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The efficacy of training on resolving therapeutic alliance ruptures

Mémoire de Maîtrise universitaire ès en science en psychologie, psychologie clinique et psychopathologie

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1 Introduction

1.1 The therapeutic alliance, alliance ruptures and outcome

The therapeutic alliance is a popular concept in psychotherapy and has been of particular interest to researchers over the past decades. Several meta-analyses conducted in the 70s concluded that the different psychotherapeutic approaches led to similar beneficial outcomes for a wide-range of mental disorders, otherwise known as the famous "dodo-bird effect" (Luborsky, Singer & Luborsky, 1975; Smith & Glass, 1977). Since then, a lot of the research in this field has focused on finding common therapeutic processes, one of which is the therapeutic alliance, a reliable, albeit moderate, predictor of successful outcome (Flückiger, Del Re, Wampold, Symonds & Horvath, 2012; Horvath, Del Re, Flückiger & Symonds, 2011; Martin, Gaske & Davis, 2000). Building a strong alliance in the first three sessions is critical in achieving beneficial outcomes by the end of the treatment and inversely, the presence of negative processes at the beginning of therapy tend to lead to poor outcomes (Henry, Strupp, Butler, Schacht & Binder, 1993).

Several more recent studies have identified the therapist, but not the patient as a significant moderator in the alliance-outcome relationship, such that some therapists are able to build better alliances and have more successful outcomes independently of the type of patient encountered (Baldwin, Wampold & Imel, 2007; Dinger, Strack, Leichsenring, Wilmers & Schauenburg, 2008; Zuroff, Kelly, Leybman, Blatt & Wampold, 2010). A recent meta-analysis estimated the size of the correlation therapist-alliance-outcome to be large and concludes that psychotherapy training should incorporate specific behaviours targeted at building high-quality relationships with patients (Del Re, Flückiger, Horvath, Symonds & Wampold, 2012). This need is substantiated by findings that managing negative therapeutic processes seems to be a difficult skill to master and therapists tend to avoid exploring the patient's hostility leading to mutual withdrawal from the relationship and encouraging a vicious cycle of

negativity and hostility on both parts (Binder & Strupp, 1993; Strupp, 1993). What is more, therapists are likely to score the alliance very differently to their patients (Horvath et al., 2011), which may inhibit their ability to predict negative outcomes (Lambert, 2007).

Building upon this knowledge, the "second generation" of alliance research dedicated itself to identifying factors that bring about the process of change in patients. In particular, negotiation is seen a central point in any psychotherapy, implying that tensions are inevitable. These tensions or fluctuations in the quality of the relationship between patient and therapist are defined alliance ruptures. Safran and Muran and their colleagues (Safran & Muran, 1996, 2000; Safran, Muran & Proskurov, 2009; Safran, Muran, Samstag & Stevens, 2001) extensively studied rupture events in session and developed a resolution stage-process model. Although they are not the only researchers to have taken an interest in alliance ruptures, their research is perhaps the most comprehensive and has unique value to clinical practice (see Baillargeon, Leduc & Côté, 2003 for a review in French or Ackerman & Hilsenroth, 2001 for a summary in English). This model considers the alliance as curative in and by itself as well as sufficient to predict successful outcome. In fact, the resolution of ruptures has been shown to be associated with a better outcome for patients as well as higher treatment retention. Conversely when ruptures go unaddressed, the alliance suffers leading to premature therapy termination and patient dropout (Safran, Muran & Eubanks-Carter, 2011).

1.2 The benefits of rupture resolution

Considering the negative impact unresolved ruptures can have on patient outcome, it is critical to deepen our understanding of ruptures and their resolution. Therefore, a better understanding of the components that foster a solid working therapeutic relationship will not only lead to better patient outcomes but are also an opportunity to improve therapists' training. Without appropriate training, it seems that the majority, if not all, of ruptures go unresolved (Coutinho, Ribeiro, Hill & Safran, 2011). In addition, successfully addressing hostility does not appear to be an innate

ability or natural talent that psychotherapists possess (Binder & Strupp, 1993). In Switzerland and probably in many other countries, rupture resolution is not included in the state-recognised psychotherapy training, although techniques to build the alliance will be addressed by some therapeutic orientations.

Some evidence-based solutions have been offered to assist therapists in managing poor evolution and outcomes. For example, sophisticated feedback systems will send alerts in case of poor evolution, and some will even provide clinical support tools in between sessions, including alliance-building tips. These are useful in terms of reducing negative patient outcome (Harmon et al., 2007; Lambert et al. 2001) but do not address the monitoring and evaluation of events that may transpire within a single session. In contrast, Safran and Muran's rupture resolution model and its associated training approach, *alliance-focused training* (AFT), teaches psychotherapists how to detect ruptures as they arise, respond to them with empathy rather than hostility whilst making sure the patient is aware of his own experience and how his behaviours may affect others. The main purpose is to develop three key psychotherapeutic skills: self-awareness, affect regulation and interpersonal sensibility. These will help the therapist be aware of his or her own experience of the relationship, better tolerate the negative emotions associated with tensions in the emotional bond and metacommunicate with patients without exacerbating the rupture. This approach is primarily based on resolving ruptures through meta-communication, and aims to address aspects of the therapeutic relationship or interactions with the outside world. AFT provides practical experience through video recording, group discussions and awareness-oriented role-plays, and further includes comprehensive mindfulness training. Increasing mindfulness practice helps trainees adopt an observer's stance when faced with ruptures, which in turn facilitates a non-judgemental and accepting response (Eubanks, Safran & Muran, 2014; Safran & Muran, 2000).

1.3 Alliance-focused training

A multitude of psychotherapy training programs exist, but are they efficient and is rupture resolution training in particular the way forward? How to effectively train burgeoning psychotherapists has been a controversial subject since the Vanderbilt studies. Whilst Vanderbilt I showed that the key ingredient in treatment success was most likely good interpersonal skills rather than the strict adherence to a particular model and its techniques, Vanderbilt II highlighted the difficulty in training therapists to increase their awareness and skill in terms of the therapeutic relationship (Henry et al., 1993; Strupp, 1993).

Recent studies have tackled the question of whether therapists can be trained to improve their alliances. Results are so far encouraging but not clear-cut. For example, Crits-Chritoph and colleagues (2006) conducted a small-scale study investigating the impact of their alliance-fostering therapy, similar to Safran & Muran's model (2000). Results were mixed, probably in part due to the small sample size; little to no impact was seen on symptomatology and all but one alliance scale, but quality of life improved slightly. However, effects on therapists' skills were not assessed. To address this, Safran and his colleagues (2014) compared the effects of CBT versus AFT training on three social behaviour dimensions. Their findings reveal that AFT trainees were less likely to display controlling behaviours, both neutral and friendly in nature, and submissive processes. Moreover, they were more likely to be affirming and understanding, disclose their own experience and shift their behaviour towards encouraging patient assertion and separation, which the authors consider as a crucial aspect of rupture resolution. In addition, AFT tended to increase the trainees' ability to think and communicate about their own experience of their relationships with their patients and make sense of it. Overall, they conclude that AFT is successful in developing key rupture resolution skills (Safran et al., 2014).

1.4 Research aims

The main objective of this paper was to design a French version of AFT and examine its effectiveness in terms of improving trainee therapists' abilities to successfully address and resolve ruptures using a randomised controlled trial (RCT) design.

2 Theoretical background

2.1 Ruptures

An alliance rupture is broadly defined as a fluctuation in the quality of the relationship, with a noticeable lack of collaboration or tension in the emotional bond. The term rupture is used to denote a variety of phenomena that may occur in psychotherapy: misunderstandings, enactments, impasses or alliance threats. Intensity, duration and frequency vary according to the particular circumstances. The ultimate rupture would be if the patient walked out of a session or terminated the therapy unexpectedly; however most ruptures are subtle and can go undetected by the therapist (Muran & Barber, 2011).

> 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. (Muran & Barber, 2011, p. 322)

The central idea behind this research is that any alliance rupture is a unique opportunity for the patient and therapist to instigate the change process, and this therapeutic event can be empirically studied (Safran, Crocker, McMain & Murray, 1990). It is important to keep in mind that the alliance will inevitably waver over the course of treatment, and every psychotherapy session will contain at least one or several ruptures, of varying intensity and significance to the alliance. Psychotherapists in training are warned that exploring ruptures could potentially lead to more ruptures; however this should not distract them from the therapeutic process that should be viewed as constantly evolving (Eubanks, et al., 2014; Safran & Muran, 2000). Ruptures can emerge as a result of untimely therapist

interventions, such as pushing to explore a sensitive subject before the patient is ready (Coutinho et al., 2011).

Two broad categories of ruptures have been identified with their own unique patterns and characteristics: withdrawal and confrontation ruptures. In both cases, and as mentioned previously, a rupture indicates a lack of collaboration between the patient and his or her therapist or a tension in the emotional bond. Some ruptures may be a combination of both withdrawal and confrontation, but it is useful to distinguish between the two because they require differential resolution, as we will see below (Muran & Barber, 2010; Safran & Muran, 2000). Furthermore, research shows that they elicit different emotional reactions and experiences in both patient and therapist (Coutinho et al., 2011). This distinction is not only useful for research but also educational purposes; providing examples of types of ruptures that may occur could be the first step in training psychotherapists to detect and resolve them (Coutinho, Ribeiro, Sousa & Safran, 2013).

Therapists may encounter two types of withdrawal ruptures. In the first the patient responds to tensions or misunderstandings by moving *away* from the therapist or the therapeutic process. For example, the patient may deny his evidently hurt feelings or give minimal responses to the therapist's interventions. The second type of withdrawal involves the patient moving *towards* the therapist but in such a manner that he or she is denying some aspects of the experience of being a patient, such as changing the topic or talking in very abstract terms (Safran & Krauss, 2014). Withdrawal ruptures often precede confrontation ruptures and are perhaps less emotionally salient to the patient (Coutinho et al., 2011).

Eubanks, Muran and Safran (2015) have published a manual designed for researching ruptures and their resolution and provide detailed explanations and examples. In the case of withdrawal, there are seven sub-categories, presented in Table 1. All information in Tables 1, 2 and 3 is taken from the same manual.

Table 1: Withdrawal ruptures sub-categories

Sub-category	Example
Denial	T: You look upset. P: I'll be fine. Don't worry about me.
Minimal response	T: So is it upsetting to even talk about it right now? P: Sort of.
Abstract communication	P: But I mean, you know, I was thinking that maybe what I would do is just not let that happen, and just say, well, you know, maybe I don't even have to understand why that happened, maybe if I just don't let that happen, that I would just be in a better place to work on things.
Avoidant storytelling and/or shifting topic	T: Are you experiencing me as angry right now? P: No, no. I feel, um, actually, um, very safe talking to you. And it's not that I don't worry-- I don't feel-- I can say to my boyfriend…
Deferential and appeasing	T: How was the homework? P: Oh, it was so helpful. You give such wonderful advice.
Content/affect split	Patient looks tearful. T: It's hard for you to tell me about those sad feelings. P: *(A bright, forced smile)*. Yes, it is. It's not easy to talk about.
Self-critical/hopelessness	T: It's hard for you to tell me "no." P: Now you see why it's impossible for me to get a job.

