrices. Being embedded in a matrix is an inevitable part of the therapeutic process, and therapists must be able to accept the fact that they will go through extended periods of being embedded without being aware of being embedded and will also go through extended periods of feeling "stuck." Therapists should also come to understand that they are always embedded in some sort of matrix with their patient—faced with the endless task of disembedding from one and embedding into another, with no other place to go (Stern, 1997).

Approaching the Termination

The end of treatment naturally evokes certain themes. With each patient, it often poses challenges for therapists that are not unlike those they faced in working through ruptures with their patient throughout the course of treatment (though perhaps more intense). Thus, we have considered the termination process as the resolution of the *ultimate alliance rupture*.

Separation and Loss

Termination obviously involves separation and loss, and thus it can evoke sadness as well as tension between the needs for individuation and relatedness. The process of individuating is inherently guilt-producing and fraught with anxiety since it threatens relatedness. Paradoxically, however, the attainment of individuation and relatedness are dependent upon each other. As attachment researchers have observed (e.g., Bowlby, 1973), one needs a sense of security in a relationship with a significant other before engaging in the exploratory behavior necessary to facilitate individuation. Conversely, one cannot maintain a mature form of relatedness to others until one has developed a sense of oneself as an individual. This is a critical theme that the therapist and patient must negotiate as treatment nears the end.

Acceptance

In the final analysis, therapists must have tolerance for their own impotence as helpers and their own inability to solve patients' problems for them or take their pain away. It is inevitable that patients will want the impossible from their therapists. They will want them to transform their lives and take their pain away. Therapists who have difficulty accepting their own limitations and being *good enough* as helpers will respond defensively in the face of patients' impossible demands. It is thus critical for therapists to come to terms with the fact that in the end there is a limited amount that one human being can do for another.

Being Alone

As human beings we thus spend our lives negotiating the paradox of our simultaneous aloneness and togetherness. We begin our lives attempting to remain in proximity to attachment figures, and the pursuit of interpersonal relatedness continues to motivate our behavior throughout our lifetime. No matter how hard we try, however, we cannot—except for brief periods—achieve the type of union with others that permits us to escape from our aloneness. This theme can also become salient as the patient faces the end of treatment and the therapeutic relationship. The critical task for the therapist is to help the patient work through this disappointment in a constructive way.

A TRAINING MODEL ON RUPTURE RECOGNITION AND RESOLUTION

In 2006 we were awarded another grant by the National Institute of Mental Health to evaluate the additive effect of our training model on a cog-

nitive-behavioral treatment (CBT) for personality disorders. In this study, inexperienced therapists trained to conduct CBT on a challenging patient population were introduced at different intervals to additional training specifically designed to improve their skills in recognizing and resolving alliance ruptures. The overall objective of the study was to evaluate the effect of our alliance-focused training model on the treatment process, that is, the interpersonal process between patient and therapist. The study resulted in a more detailed definition of our training model, which we describe in detail in this section.

Basic Therapist Skills

The training model concentrates on the development of the therapist's abilities to recognize ruptures and to resolve them. With regard to rupture recognition, our training targets three specific skills—*self-awareness*, *affect regulation*, and *interpersonal sensitivity*—which we see as interdependent and as critical to establishing an optimal observational stance. By *self-awareness*, we mean to developing therapists' immediate awareness and bare attention to their internal experience. Our aim here is to increase therapists' attunement to their emotions so that they may use them as a compass to understanding their interactions with their patients. By *affect regulation*, we mean to developing therapists' abilities to manage negative emotions and tolerate distress—their own as well as their patients'. In other words, we try to facilitate their abilities to resist the natural reaction to anxiety, namely, turning one's attention away from or avoiding dealing with it in some way, which amounts to not attending to or exploring a rupture. By *interpersonal sensitivity*, we mean increasing therapists' empathy to their patient's experience and their awareness of the interpersonal process they engage in with their patients. In this regard, we try to balance therapists' attention on what they or their patients say with a heightened sensitivity to how statements are communicated, the impact of expressions, and the nature of their interactions with patients.

