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RESEARCH ON THERAPEUTIC IMPASSES AND RUPTURES IN THE THERAPEUTIC ALLIANCE

Abstract. In this article, we provide an overview of our research program on therapeutic impasses and alliance ruptures. Beginning in the mid-1980s at the University of Toronto, and continuing in New York at Beth Israel Medical Center since the early 1990s, we have focused our efforts on trying to illuminate the processes associated with resolving ruptures in the alliance and working through therapeutic impasses. Influenced both by the relational turn in psychoanalysis and findings emerging from our own research on the process of change, we have developed and evaluated an approach to short-term treatment that appears promising. We are also developing and evaluating the effectiveness of training methods for enhancing therapists' capacities to work constructively with negative therapeutic process, regardless of the particular "brand" of treatment they are practicing. Finally, we summarize some preliminary findings regarding the impact of therapists' capacity for mentalization on both treatment process and outcome.

Keywords: alliance rupture, enactment, impasse, psychotherapy research, therapeutic action

Introduction

The therapeutic or working alliance has, for many years now, been a central focus for psychotherapy researchers. One of the factors responsible for its popularity has likely been the failure to find consistent

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evidence that some forms of treatment are superior to others (e.g., Luborsky, Singer, & Luborsky, 1975; Wampold et al., 1997; Wampold, 2001), along with the related search for common factors of change (e.g., Goldfried & Newman, 1986; Grencavage & Norcross, 1990; Lambert & Ogles, 2004). Another is the consistent evidence that the quality of the alliance is one of the more robust predictors of outcome across a range of different treatments and that, conversely, weakened alliances are correlated with unilateral termination by the patient (e.g., Tryon & Kane, 1995; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Martin, Garske, & Davis, 2000; Horvath & Bedi, 2002; Horvath, Del Re, Fluckiger, & Symonds, 2011).

Although the concept of the working alliance originated in the psychoanalytic tradition (e.g., Sterba, 1934, 1940; Greenson, 1967, 1971), it has become an important construct in other theoretical traditions as well, including cognitive therapy (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Leahy, 2003; Hayes, Hope, VanDyke, & Heimberg, 2007). Given the growing prominence of the concept of the alliance in the field at large, it is interesting that it is no longer a central topic of theoretical discourse in the psychoanalytic literature. Why is this the case? The concept of the alliance historically served an important function at a time when psychoanalytic theory tended to emphasize the technical aspects of treatment and deemphasize the relational aspects (Safran & Muran, 2000, 2006). It also provided theoretical sanction for greater therapist flexibility at a time when classical psychoanalytic prescriptions about the nature of the analyst's stance and the therapeutic frame provided less room for therapists to adapt in a responsive way to the unique needs of different patients. Finally, the concept of the alliance was particularly useful when psychoanalysts tended to understand everything that transpired in the therapeutic relationship as a reflection of the patient's transference, rather than a product of mutual influence (both conscious and unconscious) between patient and therapist. With a shift in psychoanalytic thinking that emphasizes the mutual influence between therapist and patient, therapist flexibility and spontaneity, and the authentic aspects of the therapeutic relationship, the concept of the alliance has in some ways become superfluous or taken for granted as a background assumption.

We believe, however, that there is still value in retaining the concept of the therapeutic alliance because of its centrality in the psychotherapy research literature as well as its widespread use across diverse

therapeutic traditions (Safran & Muran, 2000, 2006). In the last two decades, there has emerged what we characterize a "second generation" of alliance research that attempts to clarify the factors leading to the development of the alliance, as well as those processes involved in repairing ruptures in the alliance when they occur (Safran, Muran, Wallner-Samstag, & Stevens, 2002; Safran, Muran, & Eubanks-Carter, 2011). A rupture in the therapeutic alliance can be defined as an instance of tension or a breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2000, 2006). Alliance ruptures vary in intensity and duration, from relatively minor tensions of short duration, which one or both of the participants may be only vaguely aware of, to major breakdowns in collaboration, understanding, or communication. Concepts that are similar to or overlapping with the construct of the alliance rupture include resistance, empathic failure, therapeutic impasse, and transference–countertransference enactment.

Ruptures in the therapeutic alliance can be understood as enactments that are shaped by dissociated aspects of both patients' and therapists' experiences in interaction with one another. From a relational perspective, disembedding from an enactment and working through it in a constructive fashion often involves developing an understanding of complementary roles that both participants in the dyad are playing (Safran & Muran, 2000, 2006; Safran et al., 2011). Alliance ruptures and repairs can be measured from patient, therapist, and observer perspectives. Existing systematic methods of observation focus on rupture–repair events that take place within a session or over the course of treatment (Safran et al., 2011). To date, a number of studies have been conducted evaluating whether a particular pattern of alliance rupture and repair over the course of treatment is related to positive treatment outcome, as well as evaluating whether training therapists to identify and work constructively with alliance ruptures has a positive impact on outcome. The results are promising (see Safran et al., 2011 for a meta-analytic review).