In contrast, confrontation ruptures are moments in which the patient moves *against* the therapist in a non-collaborative or hostile manner. For example, a patient may express his dissatisfaction with the progress of therapy, criticise the therapist or reject his or her interventions. Eubanks, et al. (2015) have empirically identified seven sub-categories of confrontation ruptures (Table 2). In some cases, confrontation ruptures may arise because of unresolved preceding withdrawal ruptures (Coutinho et al., 2011). Treatment outcome and confrontation ruptures are linked; indeed, a higher number of confrontation markers in a session are associated with dropouts. Conversely, when confrontation ruptures are successfully resolved, the more

likely the patient will remain in treatment (Coutinho, Ribeiro, Fernandes, Sousa & Safran, 2014).

Table 2: Confrontation ruptures sub-categories

Sub-category	Example
Complaints/concerns about the therapist	P: I can't communicate with you.
Patient rejects therapist intervention	T: It sounds like you are concerned about him. P: *(hostile tone)* No, that is not it at all.
Complaints/concerns about the activities of therapy	P: What is this? Why are we doing this exercise? I feel really uncomfortable right now.
Complaints/concerns about the parameters of therapy	P: Once a week is not enough. It's not enough time to address all my problems!
Complaints/concerns about progress in therapy	P: As I told you, I have the feeling we are going in circles.
Patient defends self against the therapist	P: But I think it's normal for people to change. I'm going through a transitional period. So I have new ideas about what would help me get through this situation. It doesn't necessarily mean that I am unstable.
Efforts to control/pressure the therapist	P: Tell me what my problem is and what I need to do.

2.2 Resolution strategies

Throughout the years, Safran and Muran's team (Safran & Muran, 1996; Safran et al., 2011) have refined their stage-process model of rupture resolution. Resolution begins with the therapist acknowledging the rupture event, whether confrontation or withdrawal, and encouraging a thorough examination of said rupture. The second stage involves the facilitation of "a disembedding from the relational matrix" (Muran & Barber 2011, p. 323) in which metacommunication is crucial. It is at this next stage of the resolution process that the distinction between confrontation and withdrawal becomes pertinent. When addressing a confrontation rupture, the aim is to help the patient progress from hostility to the expression of underlying emotions and needs: "The resolution often involves the therapist's empathic engagement

with the patient in order to facilitate the expression of disowned feelings of disappointment, hurt, vulnerability, and the need for nurturance" (Safran & Krauss, 2014, p. 382). In withdrawal ruptures, resolution will focus on moving from avoidance to healthy self-assertiveness and involves the "exploration of interpersonal fears and internalized criticisms that inhibit the expression of negative feelings, as well as providing the patient the latitude to begin to communicate their wishes and needs" (Safran & Krauss, 2014, p. 382). In both cases the therapist must respond in a non-defensive and non-hostile manner, empathise with the patient's experience and acknowledge his or her own contribution to the rupture where appropriate.

In order to attend to ruptures effectively, Safran and Muran (2000) suggest conceptualising them according to Bordin's definition of the alliance. A rupture can thus either be an expression of a disagreement on the tasks or goals of therapy or reflect a problem in the emotional bond. The therapist can then resolve the rupture directly or indirectly, at surface-level or by exploring the underlying meaning. For example, following a patient's complaint about a homework assignment, the therapist may respond directly at surface level and explain the rationale behind the task and implications for treatment, or he could invite the patient to explore the core relational schema underlying the patient's frustration. On the other hand, addressing a disagreement on tasks or goals indirectly would involve reframing the meaning of or changing said tasks or goals.

The selection of resolution strategies to deal with ruptures will thus be based on how the rupture is conceptualised and at what level the therapist wishes to target his response. As a key ingredient to a strong alliance, agreement on tasks and goals should be addressed at the outset and the therapist should frequently check that the patient is still on board as the therapy progresses and adjust as necessary. In cases where the rupture originates from a misunderstanding or a need for clarification, a direct, surface level intervention following a complaint about tasks or goals may suffice. Some ruptures could indicate an enactment of a vicious relational cycle within the patient-therapist relationship. The key focus for the

therapist here would be an in-depth exploration of the patient's underlying schemas. In the same way, when dealing with strains in the relational bond, a direct, surface-level intervention aims to clarify a misunderstanding whilst an exploration of a core relational theme occurs at a deeper level. The latter could become a therapeutic task in itself when a sufficient degree of trust and self-awareness has been achieved. Otherwise, an indirect resolution would be more fruitful (Safran & Muran, 2000).

Another technique, allying with the resistance, comprises a validation of the patient's defensive posture and emphasising the adaptive role avoidance of negative emotions can play. This would entail, for example, reframing the need for distance in relation to a particular painful memory as a necessary step towards acceptance. In this way, instead of denying a part of the patient's experience by directly confronting the suffering, the therapist allies with it and creates a more trustful and close bond. Finally, the therapist can indirectly address a rupture by creating a new, and hopefully corrective, relational experience. In this case, it is crucial to avoid re-enacting an unhealthy and traumatising schema to instead replace it with a new type of interpersonal experience. This type of intervention involves a set of non-verbal communications or actions the therapist can adopt rather than intervening verbally (Safran & Muran, 2000). This model of resolution echoes therapist personal characteristics and therapeutic techniques fostering a solid therapeutic alliance, such as being honest, warm and open as well as facilitating the expression of affect, exploration and depth (Ackerman & Hilsenroth, 2003). In contrast, those contributing to the deterioration of the alliance are discouraged (Ackerman & Hilsenroth, 2001), thus providing support to the above potential interventions as beneficial to the therapeutic relationship.

A key principle behind the resolution process is metacommunication in the here and now, a kind of "mindfulness in action", especially when resolution entails exploring core relational themes. Metacommunication facilitates the "disembedding" from the relational cycle the patient is perpetuating with his/her therapist and promotes communication about both

patient and therapist's immediate experiences of the relationship. As such, the degree of inferences the therapist needs to make is limited to a minimum since communication is based on concrete descriptions. It is the therapist's role to initiate metacommunication, for which he may use his intuition before moving towards an overt discussion. There are three dimensions the therapist can metacommunicate about: his/her own experience ("How do you think I am feeling right now?"), the patient's experience ("I sense a lot of anger coming from you, is that correct?"), and their interpersonal interaction ("I feel like we're stuck in a rut, how do you feel about what's going on between us?") (Muran & Barber, 2011).

For the purposes of the present research and to illustrate the types of resolution strategies that can be used, the ten sub-categories are presented in Table 3. As discussed above, these can be either targeted at the surface-level (i.e. clarifying a misunderstanding) or they may explore the deeper, underlying meaning of the rupture (i.e. linking the rupture to patterns in the patient's other relationships).

2.3 General hypotheses

The main research question of this paper, as mentioned in the introduction, is to investigate whether the brief rupture and resolution training develops and improves therapist's skills to detect and deal with rupture events. In particular and following the theoretical background detailed above, we can assume that the training will decrease the number of confrontation and withdrawal ruptures through increased resolution attempts. Furthermore, the improved rupture resolution process could have a beneficial impact on the alliance.

Table 3: Resolution strategies sub-categories

Sub-category	Example
Therapist clarifies a misunderstanding	T: It sounds like you clicked with CBT P: No! I was assigned to CBT, that's totally different. T: What I'm saying by "you click with it" is that you seem to like it.
Therapist changes tasks or goals	P: It's hard to talk about my mom. *(Patient goes quiet.)* T: So how are things at work? You were going to meet with your boss to ask about a raise, right?
Therapist illustrates tasks or provides a rationale for treatment	T: It may be frustrating to have to carry these thought records around with you, but it may be really helpful to just have them in moments when you're so overwhelmed.
Therapist invites the patient to discuss thoughts or feelings about the therapist or some aspect of therapy	T: So did you feel that we weren't communicating with each other?
Therapist acknowledges his/her contribution to a rupture	T: I have to admit, in this moment, I feel a little accusatory…
Therapist discloses his/her internal experience of the patient-therapist interaction	T: I feel like walking on ice here…
Therapist links the rupture to larger interpersonal patterns between the patient and the therapist	*The patient has difficulty articulating what she wants to focus on in the session, and criticizes herself for being confused and disorganized. The therapist observes how the patient often blames herself for any misunderstandings that arise between them.*
Therapist links the rupture to larger interpersonal patterns in the patient's other relationships	T: Well, speaking of what you were just saying about the reasons why you never developed some of these important, close friendships, around this idea of being understood, it sounds like some time in the process since we last saw each other, there was this question of how much *I* understood you.
Therapist validates the patient's defensive posture	P: You will never understand me. I cannot express myself so it's much better to quit. T: Actually, I appreciate your honesty, and if you want to quit of course that's your choice.
Therapist responds to a rupture by redirecting or refocusing the patient	*The therapist attempts to stop the patient's avoidant storytelling by redirecting the patient back to the task of therapy, discussion of his anxiety.*

3 Methods

To study the efficacy of a brief rupture resolution training programme, a randomised controlled trial (RCT) design was implemented with trainee therapists currently enrolled in a Certificate of Advanced Studies in both Cognitive-Behavioural Therapy (CBT) and Psychodynamic therapy. This research project within the context of a thesis; only a portion of data will be presented in the current paper.

3.1 Sample

Trainee therapists were recruited in the lectures of both psychodynamic and CBT CAS through voluntary participation. The general purpose of the research was presented to them, highlighting that free alliance-focused training would be provided during the study for therapists in the experimental group and after study completion for those in the control group. In total, 44 trainee psychotherapists volunteered. Of these, six did not attend post-test (drop-out rate=13.64%) and one was excluded due to excessive clinical experience.

The final sample consists of 37 therapists randomly allocated to either the experimental (n=19) or control group (n=18). Around 80% were women and the mean age was just under 32 years old. The majority were psychologists in the process of obtaining their CAS in CBT for the past year or two. In terms of professional and clinical experience, most of the sample had either between one and nine hours of supervision or 20 hours or more, 20 hours or more of personal therapy, practiced in clinical settings for at least eight hours a week and with adults. With regard to alliance-focused training, the majority had taken an introductory training course, no training or reading only, no rupture resolution training in general and for Safran & Muran's model specifically (Table 5).