The Technical Principle of Metacommunication

The training also attempts to teach the various rupture resolution strategies, from direct to indirect and from surface to depth, but with special attention to the technical principle of metacommunication, which we have found useful in exploring core relational themes. The principle represents an attempt to step outside of or dismembed from the relational matrix involving patient and therapist that is currently being enacted by treating it as the focus of collaborative inquiry. It is an attempt to bring immediate awareness to bear on the interactive process as it unfolds. It involves a low degree of inference

and is grounded as much as possible in the therapist's immediate experience of some aspect of the therapeutic relationship. It also reflects a dialogic sensibility based on the recognition that ruptures are not only the result of a collaborative effort but also can only be understood or resolved through the collaboration of both patient and therapist (see Safran & Muran, 2000). Therapists are not seen as being in a privileged position of knowing. Rather, their understanding of the communication process is considered only partial in our model.

Metacommunication can begin with questions or observations by the therapist that focus the patient's attention on three parallel dimensions of their relationship (see Figure 16.3 for an illustration). The therapist might start by focusing the patient's attention on his or her own experience with a direct question such as "What are you feeling right now?" or with an observation about the patient's self-state: "You seem anxious to me right now. Am I reading you right?" The therapist might also direct attention to the interpersonal field by asking "What's going on here between us?" or by observing "It seems like we're in some kind of dance—does that fit with your sense?" A third approach is to bring the therapist's experience into relief by asking a question that encourages the patient to be curious about the therapist's self-state: "Do you have any thoughts about what might be going on for me right now?" Alternatively, the therapist could make a
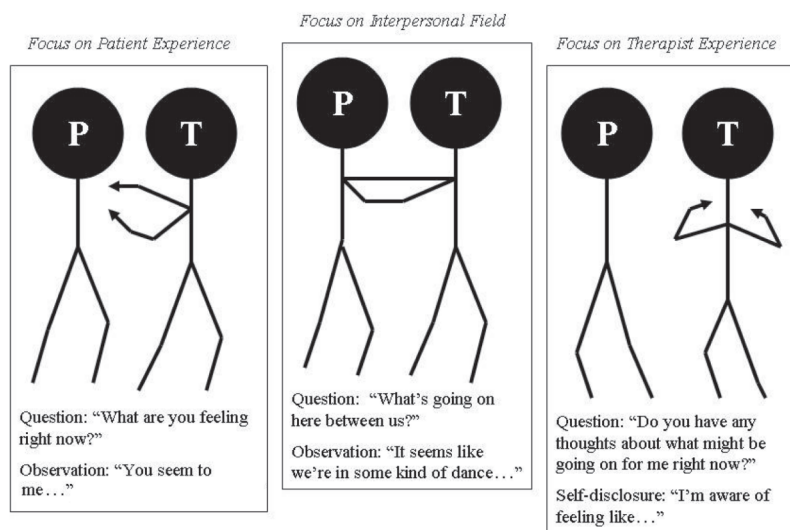

FIGURE 16.3. Metacommunication: Parallel dimensions. P, patient; T, therapist.

self-disclosure about his internal experience, such as "I'm aware of feeling defensive right now."

We have outlined a number of general and specific principles of meta-communication (see Safran & Muran, 2000), but some basic ones include the following:

Inviting a Collaborative Inquiry and Establishing a Climate of Shared Dilemma

The implicit message should always be one of inviting the patient to join the therapist in an attempt to understand their shared dilemma. Patients often feel alone and demoralized during a rupture. Therapists should try to frame a rupture as something co-created that needs to be explored collaboratively to undo. In the same vein, therapists should communicate observations in a tentative, exploratory manner that signals openness to patient input rather than conveying information with a seemingly objective attitude. In this way, instead of being yet one more in an endless succession of authority figures who do not understand the patient's struggle, the therapist allies him- or herself closely with the patient.

Keeping the Focus on the Immediate and Privileging Awareness over Change

The focus should be on the here and now—the concrete and specific—of the therapeutic relationship rather than on events in prior sessions or even earlier in the same session, and rather than on abstract intellectualized speculation. A specific immediate focus helps patients become observers of their own behavior and more aware of their own experience. Therapists should also try to convey the message to resist the urge to just make things different or better. The emphasis should be on awareness over change, with change should be understood as a byproduct of awareness, that is, with greater awareness comes change.

Recognizing That the Relationship Is Constantly Changing and Continually Gauging Relatedness

By this principle, we mean to highlight the fluidity of experience: therapists need to remember what was true a moment ago may not be true now. They should try to stay present and not get stuck in a prior moment ago, which can be very difficult when anxiety levels are high. Likewise, therapists should continually gauge relatedness to the patient and patient responsiveness to whatever they say or do. In this regard, therapists should pay close attention to their emotional experience as an important source for under-

standing the quality of relatedeness with patients in a given moment. And they should always try to use whatever is emerging in the moment as a point of departure for further metacommunication.