Over the last 25 years, our research team has conducted a series of empirical studies in an effort to illuminate the principles underlying the resolution of therapeutic impasses. We have also investigated therapist qualities associated with the ability to work through therapeutic impasses and the styles of internal processing that tend to be associated with therapists' abilities to work through alliance ruptures in a constructive fashion.

The Task Analysis of Therapeutic Impasses

Our program can be conceptualized as an ongoing process of cycling through five interdependent stages: (1) model development, (2) model testing, (3) treatment development, (4) treatment evaluation, and (5) back again to model development.

The first stage of the research program began in the mid-1980s, with intensive observation of a series of single cases in which therapeutic alliance ruptures had been successfully resolved (Safran, Crocker, McMain, & Murray, 1990). Using an approach to process research called *task analysis* (Rice & Greenberg, 1984; L. S. Greenberg, 1986; Safran, Greenberg, & Rice, 1988), we began to develop a preliminary model to capture regularities in patterns of patient–therapist interactional sequences common to cases in which therapeutic impasses were successfully resolved. The term "task" designates the processes involved in working through characteristic events or therapeutic choice points of interest to the clinician and researcher. For example, one common task consists of helping the patient transition from a state in which he or she dissociates threatening feelings to a state in which he or she begins to acknowledge these feelings. Another common task involves helping the patient to begin acknowledging his or her contribution to a core conflictual pattern that they previously experienced exclusively from the perspective of a victim. Another task involves helping the patient transition from a self-loathing state of mind to one in which he or she begins to experience self-compassion.

The first step in a *task analysis* involves mapping out a preliminary model of the relevant processes involved in constructively negotiating a therapeutic task on the basis of relevant theory, and through the process of articulating tacit expectations or implicit models that clinicians have developed on the basis of clinical experience. Task analysis research does not entail a process of putting aside theory and attempting to observe and describe sessions of therapy without preconceptions. Instead, it begins through the process of explicitly mapping out our preconceptions in the form of preliminary models. We then observe relevant sessions of therapy that have been videotaped, and examine the various ways in which specific cases either conform to or depart from our preliminary models. Through this ongoing process of moving back and forth between theory and observation, we gradually refine our model.

This process of model refinement involves: (1) the rigorous observation and description of processes that unfold in a series of single cases;

(2) the iterative refinement of the descriptive model in response to new observations; (3) developing procedures for operationalizing the different stages of the model; and (4) testing the validity of the model by contrasting sessions, cases in which the relevant therapeutic task has been successfully negotiated to session, or cases in which it has not.

In a series of studies over time, we refined the model and conducted verification or hypothesis testing studies to evaluate the extent to which the evolving model was more commonly found in therapeutic impasses that had been successfully resolved, versus those that had not (e.g., Safran, Muran, & Samstag, 1994; Safran & Muran, 2006; Safran, Muran, & Proskurov, 2009). Over time, we began to distinguish between two broad categories of impasses: (1) *confrontation ruptures*, and (2) *withdrawal ruptures* (Safran et al., 1994; Safran & Muran, 1996, 2000). *Confrontation ruptures* occur when a patient communicates to his or her therapist explicitly that he or she is in some way unhappy with treatment or with the therapist. *Withdrawal ruptures*, on the other hand, may occur in cases in which a patient finds it difficult to articulate his or her concerns or is excessively compliant, unbeknownst to the therapist. Drawing on a substantial body of theory and research that emphasizes the centrality of the dialectical tension between the need for agency versus the need for relatedness in human development and psychological experience (e.g. Buber, 1936; Winnicott, 1965; Bakan, 1966; J. Greenberg, 1991; Aron, 1996; Blatt, 2008), we conceptualize *confrontation* and *withdrawal* ruptures as reflecting different ways in which individuals negotiate this tension (Safran & Muran, 2000). When an individual is privileging the need for agency over the need for relatedness, *confrontation ruptures* are more likely to occur, whereas *withdrawal ruptures* are more likely to occur when one is privileging the need for relatedness over the need for agency. Working through alliance ruptures can therefore provide patients with opportunities to learn to negotiate the tension between the needs for agency, versus relatedness in a new, more constructive fashion (Safran & Muran, 2000).

An observer-based coding system has been developed that can reliably identify alliance ruptures and distinguish between *confrontation* versus *withdrawal* ruptures (A. Mitchell, Eubanks-Carter, Safran, & Muran, 2012). Both similarities and differences have been identified in the patterns that tend to be associated with the successful rupture or impasse resolution. Although the differences are important to understand both clinically and

theoretically, for the purposes of the present article, we will briefly describe some of the similarities that have consistently emerged in our research and in the research of other investigators who have used both task analysis and other complementary research approaches to investigate the process of rupture resolution in a range of treatment settings (for reviews of the relevant literature, see Safran, Muran, Samstag, & Stevens, 2001; Safran et al., 2011).