Table 4: Sample Characteristics

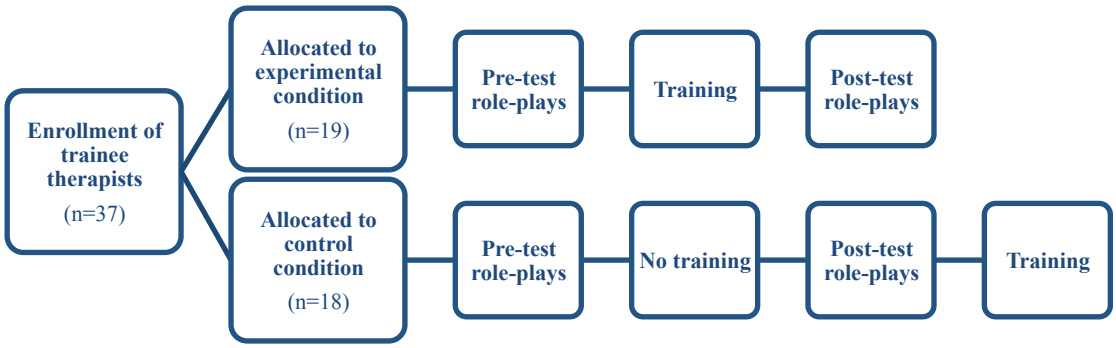
		Control (n = 18)	Experimental (n = 19)	*p*
Socio-demographics	*Age*	31.22 (4.89)	32.47 (5.02)	*ns*
	Gender			
	Men	2	5	*ns*
	Women	16	14	
	Profession			
	Psychologist	12	14	*ns*
	Psychiatrist	4	2	
	Other	2	3	
Training experience	*Training model*			
	CBT	13	18	*ns*
	Psychodynamic	5	1	
	Supervision		*(Missing n=1)*	
	0 hours	4	2	
	1-9 hours	7	4	*ns*
	10-20 hours	2	6	
	20 hours +	5	6	
	Mindfulness		*(Missing n=1)*	
	None	7	2	
	Reading	3	2	*ns*
	Introductory	3	7	
	Brief	4	5	
	Complete	1	2	
	Alliance-focused		*(Missing n=1)*	
	None	12	3	
	Reading	4	9	*ns*
	Introductory	1	5	
	Brief	0	1	
	Complete	1	0	

Categories presented in Table 5 were collapsed for profession and training variables to respect the Chi-square test requirements and test for significant differences between control and experimental groups. According to these, both groups were similar in terms of age, profession and past training experience.

3.2 Procedure

This RCT had two test times, pre-training and post-training, as illustrated in Figure 1.

Figure 1: Study design



At both test times, all participating therapists took part in two role-plays; both were videotaped and audio-recorded as a back up to the camera. The first was a dummy role-play with psychology students acting as patients and lasted 10 minutes. The same vignette was applied to all actor/therapist dyads. The purpose of the dummy test was to accustom the participants to the camera and to the stress of being in a test environment. The second role-play lasted 20 minutes for which six professional actors were recruited to play the patients, based on six different vignettes. The vignettes included information about the patient to portray as well as specific examples of confrontation ruptures. The actors were instructed to introduce at least one confrontation rupture five minutes into the role-play. No examples of withdrawal ruptures were given since it was thought that they would be more difficult to understand and initiate in a realistic fashion. Role-plays were organised so the therapists encountered different actors and vignettes at both test times. The video recordings of the second role-plays formed the basis of the data coded to test the general hypotheses. The coding system used, the Rupture Resolution Rating System (3RS) will be described below. These evaluations through role-plays were an important component of the training for the experimental group. Indeed, the first part of the training module took place immediately after all therapists had completed the role-plays. The second portion was scheduled approximately a month later and

preceded the post-test role-plays. For the control group, testing took place over several days to accommodate individual timetables whilst respecting the month-long interval applied to the experimental group.

In terms of the content of the training course, the theoretical aims were for participants to be aware of key concepts relating to the therapeutic alliance and Safran and Muran's model of rupture resolution and gain practical experience of rupture events and resolution attempts (see Appendix 5 for summary and concluding presentation slides in French). The first part of the course included an introduction to key concepts and videotape analysis in groups, providing the opportunity to practice identifying rupture events and resolution strategies. The training supervisor was available to guide group discussions, clarify key concepts and answer any questions. The second part of the training module, which took place a month later, started off with a light refresher of material covered previously followed by a series of role-plays where therapists developed their practical experience in dealing with rupture events and increasing their sense of competency. Post-testing took place after this second session and once all therapists had completed their evaluations, a final hour-long session concluded the alliance-focused training module for the experimental group. In total, the experimental group received approximately eight hours and a half of training, split over two days. The course was conducted a second time for the control group at the end of their participation in the study.

3.3 Measures

3.3.1 Participant questionnaires

Several questionnaires were administered to participating therapists. First, after the pre-test role-plays, the therapists were given a general questionnaire, including items collecting socio-demographic information as well as professional and training experience. Secondly, prior to each role-play, the therapist evaluated his or her stress level on a 10-point scale. Immediately after each role-play, both therapist and actor were asked to assess the quality of the alliance on a 10-point scale at three points in time:

at the beginning, middle and end of the role-play. The therapist's questionnaire had a further set of items evaluating their stress levels, how realistic they judged the role-play, their comfort, sense of efficacy, confidence, satisfaction and finally, adherence to their primary psychotherapy model.

3.3.2 3RS

In addition to quantitative self-ratings of the alliance, an observer's rating system was used to code the video recordings of the role-plays, thus overcoming many research biases linked to the questionnaires. The Rupture Resolution Rating System (3RS) was designed by Safran and Muran's research team and detects confrontation and withdrawal ruptures as well as resolution attempts (Mitchell, Eubanks-Carter, Muran & Safran, 2011; Eubanks, Muran & Safran, 2015). This tool has been used in a few studies to date and has proven to be a useful in studying rupture events (Coutinho et al., 2014), in terms of links to outcome (Coutinho et al., 2013) and patient and therapist experiences of therapeutic impasses (Coutinho et al., 2011).

The coding procedure recommends viewing the videotapes in five-minute segments; sections can be reviewed if any ambiguity arises. During viewing, coders are attentive to signs of lack of collaboration or tension in the bond as well as resolution attempts. The latter can only be coded in the context of a rupture and the coder has to be able to link a particular resolution to one or several ruptures. In this way, it is ensured that the therapist has identified the rupture event and is trying to address it. At the end of each segment, rupture and resolution sub-categories are noted and coded according to their clarity using a check system. A check indicates a clear occurrence and check minus an unclear example of a rupture or resolution. For analysis purposes, these were translated into numerical scores, two and one respectively, the sum of which is called degree of appearance from this point on. A total appearance score is calculated for each sub-category of rupture and resolution by summing up the segments scores. In addition, a significance grade is attributed to each sub-category according to a 5-point scale where 1 indicates "no significance" and 5 "high

significance". Based on the appreciation of the entire video, global subjective significance scores are given for withdrawal and confrontation. Finally, a global resolution score is rated on a 5-point scale where 1 denotes "poor resolution" and 5 "very good resolution". In the latest manual, Eubanks, Muran & Safran (2015) recommend "anchoring" the resolution rating at 3, or an average resolution, and then move up or down the scale according to the particular session coded. A simple "yes" or "no" score assesses the therapist's global contribution to the ruptures.

The manual detailing the 3RS coding procedure was recently republished (Eubanks et al., 2015). Most of the coding for this research, save for three cases, was however based on the prior publication (Mitchell et al., 2011). Since the 2011 version, a new resolution category was added where the therapist redirects or refocuses the patient and all marker categories are more thoroughly described. In addition, a differential diagnosis section was added to help decide between two markers, and finally, extensive coding examples are given from clinical psychotherapies. To streamline the data, in the three cases resolution strategy "redirect/refocus" was used, it was recoded as "change task/goal".

For this research, two coders were trained until high inter-reliability was reached. Inter-reliability was calculated for the current data and yielded high reliability for withdrawal (α=0.86), confrontation (α=0.94) and resolution (α=91) as well as the global subjective resolution score (α=0.85). Each of the 37 therapists produced two videotapes to be coded. Out of the 74 20-minute long videos, one coder rated 68, the other 23, with 25% overlap to calculate the inter-reliability. In this paper, for cases where there are data from both coders, the author's are used.

3.4 Operational hypotheses and statistical analysis

The general research question is operationalized into three hypotheses as described in Table 5. Firstly, it is expected that the rupture resolution training will have an impact on confrontation and withdrawal rupture markers, both in terms of appearance and significance to the alliance. Moreover, the potential impact of the training on the rupture sub-categories

will be explored. The third hypotheses postulates that trained therapists will attempt more resolutions and be more successful at post-test. Again, any evolution according to time and group of resolution sub-categories will be investigated.

Finally, it is expected that the newly acquired resolution competencies will also have a beneficial impact on the subjective alliance self-ratings of both the patient and the therapist in the experimental group at post-test. As mentioned previously, three alliance self-ratings were taken. Rather than computing the mean of the three scores, the rating of the end of the role-play was used in the analyses as it may be more representative of the rupture resolution process that had taken place throughout the role-play. Given the design of the role-plays, the other two self-ratings could reflect the introduction of rupture events and thus be poor scores, potentially skewing the mean.

Table 5: Hypothesis testing strategy

Hypotheses	Statistical Analysis
Withdrawal and confrontation ruptures	
1) Appearance and significance scores for confrontation and withdrawal ruptures will be lower in the experimental group's post-test role-plays, as ruptures are detected and addressed as they arise.	*Repeated-measures ANOVA* DVs: Appearance and significance scores Between-subjects IV: time of test Within-subjects IV: condition Post-hoc tests: repeated-measures and independent t-tests
2) Does the training have an impact on the types of rupture markers encountered?	*Descriptive analysis of rupture sub-categories according to group and test time*
Resolution strategies	
3) Appearance and global significance resolution scores will be higher for the experimental group at post-test.	*Repeated-measures ANOVA* DVs: Appearance and significance scores Between-subjects IV: time of test Within-subjects IV: condition Post-hoc tests: repeated-measures and independent t-tests
4) Does the training have an impact on the types of resolution strategies employed?	*Descriptive analysis of resolution sub-categories according to group and test time*
Alliance self-ratings	
5) Therapists and their corresponding patients in the experimental group will have higher alliance self-ratings at post-test than at pre-test and compared to those in the control group.	*Repeated-measures ANOVA* DVs: Therapist and actor alliance ratings at the end of the role-play Between-subjects IV: time of test Within-subjects IV: condition

4 Results

For all the following analyses, significance was designated at $p < 0.05$.

4.1 Sample

The therapist questionnaire administered directly after the role-play measured a series of variables related to their assessment of the situation, performance and feelings at both test times (Table 6).