Emphasizing One's Own Subjectivity and Being Open to Exploring One's Own Contribution

Therapists should emphasize the subjectivity of their perceptions. This principle plays a critical role in establishing a climate that emphasizes the subjectivity of all perceptions and helps to establish a collaborative, more egalitarian, relationship where the patient feels freer to decide how to make use of the therapist's observations. In addition, therapists should be open to exploring their own contributions to the interaction with the patient in a nondefensive manner. This process can help patients become less defensive, more able to look at their contributions, and more aware of feelings that they have but are unable to clearly articulate for fear of the therapist's response.

Expecting Initial Attempts to Lead to More Ruptures and to Be Just Beginnings in a Resolution Process

Therapists should understand that their first attempts at metacommunication are just the beginnings of a conversation to disembed from a relational matrix. They should resist the reluctance to metacommunicate and recognize that it is just one step in a resolution process rather than an ultimate intervention. Their initial attempts may lead to more ruptures and may even perpetuate an enactment, but therapists need to get *into* an enactment in order to get *out*. Even the momentary experience of hopelessness may be a necessary step toward resolution. In short, there is nothing magical or elegant in metacommunication, but it can serve as an act of freedom (Symington, 1983)—an act of breaking away from the grip of an interpersonal field (Stern, 1997).

Fundamental Training Principles

In this section, we outline some of the fundamental principles that guide our alliance-focused approach to training.

Recognizing the Relational Context

The relational context is of upmost importance in training, as in therapy. It is impossible for the supervisor to convey information to the trainee that has meaning independent of the relational context in which it is conveyed.

Supervision thus must to be tailored to the specific needs and development of the trainee. Supervisors should recognize and support trainees' needs to maintain their self-esteem and calibrate the extent to which they have more of a need for support versus new information or confrontation in any given situation. It is also critically important that supervisors continually monitor the quality of the *supervisory alliance* in a way that parallels the ongoing monitoring of the quality of the therapeutic alliance. When strains or tensions emerge, closer attention to the supervisory relationship should assume priority over other concerns.

Establishing an Experiential Focus

For many trainees, the process of establishing an experiential focus involves a partial unlearning of things that they have already been taught while doing therapy. Often the formalized training of therapists emphasizes the conceptual at the expense of the experiential. Trainees study the formulations of various psychotherapy theorists and learn to apply the ideas they are learning to their clinical experience. Although this type of knowledge is essential, it can also serve a defensive function. It can help them to manage the anxiety that inevitably arises as a result of confronting the inherent ambiguity and chaos of lived experience and lead to premature formulations that foreclose experience. It can also help them to avoid dealing with the painful and frightening conflictual feelings that inevitably emerge for both patients and therapists. In some respects, this conceptual knowledge can be useful in navigating one's anxieties and therapeutic impasses, but in certain circumstances it may serve to tighten deadlocks.

Emphasizing Self-Exploration

Although there are times when specific suggestions about ways of conceptualizing a case or intervening are useful, our approach emphasizes helping therapists to find their own unique solution to their struggle with the patient. The particular therapeutic interaction that is the focus of supervision is unique to a particular therapist–patient dyad. Therapists will thus have their own unique feelings in response to a particular patient, and the particular solution they formulate to their dilemma must emerge in the context of their own unique reactions. An important aim of training therefore is to help therapists to develop a way to dialogue with their patients about what is going on in the moment that is unique to the moment and their experience of it. Suggestions about what to say provided by supervisors or fellow trainees may look appropriate in the context of a videotape being viewed but may not be appropriate in the context of the next session. The supervisor's task is thus to help trainees

develop the ability to attend closely to their own experience and use it as a basis for intervening.

Training Strategies and Tools

Our training program makes use of various strategies to develop therapist abilities and essential skills for recognizing and resolving alliance ruptures. The main training strategies we use include the following.