1. It is common for patients to report having negative feelings about the treatment or the therapeutic relationship that their therapists are unaware of.
2. It is important for therapists not to overestimate their own capacity to identify alliance ruptures and to be attuned to subtle shifts in therapeutic process, signaling the need to explore what is emerging in the therapeutic relationship.
3. There is some evidence that patient and therapist convergence in identifying the presence of alliance ruptures is related to positive therapeutic outcome (Safran et al., 2001).
4. It is important for patients to be able to verbalize any negative feelings they are having about the treatment or the therapeutic relationship, and for therapists to be able to respond in a nondefensive fashion.
5. It can be important for patients to have the experience of accessing and expressing underlying hopes, wishes, or dissociated fantasies they may have about what the therapist and/or the treatment will ultimately provide them with.
6. It is also important for therapists to work collaboratively with their patients to coconstruct an understanding of unformulated fears or expectations contributing to the avoidance or dissociation of negative feelings about the therapist, or dissociated hopes or wishes that patients have about the treatment or the therapeutic relationship.
7. It is important for therapists to explore and accept responsibility for their own contributions to ruptures and impasses.
8. Although sometimes transference interpretations linking enactments to a patient's generalized relational patterns or making genetic transference interpretations can be helpful, at other times

such interpretations can be experienced by patients as subtly blaming. In such cases, it is not uncommon for the tone of the interpretation to be influenced by dissociated feelings of frustration or hostility on the therapist's part.

Treatment Outcome Research

In the next stage of our research program, we began to develop a treatment model informed by our own research findings, as well as developments emerging in the relational psychoanalytic literature (e.g., S. A. Mitchell, 1988, 1993, 1997; Aron, 1996; Stern, 1997; Bromberg, 1998; Hoffman, 1998; Safran, 2012). We began by developing, manualizing, and evaluating the effectiveness of a short-term version of this treatment known as Brief Relational Therapy (BRT; Safran, 2002, 2003; Safran & Muran, 2000). Some of the key features of BRT are that: (1) it assumes a two-person psychology; (2) there is an intensive focus on the here-and-now of the therapeutic relationship; (3) there is an ongoing collaborative exploration of the patient's as well as the therapist's contributions to the interaction; (4) it emphasizes in-depth exploration of the nuances of patients' experiences in the context of unfolding therapeutic enactments and is cautious about making transference interpretations that speculate about generalized relational patterns; (5) it emphasizes the subjectivity of the therapist's perceptions; (6) it assumes that the relational meaning of interventions is critical (S. A. Mitchell, 1988; Aron, 1996); and (7) it makes use of countertransference disclosure and therapeutic metacommunication.

Therapeutic metacommunication consists of an attempt to step outside of the relational cycle that is currently being enacted by treating it as the focus of collaborative exploration, i.e., communicating about the transaction or implicit communication that is taking place. We conceptualize therapeutic metacommunication as a type of *mindfulness in action* (Safran & Muran, 2000). It is an attempt to bring ongoing awareness to bear on the interactive process as it unfolds, while cultivating an attitude of curiosity and nonjudgmental acceptance (Safran & Muran, 2000). It is through this process that the therapist works towards stepping outside of the complementary relationship characteristic of therapeutic impasses towards a *third* position that encompasses or transcends both the patient's and therapist's subjective perspectives (Aron, 2006; Benjamin, 2004) so

that he or she can begin to empathize with the patient's subjective experience without losing hold of one's own subjectivity.

Therapists who practice BRT are encouraged to strive for an attitude that involves beginning every therapeutic encounter "without memory or desire" (Bion, 1967) or with a "beginner's mind" (to borrow a phrase from Zen teacher Shunru (Suzuki, 1970), and we incorporate formal mindfulness training exercises into the training protocol for therapists. In tandem with the development, piloting, and refining of BRT, our research team transitioned into testing the effectiveness of the treatment. This was in the interest of addressing questions about aspects of psychotherapy process that may contribute to treatment failure as well as to treatment drop out.