Table 6: Therapist role-play questionnaire

	Groupe contrôle		Groupe expérimental			
Mesure	**Pre-test**	**Post-test**	**Pre-test**	**Post-test**	***F***	***p***
Stress	4.86 (2.07)	4.22 (2.19)	5.72 (1.90)	5.65 (1.98)	*0.69*	*ns*
Réalisme	7.67 (2.57)	7.53 (1.78)	7.44 (1.62)	7.28 (1.76)	*0.02*	*ns*
Confort	4.30 (1.77)	4.93 (2.33)	4.04 (2.65)	4.94 (2.56)	*0.05*	*ns*
Efficacité	4.38 (2.20)	4.68 (2.32)	4.54 (1.92)	4.50 (2.27)	*0.17*	*ns*
Confiance	4.51 (2.24)	4.93 (1.99)	4.42 (2.27)	4.79 (2.26)	*0.02*	*ns*
Satisfaction	4.81 (2.59)	4.99 (2.29)	5.14 (2.22)	4.64 (2.33)	*0.66*	*ns*
Adhérance	5.08 (2.08)	5.11 (2.08)	5.23 (2.37)	5.41 (2.06)	*0.07*	*ns*

Note: *F* reported is that of the interaction between test time and group.

Stress was moderate, although slightly higher at post-test for both groups. This finding is important as higher levels of stress could have negatively impacted their performance and thus complicated the interpretation of the 3RS results. Moreover, the moderate levels of stress could imply that the dummy role-play served its purpose in habituating therapists to being in a test environment. The role-plays, although artificially designed, were judged as quite realistic. Given the obvious differences with a real therapy session, it is reassuring that therapists still felt the material brought by the professional actors was credible. Comfort, efficacy, confidence and satisfaction yielded average ratings, as did the therapists' sense of having adhered to their primary training model. To test for differences according to time and group, a factorial mixed-design ANOVA was conducted for all measures. No significant differences were revealed. Stress almost reached significance ($F(34) = 3.64$, $p = 0.065$) indicating that the experimental group had slightly higher levels of stress

compared to the control group, however the effect size of this difference is small ($d = 0.24$).

These preliminary sample analyses as well as those conducted on therapist profiles in the Methods section suggest that both groups were similar in terms of experience and training, as well as in relation to their assessment and evaluation of their performances in the role-plays. Hence, any significant differences found cannot be attributed to these variables.

4.2 Rupture markers

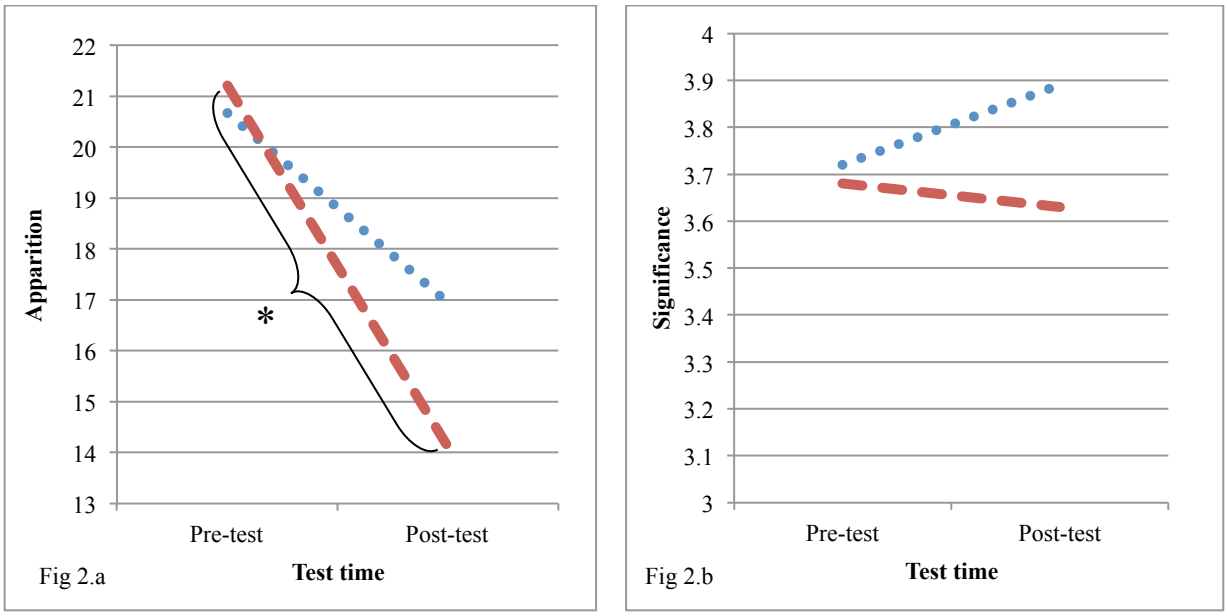
The first research question hypothesised that there would be fewer clear rupture occurrences in the experimental group's post-test role-plays, as they would be addressed immediately. Table 8 in Appendix 1 contains detailed scores per category of rupture markers.

4.2.1 Confrontation

The first two multivariate models tested the appearance and significance of confrontation markers separately according to time (pre-training vs. post-training) and condition (experimental or control group). Since there are only two levels per independent variable, as in all models presented below, Mauchly's assumption of Sphericity is met each time.

Regarding appearance, there was a significant main effect of time ($F(1,35) = 7.17$, $p = 0.011$), with fewer occurrences at post-test as compared to pre-test in both groups. However, the effect size was small ($r = 0.17$). No main effect of group was found ($F(1,35) = 0.33$, *ns*) and there was no significant interaction ($F(1,35) = 0.70$, *ns*), indicating that the appearance of confrontation markers evolved similarly in both groups across time. Post-hoc analyses were conducted to explore the decrease in confrontation ruptures from pre-training to post-training according to group. As shown in Figure 2.a, the decrease from pre to post-test was only significant for the experimental group ($t(18) = 3.58$, $p < 0.005$, $d = 3.22$). Although therapists in the control group tended to encounter more confrontation ruptures at post-test compared to the experimental group, the difference was not statistically significant ($t(35) = -0.18$, *ns*).

Figure 2: Impact of training on confrontation markers



Legend * $p < 0.005$

Control

Experimental

Concerning the significance of these ruptures, neither a significant main effect of time ($F(1,35) = 0.17$, *ns*) nor group was found ($F(1,35) = 1.07$, *ns*). Similarly, the interaction was non-significant ($F(1,35) = 0.61$, *ns*). This suggests that confrontation markers had comparable significance levels at both test times in the two groups, ranging from some impact to moderate impact on the alliance (Fig 2.b).

Although only global scores of appearance and significance were analysed above, it would be interesting to explore whether the training affected the types of confrontation ruptures displayed by the actors. In general, complaints concerning the therapist, activities or progress of the therapy as well as attempts to control or put pressure on the therapist appeared the most at both test times. Differences will only be explored descriptively according to the Figures 8.a and 8.b in Appendix 2. It was decided that the difference in mean scores of clarity was significant only if superior to 2 points. Following this rule, the types of confrontation ruptures

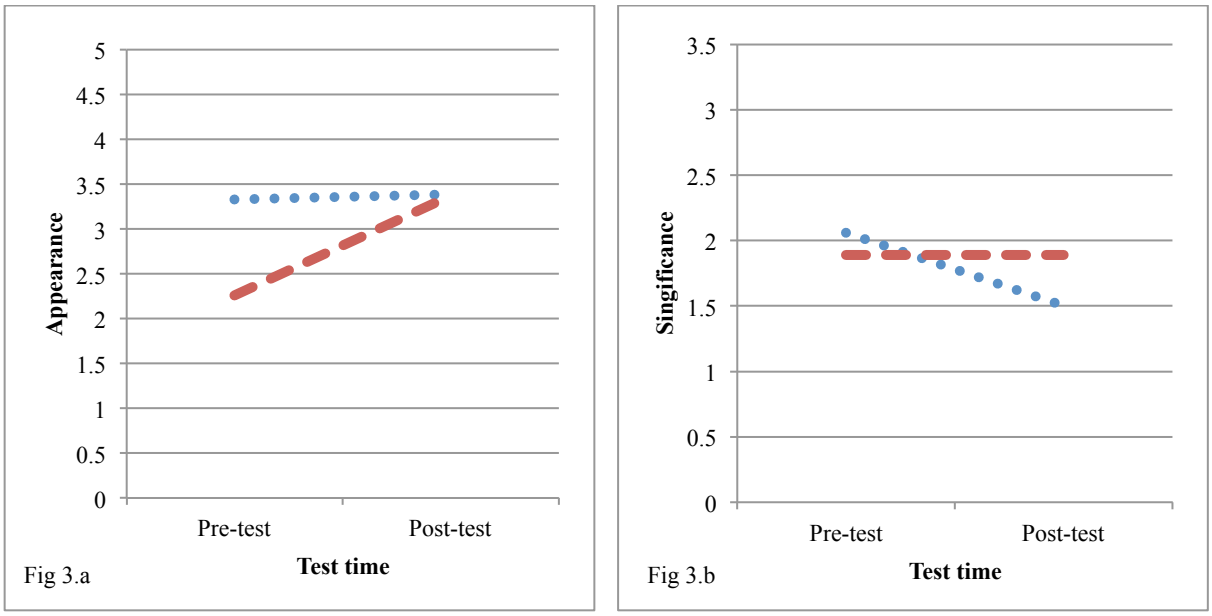
used were similar amongst the two groups at pre-test, although there was a tendency for the experimental group to have encountered more complaints concerning the progress of therapy. At post-test, this tendency was reversed and reached the significance level determined, such that therapists in the control group were confronted with more complaints concerning the progress of therapy than those in the experimental group. Otherwise, no differences between the groups were identified.

4.2.2 Withdrawal

The appearance of withdrawal rupture markers remained relatively stable across time for both groups. A slight increase can be observed in the experimental group (Fig 3.a) but no significant main effects of time ($F(1,35) = 0.87$, *ns*) or group ($F(1,35) = 0.42$, *ns*) were found and the interaction was also non-significant ($F(1,35) = 0.71$, *ns*). Withdrawal ruptures appeared noticeably less than confrontation ruptures, consistent with the instructions given to the professional actors. Indeed, taking into account that a score of 2 indicates one clear marker and 1 an unclear rupture, there were on average two to three occurrences of withdrawal ruptures per role-play, compared to around 14 to 21 confrontation markers.

The same analyses were replicated for the significance of withdrawal ruptures, no significant main effects of time ($F(1,35) = 1.04$, *ns*) and group ($F(1,35) = 0.17$, *ns*) were detected and the interaction also failed to reach significance ($F(1,35) = 1.04$, *ns*). Withdrawal markers were slightly less significant than confrontation ruptures, averaging around a score of 2, representing a minor impact on the alliance. These findings suggest that the training did not have any discernable impact on withdrawal ruptures, both in appearance and significance (Figure 3).

Figure 3: Impact of training on withdrawal markers



Given that the mean appearance of each category of withdrawal was never superior to 1.37, the descriptive analysis conducted for confrontation markers could not be repeated here. Nonetheless, it appears that experimental and control therapists faced similar withdrawal experiences; at both pre and post-test, the most frequent withdrawal rupture markers were minimal responses and being self-critical or hopeless in both groups (Figures 9.a and 9.b in Appendix 3).