Manualization

In this regard, we use our book *Negotiating the Therapeutic Alliance: A Relational Treatment Guide* (Safran & Muran, 2000) as a training manual. It provides background and justification for our relational approach to practice and training. Probably the most important benefit of this book is that it presents various clinical principles and models, including our own empirically derived rupture resolution model (Figure 16.2), that can serve to help therapists organize their experience, regulate their affect, and manage their anxiety in the face of a very difficult treatment process (see Aron, 1999, for more on this point).

Process Coding

We provide a brief orientation to various research measures of psychotherapy process, such as those that focus on vocal quality, emotional involvement, and interpersonal behavior, in order to sensitize trainees to the psychotherapy process. This orientation can be very important to the development of one's clinical ear, namely, how to observe and listen to process (and not just content). Trainees may even be asked to track one of their sessions with a particular coding scheme in mind. The use of such measures (in addition to the rupture resolution model) is a good example of how research can influence practice.

Videotape Analysis

We also conduct intensive analysis of videotaped psychotherapy sessions. This type of analysis provides a view of a treatment process unfiltered by the trainees' reconstructions and an opportunity to step outside their participation and to view their interactions as a third-party observer. It facilitates an orientation to interpersonal process. There are many useful ways to use videotape, including as a prompt for accessing and defining trainees' internal experience as well as providing them with subjective feedback about the impact of the patient on others—which can be validating when

it corresponds, but also illustrative of the uniqueness of interactions when it differs.

Mindfulness Training

We introduce mindfulness meditation to our trainees, which we consider a systematic strategy for developing an optimal observational stance toward internal experience. Often trainees have difficulty at first in distinguishing between their experience and their ideas about their experience, and it is useful to use structured mindfulness exercises to help them grasp this distinction and develop openness to their experience. Such exercises also help trainees sharpen their abilities to become participant–observers. We also appreciate the benefits of this training in developing affect regulation and interpersonal sensitivity. We incorporate mindfulness in supervised sessions, but we also encourage trainees to establish a personal practice of it.

Awareness Exercises

We make extensive use of awareness-oriented exercises, including the use of role plays and two-chair techniques to practice metacommunication. For example, trainees might be asked to alternate between playing their patient and then themselves around a difficult enactment observed on video, the aim being to explore their experience (especially their fears and expectations regarding the patient) and to experiment with different ways of trying metacommunication. These exercises are at the heart of the training model. They are valuable for grounding training at the experiential level and promoting self-awareness and empathy.

Training Process and Structure

Our primary mode of supervision is by group format in a 90-minute session. The group setting poses many challenges for the supervisors, given the relational orientation. It can be quite daunting for the supervisor to be sensitive to the group process and the complexity of negotiating multiple supervisory alliances while trying to maintain group cohesion. This challenge is intensified when you consider the focus on rupture events and the emphasis on self-exploration. We try to establish a culture of struggle and support. Every case poses problems for every therapist. No one is beyond this. We do privilege the presentation of difficult moments. Because of this, we expect that presenting will be especially fraught with anxiety and shame in our training sessions, and so we are careful to continually track the trainee's experience and take great pains to grant control to the trainee, allowing him or her to feel as free as possible to rein in the process at any time. We make it clear

that, while self-exploration plays a central role in the training process, it is also critical for therapists to respect their own needs for privacy and their own fluctuating assessments of what feels safe to explore in front of supervisors and fellow trainees at any point in time.

Each supervisory session follows a typical structure. We usually begin with a mindfulness induction exercise. We then canvass group members to check in on their progress and to decide on which cases will be the focus of the session. Usually we focus on cases that are posing particular problems or those that have not been presented lately. When it comes to playing videotaped session segments, although we allow trainees to preface their presentation with some sort of case history (primarily to grant the trainee a sense of control), we also encourage the playing of the taped session without any introduction, based on the perspective that all the history you really need to know is captured in the patient–therapist interactions. As for the amount of the session viewed, we always err on the side of playing more rather than less. And often we invite trainees to provide narration of what they remember experiencing during the session to the best of their ability as they watch it in the group setting. As for the other trainees, we typically direct their attention toward their affective awareness rather than exhibiting their conceptual skills, which too often result in competition in the group and defensiveness in the presenter.

The initial task upon viewing the video is defining the rupture event. From this observation, we design an experiential exercise. In addition to the example described above where trainees play themselves and the patient in a two-chair exercise, we might do a role play where the presenting trainee plays the patient and the other trainees take turns trying to metacommunicate. During these exercises we try to establish a climate of experimentation and mutuality. As previously mentioned, we recognize that in the final analysis the resolution of rupture is both personal (depending on the trainee's own history and experience) and interpersonal (requiring the participation of the patient). We conclude each session by debriefing the group, gathering any final impressions, and finally we check in with the trainee who presented to see where he or she is experientially with regard to the group and then the case presented.