In a first effort to evaluate whether BRT is more effective for treatment resistant patients than standard forms of short-term psychotherapy, Safran, Muran, Samstag, and Winston (2005) conducted a two-phase pilot study. In the first phase, patients diagnosed with either a Cluster C (anxious/inhibited) personality disorder or Personality Disorder Not Otherwise Specified (PD NOS) were randomly assigned to either *short-term cognitive therapy* (CBT), or *short-term dynamic psychotherapy* (STDP). STDP is a commonly practiced and well-researched form of brief dynamic treatment that places less emphasis on the mutual and coconstructed nature of the therapeutic relationship than BRT. Instead, the emphasis is on analyzing patients' intrapsychic conflicts and self-defeating interpersonal patterns through both transference interpretations and extra-transference interpretations. Unlike BRT, short-term dynamic psychotherapy does not emphasize the importance of collaboratively exploring the ways in which both therapists and patients are contributing to the emergence of alliance ruptures and transference–countertransference enactments

In phase I, treatment progress was monitored carefully using questionnaires that patients filled out after every session. These questionnaires included a number of subscales including a commonly used 12-item self-report measure of the therapeutic alliance. When patients were identified as at risk for treatment deterioration, based on predetermined cut-off scores on their post-session questionnaires, they were approached by a research assistant and asked if they would like to be reassigned to a new therapist, practicing a different form of short-term therapy. If they chose to change treatments, they were entered into phase II of the study.

In phase II, those patients who elected to change treatments were randomly assigned to one of two conditions: (1) BRT, or (2) a control

condition, consisting of either: (a) CBT (for those patients who were treated in phase one with STDP), or (b) STDP (for those who were treated with CBT in phase I). The results of the pilot study were consistent with our main hypothesis. Of those patients who were assigned to the control condition, all dropped out of treatment prematurely. In contrast, the majority of patients who were reassigned to BRT went on to have good therapeutic outcome. Finally, all patients who chose to stay with their current therapist when offered the option of being reassigned to a new treatment ultimately dropped out of treatment prematurely. This last finding was somewhat unexpected: We anticipated that patients who chose to stay with their current therapists might begin discussing their concerns about their treatment with the therapist, work through any problems in the therapeutic relationship, and ultimately recommit to the treatment. Despite the small sample size, this pilot study suggests that BRT may be particularly useful for cases in which it is especially difficult to develop a therapeutic alliance, and highlights the risk of treatment failure when early alliance problems are not addressed.

In a second study, Muran, Safran, Samstag, and Winston (2005) evaluated the relative effectiveness of BRT, CBT and STDP. Patients who had been diagnosed with either a Cluster C personality disorder or PD NOS were assigned to 30 sessions of CBT, BRT, or STDP. Although there were no significant differences between treatment conditions at termination, (a common finding in psychotherapy research), we did find that patients in the BRT condition were less likely to terminate treatment prematurely than patients in the other two conditions

Alliance-Focused Training

Although BRT was initially evaluated as a "stand alone" treatment modality, we have also been interested in incorporating elements of BRT into a more general approach that can be employed by therapists and researchers from a range of different treatment modalities. For example, we are currently conducting a study that provides trainees who are initially trained in the cognitive-behavioral modality (CBT) with adjunctive training designed to improve their ability to detect and constructively work through alliance ruptures, negative interpersonal process, and transference-countertransference enactments. This adjunctive training approach is called alliance focused training (AFT).

Our reasoning in conducting this type of research is that, given the widespread prevalence of cognitive therapy as a treatment modality, it is important to develop ways of distilling the expertise about the therapeutic relationship that can be gleaned from psychoanalytic theory, practice, and research, and making it more readily accessible to the cognitive-behaviorally oriented clinicians and training programs. Our preliminary findings have been encouraging (Safran et al., 2014). It appears that after receiving a relatively limited amount of AFT, there are important changes in the patterns of interpersonal process that play out between trainees and their patients. To briefly summarize, after switching from CBT supervision to AFT, the following changes emerge: (1) therapists are less likely to assume a dominant or controlling interpersonal stance than they were when conducting CBT, and patients are less likely to assume a submissive or deferential interpersonal stance; (2) patients are less likely to exhibit a passively resentful and withdrawn stance in relationship to their therapists; (3) therapists are more likely to encourage an autonomous stance by their patients, and patients are more likely to assert their wishes and needs about the therapist or therapy directly to their therapists; and (4) both therapists and patients are more likely to be self-disclosing. The next stage of this research will involve looking at the relationship between these shifts in interpersonal processes and therapeutic outcome at both termination and follow-up.

The Therapist's Capacity for Mentalization

Another arm of our research program involves exploring the relationship between therapists' capacity to reflect on their relationships with their patients in a fashion that simultaneously holds in mind both their own subjective experiences and their patients' subjective experiences, and the ways in which this may be conducive to working constructively with therapeutic alliance impasses. This capacity, which we view as akin to Benjamin's (2004) notion of intersubjectivity, can also be conceptualized as the capacity for mentalization. Mentalization refers to an individual's ability to access and reflect upon the mental states underlying behaviors of self and other, including desires, feelings, and beliefs. It describes not only the implicit knowledge of mental states, but also the activity of "thinking explicitly about states of mind" (Fonagy, Gergely, Jurist, & Target, 2002, p. 2). Mentalization refers not just to self-awareness, but also to the explicit knowledge about the minds of self *and* others. The

capacity for mentalization emerges within the relational context of one's attachment to a primary caregiver (Fonagy & Target, 1998). Fonagy and Target (1998) maintain that the development of a stable capacity for mentalization is dependent on a secure attachment relationship, one that fosters a child's representation of self as a separate, yet related thinking and feeling being.