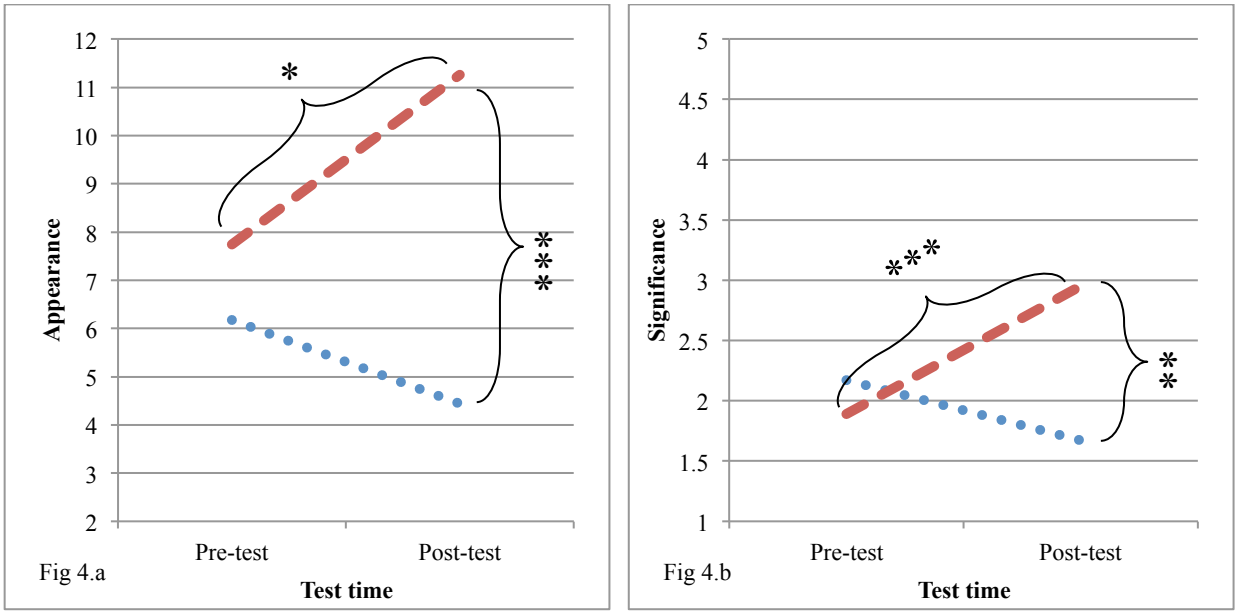
4.3 Resolution strategies

The third hypothesis posited that, as a result of the training, the experimental group would use more resolution strategies and be more successful in their resolution attempts at post-test than the control group.

There was no significant main effect of time on appearance of resolution strategies ($F(1,35) = 1.10$, *ns*) but the main effect of group was significant ($F(1,35) = 11.19$, $p = 0.002$, $r = 0.24$), as was the interaction of both variables ($F(1,35) = 9.30$, $p = 0.004$, $r = 0.21$). Indeed, whilst resolution

strategies appeared with similar frequency and clarity at pre-test by both groups, it seems that at post-test the experimental group employed significantly more strategies than the control group (Fig 4.a). Post-hoc analyses further support this result in that therapists in the experimental group used significantly more strategies after the training ($t(18) = -2.70$, $p < 0.05$, $d = 0.71$) and as compared to the control group at post-test ($t(35) = -4.56$, $p < 0.0001$, $d = 1.50$).

Figure 4: Impact of training on resolution strategies



Legend * $p < 0.05$ ** $p < 0.0005$ *** $p < 0.0001$

Control

Experimental

The global significance of resolution did not differ significantly according to time only ($F(1,35) = 2.08$, *ns*), nor according to condition only ($F(1,35) = 3.62$, *ns*), though when taking into account condition and time, the interaction was significant ($F(1,35) = 16.44$, $p < 0.001$) with a moderate effect size ($r = 0.32$). Whilst global resolution significance decreased slightly according to time for the control group, the score increased for the experimental group who achieved a significantly higher resolution at post-test (Fig 4.b). Post-hoc analyses corroborate these findings: the significance of resolution attempts

increased from pre to post-test for the experimental group ($t(18) = -5.03$, $p < 0.0001$, $d = 1.61$) and were higher than the control group's after the training ($t(35) = -3.90$, $p < 0.0005$, $d = 1.28$).

Both groups had a mean resolution score of approximately 2 at pre-test, representative a below average resolution. According to the 3RS coding manual, this indicates that either "minor ruptures were not resolved or major ruptures were only slightly resolved" (Eubanks et al., 2015, p. 9) where strategies employed do not impact the alliance, neither positively nor negatively. The control group's global resolution score slightly decreased at post-test whereas the experimental group's increased to nearly reach a score of 3. The manual describes the latter as an OK or average resolution where "ruptures were at least partly addressed and resolved" (Eubanks et al.,2015, p. 9). In such sessions, therapist and patient are generally capable of communicating and agreeing on tasks and goals and have some form of relational bond.

Perhaps interesting to note is that there were more confrontation markers than resolution strategies at both test times (see Tables 8 and 9 in Appendix 1), such that there was approximately one resolution attempt for every three ruptures at pre-test for both groups. At post-test, however, the therapists in the control group displayed one resolution strategy for every four or so confrontation marker whereas in the experimental group degrees of appearance almost match. This could indicate that for every confrontation rupture identified, therapists who had received the training attempted to resolve it. Correlations between appearance of resolution strategies and confrontation rupture markers do not however, support this hypothesis. Indeed results were non-significant for the experimental group at post-test ($r = 0.11$, *ns*) whereas analyses on pre-test scores yielded a significant correlation ($r = 0.52$, $p < 0.05$). Moreover, the same analyses for the control group scores were non-significant at pre-test ($r = 0.27$, *ns*) and almost reached the significance level at post-test ($r = 0.47$, $p = 0.051$).

Regardless of experimental condition, therapists used similar resolution strategies most frequently, such as illustrating the task or providing a rationale for the treatment and inviting thoughts and feelings (Figures 10.a

and 10.b in Appendix 4). These could be described as surface-level interventions, which are potentially easier to learn and apply in-session than in-depth relational exploration strategies. Indeed, linking the rupture to larger patterns between patient and therapist or with other relations were strategies hardly used by either group. In contrast, changing the tasks or the goals of the therapy, although relatively easy to implement, was not used as frequently as could be expected. Applying the 2-point difference rule to determine descriptive significance did not yield any results. However, therapists who had participated in the training tended to invite the patient's thoughts and feelings, disclose their own internal experience of the rupture or relationship and acknowledge their own contribution to the rupture more often than those who didn't receive the training. Interestingly, at pre-test, the experimental group tended to illustrate the task or the rationale for therapy relatively more frequently than the control group, although not significantly so. At post-test, the difference between the groups is reduced for this strategy in particular. This descriptive analysis, although infructuous in relation to the significance level, shows that whilst therapists in the control group vary very little according to test time in the types of resolution attempted, those in the experimental group increase implementation of certain types of strategies, but not all.

4.4 Alliance self-ratings

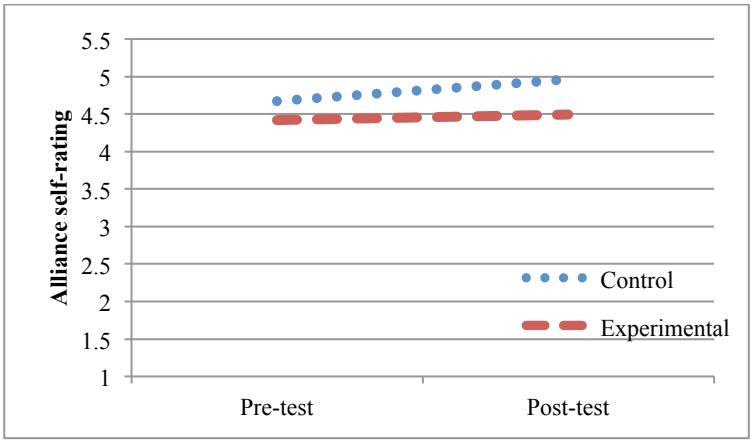
It was thought that the training would also have a beneficial impact on the alliance self-ratings representative of the end of the role-play in that they would be higher at post-test in the experimental group as compared to the control group for both therapist and actor. Separate multivariate analyses were conducted for therapist and actor alliance self-ratings and finally a factorial multivariate model was used to compare both role-play participants. As for the models on the 3RS scores, given that each variable had only two levels, Mauchly's assumption of sphericity was met for all below analyses

4.4.1 Therapists

Therapists' end of role-play alliance scores remained stable across time and group as shown by non-significant main effects of time ($F(1,35) = 0.11$,

ns), group ($F(1,35) = 0.54$, *ns*) and the interaction between time and group ($F(1,35) = 0.40$, *ns*). Therapists in the control group tended to rate the alliance as slightly higher than those in the experimental group (Figure 5), but only marginally so as statistical analysis did not support any significant difference in their ratings.

Figure 5: Impact of training on therapist alliance ratings

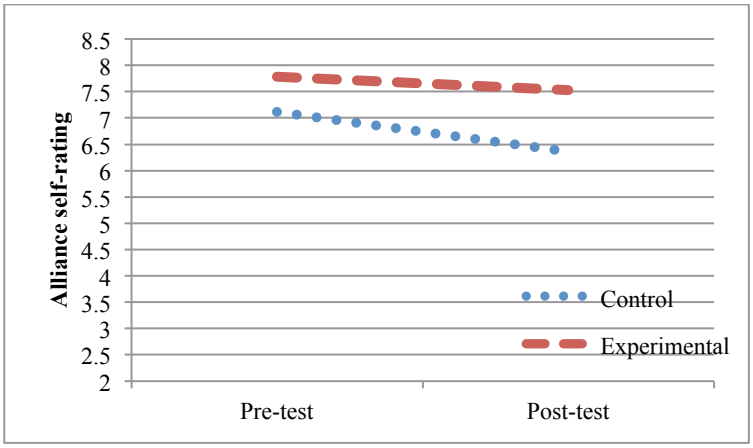


Therapists' ratings of the alliance at the end of the role-play at pre-test were not correlated with their respective ratings at post-test, for both the control ($r = -0.07$, *ns*) and experimental groups ($r = -0.13$, *ns*), suggesting that the evaluations at post-test were independent from those at pre-test.

4.4.2 Actors

The alliance of the end of the role-play, as perceived by the actors, also barely evolved according to test time in both groups although a slight decrease can be observed in the control group (Figure 6). Statistical analyses did not support any significant differences as main effects of time ($F(1,35) = 0.58$, *ns*), group ($F(1,35) = 2.56$, *ns*) as well as the interaction failed to reach significance ($F(1,35) = 0.14$, *ns*).