SOME FUTURE DIRECTIONS

Much more research needs to be conducted to evaluate our training model—in addition to our current effort to collect data on its additive effect on a CBT for personality disorders (the results of which have yet to be determined). As part of our current protocol, we are also conducting semistructured interviews with our therapists and supervisors to assess their experience of

the training model, its various strategies, and its impact on the development of their clinical skills, including self-awareness, affect regulation, and interpersonal sensitivity. We have recorded supervision sessions and plan to continue to collect periodic recordings (along with postsession ratings of the group supervision process, including measures of cohesion and alliance) that will allow for more intensive analysis of our training process. There are several elements to our training model, including a variety of strategies and tools, so future efforts should attempt to evaluate what components are most essential through dismantling studies. In general, the research literature on training is relatively thin. The field has yet to approach the study of supervision with the same attention and technology that have been applied to the psychotherapy process. Although we are far from understanding the process of psychotherapy in any definitive sense, much more exacting study of the training process should represent the next frontier.

REFERENCES

Aron, L. (1999). Clinical choices and the relational matrix. *Psychoanalytic Dialogues*, *9*, 1–29.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance–outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842–852.

Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology*, 7, 33–46.

Blatt, S. J. (2008). *Polarities of experience: Relatedness and self-definition in personality development, psychopathology, and the therapeutic process*. Washington, DC: American Psychological Association.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation*. New York: Basic Books.

Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 194–226). New York: Wiley.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 37–70). New York: Oxford University Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Study. *Archives of General Psychiatry*, *51*, 8–19.

Kiesler, D. J. (1988). *Therapeutic metacommunication: Therapist impact disclosure as feedback in psychotherapy*. Palo Alto, CA: Consulting Psychologists Press.

Kiesler, D. J. (1996). *Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy.* New York: Wiley.

Lambert, M. J. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.

Luborsky, L., Crits-Christoph, P., McLellan, A. T., Woody, G., Piper, W., Liberman, B., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry, 56*, 501–512.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis.* Cambridge, MA: Harvard University Press.

Muran, J. C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research, 12*, 113–138.

Muran, J. C., & Safran, J. D. (1998). Negotiating the therapeutic alliance in brief psychotherapy: An introduction. In J. D. Safran & J. C. Muran (Eds.), *The therapeutic alliance in brief psychotherapy* (pp. 3–14). Washington, DC: American Psychological Association.

Muran, J. C., & Safran, J. D. (2002). A relational approach to psychotherapy. In F. W. Kaslow & J. J. Magnavita (Eds.), *Comprehensive handbook of psychotherapy: Psychodynamic/object relations* (Vol. 1, pp. 253–281). Hoboken, NJ: Wiley.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 532–545.

Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: A process-outcome study. *Psychotherapy, 31*, 114–123.

Pizer, S. A. (1998). *Building bridges: The negotiation of paradox in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Safran, J. D. (2002). Brief relational psychoanalytic treatment. *Psychoanalytic Dialogues*, *12*, 171–195.

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, and Practice*, *27*, 154–165.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology*, *64*, 447–458.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, *43*, 286–291.

Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 225–255). New York: Wiley.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alli-

ance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 235–254). New York: Oxford University Press.

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 512–531.

Stern, D. B. (1997). *Unformulated experience*. Hillsdale, NJ: Analytic Press.

Symington, N. (1983). The analyst's act of freedom as an agent of therapeutic change. *International Review of Psycho-Analysis*, *10*, 783–792.

Tronick, E. (1989). Emotions and emotional communications in infants. *American Psychologist*, *44*, 112–119.

Wachtel, P. L. (2007). Commentary: Making invisibility visible—probing the interface between race and gender. In J. C. Muran (Ed.), *Dialogues on difference: Studies of diversity in the therapeutic relationship* (pp. 132–140). Washington, DC: American Psychological Association.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190–195.

Zimmerman, M., Chelminski, I., & Young, D. (2008). The frequency of personality disorders in psychiatric patients. *Psychiatric Clinics of North America*, *31*, 405–420.