Fonagy, Target, Steele, and Steele (1998) have operationalized the construct of mentalization with the Reflective Functioning Scale (RF). RF taps four aspects of the capacity for mentalization: (1) awareness of the nature of mental states including, for example, that our understanding of self and others is invariably limited; (2) explicit efforts to identify mental states underlying behavior, as well as understanding that our interpretations of others may be influenced by our own mental states; (3) recognition of the developmental aspects of mental states, including the understanding that mental states and perspectives can, and do, change over time; and (4) awareness of mental states in relation to the other, for example, that the other cannot fully know what one knows about his or her own mental states. Thus, mentalization as measured by the RF scale includes self-awareness, awareness of the other, and perspective taking.

In order to assess therapist capacity for mentalization, we have developed a semi- structured interview known as the Therapist Relationship Interview (TRI; Safran & Muran, 2007) designed to probe for therapists' memories, thoughts, and reflections about a particular patient they are working with. The questions in the TRI are open ended, thereby giving therapists the freedom to respond in a fashion that is as personal, emotionally distant, or factual as they choose.

The TRI is administered to therapists at different points in the treatment process, e.g., mid-way through a time-limited treatment. It consists of nine open-ended questions and a number of follow up questions asking about the therapist's experience of his or her relationship with the patient. Administration time is 45–60 minutes. The objective of the TRI is to elicit a sample of therapists' verbal accounts of their experiences, which can then be coded for quality and style of reflection. For example, therapists are asked to choose five adjectives that reflect how they feel about the patient and to then elaborate on each adjective. Additional questions ask therapists whether there is anything about this specific patient that they find puzzling. Considerable attention in the TRI is given to moments of tension in the therapeutic relationship and to negative process. Examples of relevant questions include:

- Did you experience any moments of conflict, disagreement, misunderstanding, or tension in your relationship with your patient, or a particular time when you felt rejected, attacked, or criticized by your patient?
- Can you describe a specific time that happened? When did this occur?
- What did you do? How did your patient respond?
- What was your understanding of the cause? What was your initial feeling or experience of it?
- Have you ever felt your patient would end therapy?
- Have you ever felt criticized, rejected, or attacked by your patient?

In this article, we briefly describe the results of one recent study designed to assess the relationship between therapists' capacities for mentalization as assessed via the TRI and a number of dimensions of treatment process and outcome (Reading, 2013). In the study, we administered the TRI to 43 therapists treating patients using BRT and assessed therapists' capacities for mentalization when reflecting on their relationship with these patients, by coding their TRIs using the RF Scale (Fonagy et al., 1998). We then examined the relationship between therapist RF (as coded using their transcribed TRI interview), and measures of treatment process and outcome. A number of intriguing findings emerged. First, with respect to therapeutic process, high therapist RF predicted higher therapist ratings of the therapeutic alliance (on post-session questionnaires), but not high patient ratings of the therapeutic alliance. In addition, high therapist RF predicted both high therapist and patient ratings of the extent to which alliance ruptures were focused on and addressed. Moreover, high therapist RF predicted high therapist and patient ratings of the degree to which alliance ruptures were resolved. It is interesting that when we looked at treatment outcome at termination, we found that high therapist RF, although not predicting patient ratings of changes in interpersonal functioning, was negatively related to patient ratings of improvement in general symptomatology. In contrast to these mixed findings at termination, when we looked at change between termination and the six-month follow-up interval, we found that high therapist RF was positively related to patient report of both change in overall symptomatology and change in interpersonal functioning.

In terms of the findings regarding therapist RF and other therapist and patient ratings of the therapeutic alliance, we were not particularly surprised that high therapist RF was not predictive of patient ratings of

the quality of the therapeutic alliance. There are both theoretical and empirical grounds to suspect that patient ratings of the alliance can be influenced by factors such as a tendency towards patient compliance or submission (Muran, Segal, Samstag, & Crawford, 1994; Cushman, 2000; Doran, Safran, Waizmann, Bolger, & Muran, 2012). On the other hand, the finding that high therapist RF predicted both therapist and patient ratings of alliance rupture resolution is consistent with our hypotheses. The meaning of the mixed findings at termination, combined with the positive findings with respect to both measures at termination and follow-up, is a matter of speculation. One plausible explanation, however, is that because high therapist RF predicts the likelihood that therapists will actually address ruptures (as reflected in both therapist and patients ratings), therapists with a higher capacity for mentalization are more likely to explore the relationship in a deep way that may actually lead to a type of destabilization for the patient at the time of termination. The evidence of a positive relationship between therapist RF and degree of continuing change from termination to follow-up, however, suggests the possibility that this process of destabilization may promote a type of structural change (or change in patients' representation of interactions that have been generalized [Stern, 1985]), which consolidates over time, leading to continued growth after treatment.