Figure 6: Impact of training on actor alliance ratings



Similarly to therapists' ratings, the actors' evaluations of the alliance at post-test were not correlated with their previous scores in the experimental role-plays (r = 0.23, *ns*). Analyses of the control evaluations nearly yielded a significant result (r = -0.41, p = 0.09), indicating a potential bias. However, when combining scores from the two groups, the correlation was small and non-significant (r = -0.13, *ns*).

4.4.3 Comparison between therapists and actors

As illustrated in Table 7, therapists consistently judged the alliance as weaker compared to the actors, with relatively low scores for both groups at both test times. The factorial multivariate analyses partially supports this difference since the main effect of person (therapist vs. actor) was significant (F(1,35) = 64.66, p < 0.0001, r = 0.65) and the interaction between person and group almost reached significance (F(1,35) = 3.99, p = 0.054, r = 0.10). Main effects of time (F(1,35) = 0.10, *ns*) and group (F(1,35) = 0.43, *ns*) and other interactions were non-significant.

These results suggest that therapists rated the alliance as significantly lower than the actors in both groups but the evolution from pre to post-test was similar for both parties. Post-hoc independent t-tests further reveal that while the difference between actor and therapist ratings was significant for both groups at both test times, effect sizes were larger in the experimental group, indicating a higher discrepancy as compared to the control group (Table 7).

Table 7: End of role-play alliance self-ratings

	Pre-test		Post-test	
	Contrôle	**Expérimental**	**Contrôle**	**Expérimental**
Thérapeute	4.67 (2.15)	4.42 (1.93)	4.96 (2.36)	4.49 (2.35)
Acteur	7.12 (2.90)	7.79 (1.80)	6.36 (3.07)	7.53 (2.83)
t	-3.77**	-5.45****	-2.69*	-5.13***
d	0.70	1.39	0.37	0.90

Légende M (SD) *** p < 0.05 ** p < 0.005 *** p < 0.0005 **** p < 0.00005**

Correlations extended the exploration of the relationship between therapist and actor's evaluations of the alliance. Combining results from both groups, both participants' self-ratings were significantly and positively correlated only at post-test ($r = 0.57$, $p < 0.0005$). The size of this correlation increased when taking into account only the control group's post-test ratings ($r = 0.70$, $p = 0.001$) whereas it was slightly lower for the experimental group ($r = 0.52$, $p = 0.024$). Interestingly, in the control group, post-test therapist's ratings were significantly and negatively correlated with actor's ratings at pre-test ($r = - 0.47$, $p = 0.05$). This result suggests a bias in therapist's ratings at post-test as they seem to have been influenced by the alliance judged by the actors at pre-test.

5 Discussion

5.1 Main findings

5.1.1 Rupture markers and resolution strategies

The primary aim of this paper was to examine whether a French version of AFT had an impact on therapists' ability to address and successfully repair alliance ruptures. As a secondary objective, the impact of the training on the alliance as rated by therapists and actors was also explored. The expected effect was that fewer ruptures would occur in experimental therapist-actor dyads following the training due to a higher and more successful use of resolution strategies. In turn, this enhanced rupture resolution would lead to greater alliance ratings on both parts.

Results suggest that rupture resolution training does not have an impact on the degree of appearance or significance of confrontation and withdrawal ruptures. Although a notable decrease in the appearance of confrontation ruptures was identified in the experimental group following the training, it was not significantly different to the appearance of such ruptures in the control group's role-plays at the same test time. Indeed, confrontation ruptures declined in both groups, indicating a bias in the actor's performances linked to a habituation to test conditions. This interpretation of the results is made all the more plausible by the fact that the same actors were used at both test times. In any case, the training did not render confrontation ruptures any less significant to the alliance, nor did it diminish the appearance or significance of withdrawal ruptures. The fact that ruptures appeared to a similar degree and with comparable importance, regardless of whether the therapists had received training or not, is also indicative of a lack of favouritism on the actor's part, validating their performance and the study design to some degree. On the one hand, the above results support the notion that therapy is a negotiation process in which tensions are inevitable and the exploration of ruptures may lead to more ruptures (Eubanks et al., 2014). On the other, it could be that, despite having been trained, therapists did not address and resolve ruptures adequately, so that their interventions led to more ruptures because of their untimely use (Coutinho et al., 2011). It could

be the case that therapists in both groups exacerbated ruptures to a greater extent at pre-test than at post-test. However, since therapist contribution was disregarded for the sake of simplicity, this hypothesis could not be verified.

This study tends to show a positive impact of the training on the degree of appearance as well as success of resolution attempts. Therapists who received rupture resolution training performed significantly better in terms of detecting the ruptures that occurred and addressing them. Furthermore, the interventions made were more meaningful and beneficial to the alliance and to the "patients". Thus, therapists can acquire new interpersonal skills that foster a good therapeutic alliance through appropriate training. The training appeared to influence the types of interventions used by the therapists, namely in relation to inviting the patient's thoughts and feelings, disclosing one's internal experience of the relationship and acknowledging their own contribution to the rupture. These reflect invitations for both parties to explore the therapeutic relationship in the here and now, or in other words, to metacommunicate about rupture events. The therapist acknowledging his or her contribution to the rupture is one of the fundamental skills taught in AFT (Safran & Muran, 2000; Eubanks et al., 2014) and therefore it is encouraging to see that the training provided in the context of this research was successful in that regard. Therapists who did not receive the training tended to address ruptures by illustrating the rationale for the task or the treatment and also by inviting the patient's thoughts and feelings, although still less often than the experimental group. Perhaps these two strategies could be considered as fundamental therapeutic interventions, especially in cognitive-behavioural therapy. To conclude on this section, not only was the training effective in teaching basic metacommunication skills, but also in developing a key therapist attribute to recognise the potential negative impact of his or her own behaviours. In addition, it appears that some strategies occur quite naturally and spontaneously and do not require intensive training to master, whilst others may be harder to use in the right circumstances and, perhaps more importantly, successfully.

In spite of this promising outcome, other crucial components of rupture resolution were hardly displayed by the therapists. Most noteworthy is the

relative absence of linking the rupture to larger interpersonal patterns between the patient and the therapist as well as in the patient's other relationships. Considering Safran and Muran's (2000) resolution model, these reflect direct, in-depth interventions that can both explore tensions in the relational bond and disagreements on tasks and goals by addressing core relational themes. In doing so, therapists open the door to providing a new relational experience for the patient by refusing to re-enact dysfunctional schemas. Instead, and by using the afore-mentioned strategies, metacommunication favours stepping out of the vicious cycle and exploring the relationship in the here and now. Furthermore, although the significance of therapist's resolution attempts improved, the mean global resolution score of the experimental group was only of 3, or an OK/average resolution, where the alliance is also typically average (Eubanks et al., 2015).

In addition, the training had the surprising effect of *reducing* the link between appearance of rupture markers and resolution strategies, suggesting that accurate rupture resolution may be more complicated than the simple adherence to the model. Excessive application of technique rather than focusing on interpersonal concerns is known to have detrimental effects on both the therapeutic relationship and patient outcome (Binder & Strupp, 1993). Although AFT favours and encourages treating each relationship as unique and focusing on the here and now, training programs should ensure that basic principles are understood and are effectively put into practice.

Nevertheless, it would be wise to also take into account the study design before drawing conclusions. Two potential interpretations can be put forward: the role-play system was inadequate and/or the duration of the training was insufficient. The role-plays lasted only 20 minutes and were artificial, despite being seen as realistic by the participants. Exploring core relational schemes occurs at a deeper level, possibly beyond the scope of these test conditions. It is undoubtedly difficult for even an accomplished and experienced therapist to engage in deeper relational elaborations with a patient he had just met, let alone for trainee therapists under the stress of test conditions. Moreover, such interventions could require a strong alliance to be put into practice and successful; patients may be reluctant to address such topics without having

established a trustworthy and secure relationship with their therapist. Further research could address this issue by using a more naturalistic design, notably by examining the impact of training on real clinical therapy sessions.

Alternatively, the duration and content of the training may not have sufficed to develop certain resolution skills that were clearly lacking in the role-plays. AFT is administered in the form of weekly group supervision sessions over the course of treatment (from 14 to 30 sessions, depending on the study) where trainees have the opportunity to discuss difficulties encountered with patients after having been introduced to the training material. In addition, the supervisory component of AFT allows for personalised advice on how to apply specific interventions in a timely and appropriate fashion (Eubanks et al., 2014; Safran et al., 2014). Conceivably, teaching the set of skills necessary in order to successfully manage all types of ruptures that can occur in psychotherapy sessions may have simply been an unattainable objective for the present study, considering the restricted time frame. The average therapist confidence and efficacy scores in both groups also substantiate the hypothesis that trainee therapists may need more time and practical experience to feel comfortable integrating resolution techniques into their practice. These elements combined with intensive supervision may be necessary for therapists to be most effective and successful (Coutinho et al., 2011). Supervision for issues in a particular therapist-patient dyad will understandably produce wide variability, however this way of training respects the fundamentals of psychotherapy, that each dyad is unique and requires particular attention (Safran et al., 2014). Due to the study design and resources available, it was not possible to implement these elements into this research. Rather, it served as an introduction to rupture resolution, including videotape analyses and the opportunity to exercise therapist self-awareness but no comprehensive mindfulness training. The lack of mindfulness and metacommunication practice in this study's training course could have influenced the present results, specifically that therapists barely employed resolution strategies requiring more advanced metacommunication abilities. General rules and specific techniques are necessary but it is important to keep in mind that there is no one trick that will resolve all ruptures with all types of

patients. Rather, each therapeutic relationship should be built piece by piece, on an individual basis.

5.1.2 Alliance self-ratings

The present study revealed that the training had no significant positive effect on both therapist and patient alliance self-ratings. Although there was a slight decrease in actor's ratings was seen in the control group at post-test, it was not significantly different to the experimental group's at the same test time. Furthermore, the expected effect of the training was to increase ratings for both parties and this was not supported by the data. Findings from previous research were replicated in that therapist and patient perceive and thus score the alliance differently (Horvath et al., 2011). Irrespective of test condition, there was only a moderate significant correlation between therapist and actor self-ratings. Comparisons between therapist and fictitious patient's view of the alliance according to group point towards a higher discrepancy in the experimental group at both test times, possibly indicating a bias linked to the stress of being evaluated. Although the difference in stress levels between groups pre-training and post-training failed only just to reach statistical significance, the experimental group experienced the role-plays as more stressful by 1 point on the scale. Several results from these analyses point to potential biases, both in therapist and actor's ratings of the alliance. Therefore, caution should be exercised and it is difficult to give meaning to these findings.

It is tempting to conclude that although the training had an impact on data obtained from observers' ratings, no improvement was discernable in terms of how the primary concerned perceived the alliance. This could potentially call into question the relevance of providing training if neither patient nor therapist feels the bond is made stronger. However, the differential impact of training on alliance measures and 3RS ratings could be due to different processes being assessed. For example, Crits-Christoph and colleagues (2006) conclude that the WAI measures the relationship across one whole session whereas the 3RS is more time-sensitive and detailed. Even though the measure used here attempts to capture the alliance at different points in time,

it is important to keep in mind that the alliance questionnaire was given at the end of the role-play and thus the beginning and middle ratings could be influenced by events in the last segment and not reflect the reality of the role-play. Besides, it is possible that the therapists' attempts at resolving ruptures were not significant enough to the alliance to induce an increase in the ratings. Both groups' global resolution scores at pre-test were indicative of a below average resolution. In contrast, confrontation ruptures' global significance ratings were much higher, nearly reaching a mean score of just under 4, or of moderate significance to the alliance. This discrepancy could have played an important role in the perceptions of the quality of the relationship.

5.2 Limitations

There are several limitations to this study. To begin with, limitations related to the 3RS will be discussed. The first version of the coding procedure manual (Mitchell et al., 2011) was used for the majority of the data presented here. During the coders' training, several of its shortcomings were brought up, most particularly concerning rupture marker differential "diagnosis". Indeed, some of the examples and illustrations provided did not completely satisfy requirements when trying to choose between two sub-categories. Since only one example was provided per marker or resolution strategy, it was sometimes problematic to draw parallels with the data collected for this study. As a group, it was decided that the most important task was to correctly identify the rupture as either confrontation or withdrawal, rather than spend excessive amounts of time determining which sub-category was the best fit. The most recent version of the manual (Eubanks et al., 2015) is far more comprehensive and includes numerous examples of each marker as well as excerpts from real clinical cases. A special section is also dedicated to differential diagnosis and is extremely helpful and detailed. Choosing a score of significance to the alliance of ruptures and resolution strategies as well as a global resolution score remained also elusive from time to time, giving an overall sense that this procedure was highly subjective, in spite of good inter-reliability amongst judges. This has also been improved upon in the latest manual, particularly with regard to the global resolution score. Due to

logistical and time constraints, it was not possible to recode all videos consistent with the new guidelines. Global resolution scores remained as according to the scale in the 2011 manual, and this could be the reason why the mean is relatively low in this sample. Another drawback noted was that coding the role-plays according to the 5-minute segments proved to be awkward at times. Proceeding in such a manner arbitrarily interrupts the flow of events watched, sometimes in the middle of a very rupture or resolution. Understandably, there are numerous advantages, particularly for research purposes, in such partitioning, especially when coding videos longer than 20 minutes. However, in terms of understanding and dissecting the content and what is actually occurring in the alliance, segmentation was occasionally unfortunate.

A second limitation related to the 3RS is the ambiguous measure of rupture appearance. Each rupture and resolution marker is rated according to its clarity; these scores were converted into numerical form for analysis. However, summing up these scores created an ambiguous variable rendering interpretation problematic. Indeed, a total score of 14 ruptures for example could either indicate 14 unclear or seven clear occurrences. Despite the fact that rating the clarity of the rupture has advantages, a well-defined frequency score could have been more relevant in the context of this research.

In terms of study design, a bias in actor's performances and ratings could have influenced results from the 3RS coding. Even though the study was designed such that therapists did not encounter the same actors from pre to post-test, it is highly probable that actors used their experiences of the pre-test role-plays to evaluate therapists' performances at post-test. Although the actors were blind to experimental condition, they were obviously aware of test time, which is difficult to conceal. That is, they knew that all therapists were somewhat equivalent in the first role-play but that they may experience some improvement at post-test. Naturally, using actors instead of collecting data from real therapy sessions is also a significant limitation in the study's design. In terms of practicality and study feasibility however, this enabled an evaluation of a French rupture resolution training program, a first in French-speaking countries.

Some limitations of the alliance measure have been briefly mentioned above; these will at present be examined more thoroughly. The alliance measurement used lacked in sensitivity and reliability as shown by trends in ratings. For example, the rupture or resolution events participants thought about when rating the alliance at the beginning, middle and end of the role-play may be somewhat falsified since they were all made at the end. To address this issue, it would have been more appropriate to either detail in the questionnaire the specific time segment to rate, for example "Thinking about the first five minutes of the role-play, how would you judge the quality of the alliance?" or to measure the alliance at the end of each 5-minute segment. Nonetheless, both options have disadvantages, for example interrupting the role-play every five minutes would surely have had a negative impact on the flow of the session and it is hard for participants to keep track of time when trying to perform under test conditions. Perhaps a more feasible and appropriate solution would have been to use the observer's rating of the alliance, which could have been done at the same time as the coding. Previous research has shown that observer's alliance evaluations tend to be comparable to the patient's (Horvath et al., 2011), so it would have been interesting to include this measurement and analyse its evolution according to rupture resolution training. Another limitation of this tool is that the alliance is a term well known by psychotherapy researchers and practitioners but less so by the lay population. Despite briefing the professional actors as to the study's general purpose and the concept of alliance ruptures, it is possible that the questionnaire used did not truly measure their perception of the quality of the relationship. Conversely, the WAI is designed to measure the alliance but with specific items on the degree of collaboration on tasks and goals as well as questions assessing the quality of the emotional bond rather than directly evaluating the alliance per se (Horvath & Greenberg, 1989). The items used in this study to measure the alliance were perhaps too general and certainly required some theoretical concept of the alliance to respond.

6 Conclusion

This study shows that alliance-focused training is effective, to a certain extent, in adding new skills to the therapists' repertoire that are focused on exploring and improving the quality of the relationship, essential for preventing patient dropout and instigating the process of therapeutic change (Safran, Muran & Eubanks-Carter, 2011). Some resolution interventions require more experience and intensive supervision to be successfully integrated and applied by trainee therapists. The data collected here failed to identify any improvement in alliance ratings, which questions the usefulness and pertinence of implementing such training. However, caution is advisable as several important limitations may account for these findings.

Managing negative processes is a challenging skill to teach psychotherapists (Strupp, 1993; Binder & Strupp, 1993). Given the central role played by the alliance in the process of therapeutic change, integrating alliance-fostering techniques into current training models should be of primary concern (Ackerman & Hilsenroth, 2001) in Switzerland. Safran and Muran along with their team (Safran et al., 2002; Safran & Muran, 2000; Eubanks et al., 2014) have endeavoured to promote such training and developed a comprehensive model exclusively targeted at alliance-fostering interventions. A few studies aimed at evaluating the efficiency of such training show promising results so far (Eubanks, Safran & Muran, 2014; Crits-Christoph et al., 2006).

The present research adds to the existing literature by examining the efficacy of rupture resolution training in French, however more research is needed to improve our knowledge not only in terms of content but also feasibility. The resources available did not permit this research to take place in naturalistic settings, a significant limitation in terms of applying these conclusions to clinical practice. There is no way of knowing the impact fictitious patients had on therapists' commitment and performance. In addition, the focus here was on confrontation ruptures, however, research shows that not only do withdrawal ruptures elicit different experiences in therapists and patients (Coutinho et al., 2011), but they also require different interventions to be resolved (Safran & Krauss, 2014). Future research could

address these concerns by conducting evaluations of patient-therapist dyads in private practices or institutions. In this context, types of ruptures would probably be more balanced and occur of their own accord rather than be enforced. This would also permit linking specific types of resolution strategies according to rupture categories.

The format and content of the training designed for this research may need perfecting in order to be more efficient. Limited resources prevented the inclusion of supervision as well as comprehensive mindfulness training. Further research on this topic should incorporate these elements, as they could be necessary to develop valuable and advanced rupture resolution skills. In addition, the duration of the module should be extended beyond the two half-days provided here. As done in AFT, trainee therapists would probably benefit from on-going supervision and support (Safran et al., 2014). In Switzerland, the format of postgraduate training is currently undergoing some changes and perhaps these findings could assist in an optimal design. Although the aim here was to examine the effectiveness of rupture resolution training on relatively inexperienced therapists, it would be interesting to explore whether similar results are obtained with more experienced therapists, who have completed their psychotherapy certificate. Perhaps the brief format of this training will yield even more encouraging results in this context.

Most recently, in the concluding remarks of a meta-analysis on therapist contribution to the therapeutic alliance, the question of screening was brought up: "Nevertheless, alliance-building behaviours may be difficult to teach, in which case it might be beneficial for clinical administrators and training programs to screen therapy trainees for these relevant behaviours and the ability to form alliances across a range of patients." (Del Re et al., 2012, p. 647). Evidence from the present study tend to support this notion, that some behaviours and skills are more easily mastered than others, and that perhaps those most important to exploring and improving the alliance remained unattainable. Whether this constitutes valid proof for screening trainee therapists or for intensifying the training process remains to be seen.

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Appendix 1

Table 8: Appearance and significance of rupture markers

Rupture marker	Pre-test		Post-test	
	Control	**Experimental**	**Control**	**Experimental**
		Withdrawal		
Denial	0.11 (0.47)	0.21 (0.63)	0.00 (0.00)	0.26 (0.65)
Minimal response	1.33 (1.14)	0.63 (1.17)	1.11 (1.53)	0.79 (1.18)
Abstract communication	0.00 (0.00)	0.05 (0.23)	0.00 (0.00)	0.37 (1.38)
Shifting topic	0.39 (0.83)	0.21 (0.63)	0.44 (1.10)	0.32 (0.95)
Deferential	0.28 (0.83)	0.32 (1.00)	0.00 (0.00)	0.05 (0.23)
Content-affect split	0.00 (0.00)	0.05 (0.23)	0.00 (0.00)	0.00 (0.00)
Self-critical/hopeless	0.22 (0.65)	0.79 (1.03)	1.06 (1.73)	1.37 (1.89)
Non-verbal	0.56 (1.34)	0.00 (0.00)	0.78 (1.67)	0.21 (0.92(
Other	0.44 (1.89)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total appearance	**3.33 (2.33)**	**2.26 (1.88)**	**3.39 (4.62)**	**3.37 (3.25)**
Global significance	**2.06 (0.64)**	**1.89 (1.15)**	**1.50 (1.47)**	**1.89 (0.66)**
		Confrontation		
Complaint therapist	4.56 (2.73)	3.84 (3.47)	3.61 (2.30)	3.11 (2.56)
Reject formulation	1.78 (1.90)	2.21 (2.10)	1.39 (1.50)	1.89 (1.94)
Complaint activities	3.78 (2.46)	4.26 (2.42)	3.83 (2.83)	3.05 (2.95)
Complaint parameters	2.39 (2.81)	0.84 (1.80)	0.89 (1.97)	1.37 (2.22)
Complaint Progress	2.56 (2.62)	3.74 (2.49)	3.61 (3.27)	1.53 (1.95)
Defends self	1.39 (2.06)	1.68 (2.31)	0.67 (3.27)	1.00 (1.67)
Control/Pressure	3.93 (2.43)	4.53 (2.93)	2.67 (2.70)	2.00 (1.83)
Non-verbal	0.39 (1.42)	0.00 (0.00)	0.28 (0.67)	0.16 (0.50)
Other	0.00 (0.00)	0.11 (0.46)	0.00 (0.00)	0.00 (0.00)
Total appearance	**20.67 (9.95)**	**21.21 (8.67)**	**16.94 (9.53)**	**14.11 (5.91)**
Global significance	**3.72 (0.58)**	**3.68 (0.58)**	**3.89 (0.68)**	**3.63 (0.60)**