Case Illustration

In order to illustrate the use of BRT and to demonstrate case conceptualization within the BRT framework, we will now provide a case example, first presented in *Negotiating the Therapeutic Alliance* (Safran & Muran, 2000). It is our hope that this excerpt will bring to life some of the key features of BRT, such as therapeutic metacommunication and an intensive focus on the here-and-now of the therapeutic relationship, as previously discussed. Further, this excerpt is intended to demonstrate the ways in which BRT can facilitate the process of working through therapeutic impasses and making constructive use of transference–countertransference enactments. It also provides an illustration of how this process can help the patient become aware of disowned wishes and needs in the context of the therapeutic relationship.

The patient, Ruth, received 30 sessions of time-limited BRT from the first author (Jeremy Safran) as part of a psychotherapy research program. Because the treatment took place in the context of a research program,

all sessions were videotaped and subsequently transcribed for research purposes. Ruth was an attractive, young-looking, 52-year-old woman, who had been divorced for 16 years and had a 22-year-old daughter. She worked as a high school teacher. She had ended her marriage of 12 years at the age of 36 because she felt that her husband was controlling, emotionally abusive, and generally unable or unwilling to be responsive to her emotional needs. Since her divorce, she had had a series of short-term affairs with men, which she typically ended because of her dissatisfaction with them. She had a tendency to get involved with people she looked down on, and reported that she was afraid of pursuing men that she was more interested in for fear of being rejected. She maintained that in the past, she had difficulty acknowledging to herself that she really wanted an enduring intimate relationship. At the beginning of treatment, she acknowledged that she desperately wanted to be in a "real relationship," but felt hopeless about the possibility. A second presenting problem revolved around her feeling "disempowered" and treated disrespectfully by colleagues at work.

Although I (JS) initially felt very sympathetic toward her, a pattern developed fairly rapidly, in which I had difficulty maintaining a sense of emotional engagement with her and found myself biding time until the session ended. Ruth had a tendency to tell long stories with considerable obsessional detail, and to do so in an unemotional droning fashion, which left me feeling distant and unengaged. In addition, Ruth rarely paused to welcome any input or feedback from me. This resulted in what seemed like an unending monologue, in which my presence was barely acknowledged. Although I typically began sessions with a renewed intention of taking an interest in Ruth, I consistently ended up feeling bored and vaguely irritated.

Ruth: How many sessions do we have left?

Jeremy: Ten more, including today.

Ruth: Okay . . . okay . . . so ten more. Oh my God. . . .

Jeremy: So what's the "Oh my God?"

Ruth: Well . . . I certainly don't feel like everything's resolved . . . you know . . . and [*clears throat*] umm . . . how can we speed it up [*laughs anxiously*]? Well, you know, I don't know if just coming here and complaining and being teary . . . if that's really the most productive thing.

Jeremy: It sounds like you're feeling kind of frustrated. Can you say any more?

Ruth: Well ... I guess I feel like asking you for an evaluation ... or how we should proceed or something.

Jeremy: I don't want to sound evasive ... but I'm not sure how to answer your question at this moment. Maybe we'll be able to come back to it later, and I'll be able to answer it in a way that feels helpful. But I'm wondering how you're feeling about what's going on between us in this moment?

Ruth: Well ... I mean ... I don't feel like I'm blaming you in any way. I just think that it's easy for me to get sidetracked ... and I may need help being reined in a little. I just feel like I need to have some concrete ... not direction ... I don't know ... I feel like I need help being brought back on topic. And as we've discussed, when I don't know what the other person is thinking, I tend to go on and keep throwing lines out in an attempt to get a response.

Jeremy: So part of it is that you want me to help you keep focused .... And are you also saying that you'd feel more comfortable if I were more forthcoming about what's going on for me?

Ruth: Well, I guess so. I mean sometimes I feel like there's some kind of real connection that goes on, and then other times I'm just rambling ... and you know ... you're just waiting for me to come back or something.

Jeremy: It sounds like your sense of how connected we are ... how engaged I am and how much I'm there for you ... fluctuates!

Ruth: Uh-huh. I mean ... I don't think that you don't like me, but I think this has been hard work. And hard work for you too. And I know from working with people ... you like them the best when they make you feel good about what you're doing. And I don't know if I've been a success story.

Jeremy: Uh-huh.

Ruth: So you know ... when somebody ... when I'm feeling like embraced ... you know ... totally accepted ... like purely and unconditionally ... then I'm more relaxed in a way.

Jeremy: Right ... and you haven't always gotten that sense from me.

Ruth: Right. Yeah.

Jeremy: That at some fundamental level ... that I'm here for you and feel good about you?

Ruth: Right. There's a reservation. And I think I'm always trying to figure out where the other person is ... like feeling their pulse in a way.

Jeremy: So ... how am I doing right now?

Ruth: I think that you're receptive ... but I also want to know about my perceptions so far. I want you to tell me if I'm right or not. Are my perceptions accurate or distorted?

Jeremy: Well, I think you're right that my feeling of engagement fluctuates. ... We've talked about this before to some extent. But also, it feels to me that I've been feeling increasingly more engaged over the last few sessions.

Ruth: And your feeling disengaged relates to my wandering and losing focus?

Jeremy: I'm not completely sure ... but I think so. ...

Ruth: Well, then in the time we have left, I want you to help me to stay focused. And I also want to know why I drift away. Okay? So where do we go from here?

Jeremy: I'm not sure ... but I'm wondering if you can say anything about how my feedback felt for you ... and also when you say, "Where do we go from here?" what you're feeling?

Ruth: It's like ... I'm not going to take all the responsibility.

Jeremy: So ... is there a sense maybe ... that it feels like I've been blaming you?

Ruth: Yeah ... I guess so. It's like I've really sincerely tried to get at important things ... and it's like ... I guess I'm asking for your help.

Jeremy: Okay ... so that sounds important. ...

Ruth: Yeah. ...

Jeremy: It's like you're saying, "I'm really doing everything I can."

Ruth: Right. It's not like you have to keep prodding me to get me to say what I feel. You might in a certain way ... but I think I've been very forthcoming about my feelings as far as I know them.

Jeremy: Right. And you're basically saying "I need help. I want more from you."

Ruth: Right.

Jeremy: What does that feel like to say, "I want more from you?"

Ruth: Well, I immediately want to qualify it. I mean ... I need more from you because we only have 10 sessions ... so we need to work faster.

Jeremy: So it sounds like it's uncomfortable to ask for what you want from me.

Ruth: Yeah.

Jeremy: Can you say any more about your discomfort?

Ruth: Well ... it's like I'm being unreasonable and expecting too much ... but still ... I have a tendency to blame myself when things aren't going well in a relationship. And I don't want to do that here.

Jeremy: Yeah. It's not really fair for you to have to take all the blame if things don't work out for you here. ...

Ruth: If I'm not to blame. I'm asking you to be really honest and tell me if I go off and start talking about a crack in the ceiling or whatever. Actually, as I'm saying that, I'm feeling stronger.

Jeremy: Uh-huh ... and the essence of what you're saying in feeling stronger ... is that you want me to take some of the responsibility for what's going on ... and you don't want to feel blamed for something that's not your fault. ...

Ruth: Yeah. ... And I just had a thought, "I want this time to be about me."

Jeremy: Uh-huh.

Ruth: I don't want this to be a kind of academic observation ... and I'm demanding that you be engaged in whatever problems I have ... as mundane as they may be, as repetitive as they may be.

Jeremy: That sounds important. What does it feel like to say that?

Ruth: Well ... I feel like I'm stamping my feet in a way. You know ... like "Goddamn it!" [*laughs anxiously*]. You know ... like "Give me that!"

Jeremy: Right.

Ruth: But you know ... it feels okay to say it ... and actually I don't know that I thought this consciously at all. ...

Jeremy: Uh-huh.

Ruth: But I guess a momentum is building, and I'm becoming more self-centered in it, like I want this to be about me and it should be.

Jeremy: Right.

Ruth: And the defensive part of me thinks, "It has to be about me ... and the person that I am ... I can't try to be a more interesting person for you to be more engaged."

Jeremy: I don't see how that's defensive. Basically, you're saying "I want to be accepted on my own terms ... for who I am."

Ruth: Yeah ... yeah. ...

Jeremy: And that sounds important. You know ... I think that part of what you're saying is that when I tell you that my attention is wandering, you're feeling "The hell with you! I want you to accept me for who I am."

Ruth: Yeah. Exactly.

This excerpt demonstrates some of the features of working through a withdrawal rupture within the BRT framework. Ruth initially struggles to speak openly about her misgivings around the treatment process and about me (JS). I then work with Ruth to develop her ability to articulate what she feels is missing from treatment, and try to create a space in which she is able to begin to assert herself within our relationship. I explicitly discuss the ways in which Ruth may be unhappy with my role in, and contributions to, the treatment, further encouraging her to take a more assertive stance. Through a process of metacommunication, I am

able to address Ruth's sense of not being fully accepted by me and to acknowledge my own role in this experience. Also by way of metacommunication, I provide an opportunity for Ruth to speak openly about her experience of our relationship, and she is able to work toward speaking her mind without qualifying her wishes and needs (Safran & Muran, 2000).

Conclusion

The studies reviewed in this article and the case example discussed above provide a brief overview of our research program on therapeutic impasses and alliance ruptures, as well as its clinical application. Interest in elements of the therapeutic process that are of particular importance has brought us to focus on aspects of the therapeutic relationship that may facilitate or impede shifts over time. Our ongoing research continues to work toward developing an understanding of the ways in which psychotherapy brings about meaningful change. It is our hope that through this bridging of clinical and research-oriented thinking about the change process, and by drawing on the wisdom of clinicians and researchers together, the field will move forward in developing a more nuanced understanding of the relationship between psychotherapy process and change.

REFERENCES

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Aron, L. (2006). Analytic impasses and the third: Clinical implications of intersubjectivity theory. *International Journal of Psychoanalysis, 87,* 349–368.

Bakan, D. (1966). *The duality of human existence.* Boston, MA: Beacon Press.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73,* 5–46.

Bion, W. R. (1967). Notes on memory and desire. In E. B. Spillius (Ed.), *Melanie Klein today* (Vol. 2, pp. 17–21). London, UK: Routledge.

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

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation.* Hillsdale, NJ: Analytic Press.

Buber, M. (1947). *Between man and man* (R. G. Smith, Trans.). London, UK: Routledge & Kegan Paul. (Originally published 1936.)

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of

unique and common factors. *Journal of Consulting & Clinical Psychology, 64*, 497–504.

Cushman, P. (2000). Will managed care change our way of being? *American Psychologist, 55*, 985–996.

Doran, J. M., Safran, J. D., Waizmann, V., Bolger, K., & Muran, J. C. (2012). The alliance negotiation scale: Psychometric construction and preliminary reliability and validity analysis. *Psychotherapy Research, 22*, 710–719.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self.* New York, NY: Other Press.

Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues, 8*, 87–114.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to adult attachment interviews* (Unpublished manuscript). University College London, London, UK.

Goldfried, M. R., & Newman, C. (1986). Psychotherapy integration: An historical perspective. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 25–61). New York, NY: Brunner/Mazel.

Greenberg, J. (1991). *Oedipus and beyond.* Cambridge, MA: Harvard University Press.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting & Clinical Psychology, 54*, 4–9.

Greenson, R. (1967). *The technique and practice of psychoanalysis.* New York, NY: International Universities Press.

Greenson, R. (1971). The real relationship between the patient and the psychoanalyst. In M. Kanzer (Ed.), *The unconscious today* (pp. 213–232). New York, NY: International Universities Press.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among therapeutic common factors? *Professional Psychology: Research & Practice, 21*, 372–378.

Hayes, S. A., Hope, D. A., VanDyke, M. M., & Heimberg, R. G. (2007). The working alliance for clients with social anxiety disorder: Relationship with session helpfulness and within-session habituation. *Cognitive Behavioral Therapy, 36*, 34–42.

Hoffman, I. Z. (1998). *Ritual and spontaneity in the psychoanalytic process: A dialectical-constructivist view.* Hillsdale, NJ: Analytic Press.

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

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9–16.

Lambert, M., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy* (pp. 139–193). New York, NY: Wiley.

Leahy, R. (2003). *Overcoming resistance in cognitive therapy*. New York, NY: Guilford Press.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative study of psychotherapies: "Is it true that everyone has won and all must have prizes?" *Archives of General Psychiatry, 32*, 995–1008.

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

Mitchell, A., Eubanks-Carter, C., Safran, J. D., & Muran, J. C. (2012, June). *The rupture resolution rating system, version III (3RS-III)*. Paper presented at the Society for Psychotherapy Research conference, Virginia Beach, VA.

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

Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York, NY: Basic Books.

Mitchell, S. A. (1997). *Influence and autonomy in psychoanalysis*. Hillsdale, NJ: Analytic Press.

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.

Muran, J. C., Segal, Z. V., Samstag, L. W., & Crawford, C. E. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting & Clinical Psychology, 62*, 185–190.

Reading, R. A. (2013). *The role of therapist reflective functioning in psychotherapy process and outcome* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMT No. 3566470).

Rice, L., & Greenberg, L. (1984). *Patterns of change: Intensive analysis of psychotherapy*. New York, NY: Guilford Press.

Safran, J. D. (2002). Brief relational psychoanalytic treatment. *Psychoanalytic Dialogues, 12*, 171–196.

Safran, J. D. (2003). The relational turn, the therapeutic alliance and psychotherapy research: Strange bedfellows or postmodern marriage? *Contemporary Psychoanalysis, 39*, 449–475.

Safran, J. D. (2012). *Psychoanalysis and psychoanalytic therapies*. Washington, DC: American Psychological Association.

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

Safran, J. D., Greenberg, L. S., & Rice, L. N. (1988). Integrating psychotherapy research and practice: Modeling the change process. *Psychotherapy: Theory, Research, & Practice, 25*, 1–17.

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