Legend M (SD)

Table 9: Appearance and significance of resolution strategies

Resolution Strategy	Pre-test		Post-test	
	Control	**Experimental**	**Control**	**Experimental**
Clarify misunderstanding	0.39 (1.04)	0.63 (0.90)	0.17 (0.51)	0.95 (1.18)
Change task/goal	0.61 (1.50)	0.95 (1.68)	0.44 (0.85)	0.84 (1.21)
Illustrate rationale	1.28 (1.57)	2.42 (1.43)	1.44 (1.46)	1.95 (1.93)
Invite thoughts/feelings	2.11 (2.30)	1.95 (1.96)	1.67 (2.06)	3.00 (2.33)
Disclose experience	0.28 (0.58)	0.37 (1.01)	0.17 (0.71)	1.37 (1.61)
Acknowledge contribution	0.56 (1.34)	0.37 (1.12)	0.33 (0.69)	1.58 (1.71)
Link patient/therapist	0.22 (0.94)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Link other relations	0.33 (0.77)	0.47 (0.91)	0.11 (0.32)	0.58 (1.61)
Justify defence	0.39 (0.92)	0.58 (1.07)	0.28 (0.58)	1.00 (1.25)
Total appearance	**6.17 (4.42)**	**7.74 (4.94)**	**4.44 (3.67)**	**11.26 (5.25)**
Global resolution score	**2.17 (1.25)**	**1.89 (0.66)**	**1.67 (0.84)**	**2.95 (1.13)**

Legend M (SD)

Appendix 2

Figure 7: Categories of confrontation ruptures according to group and time

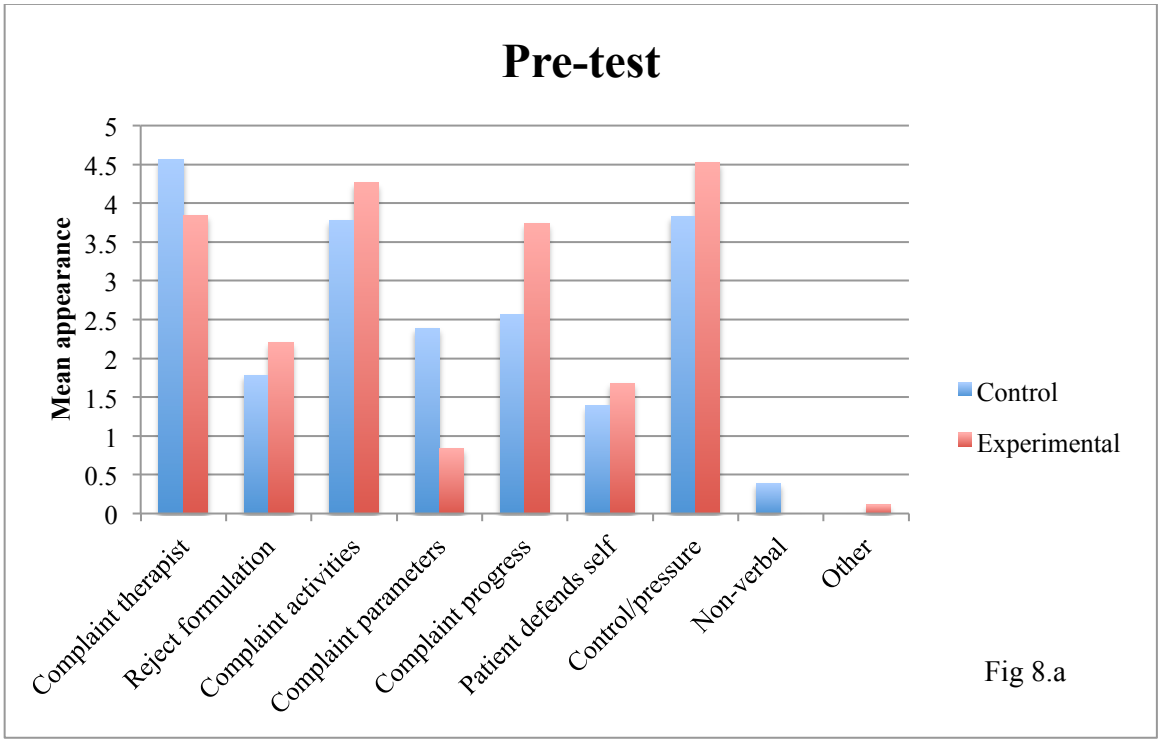


Fig 8.a

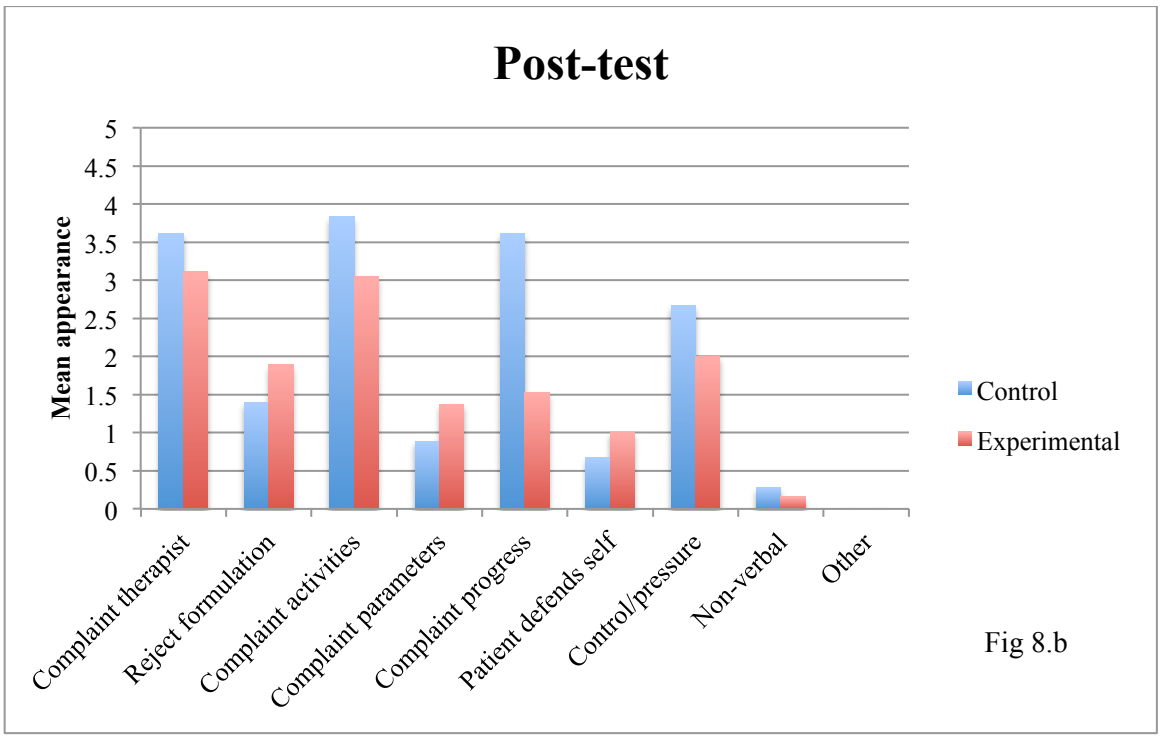


Fig 8.b

Appendix 3

Figure 8: Categories of withdrawal ruptures according to group and time

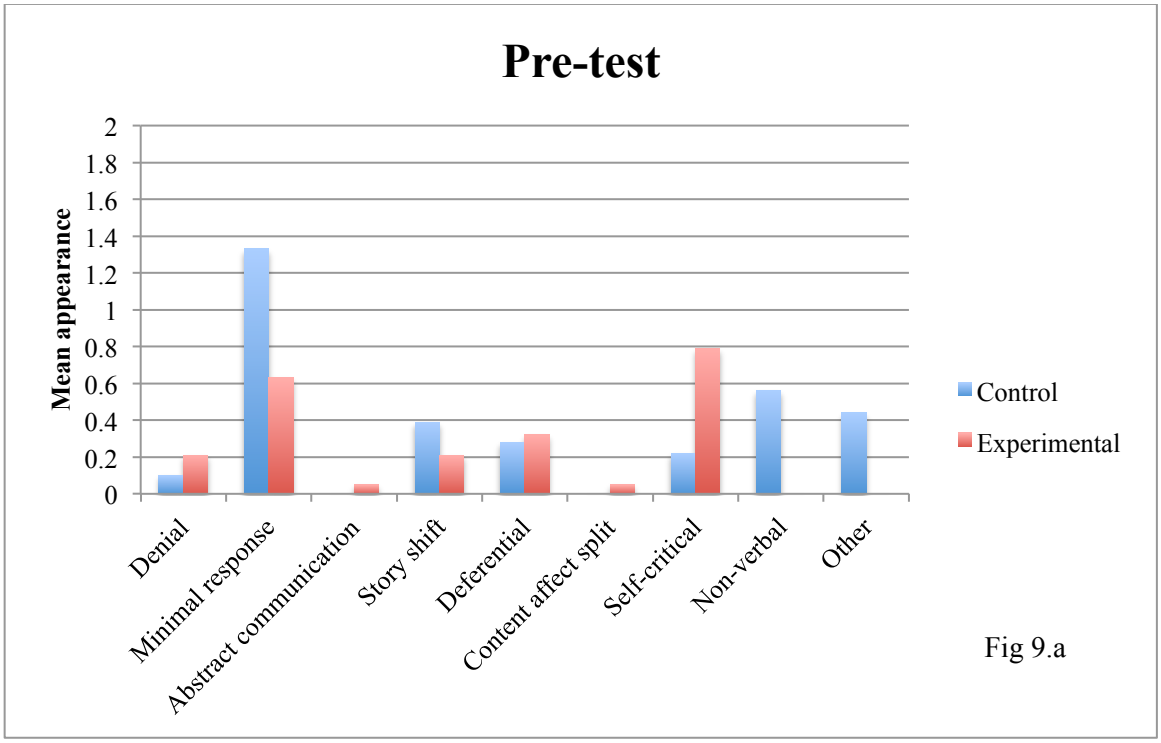


Fig 9.a

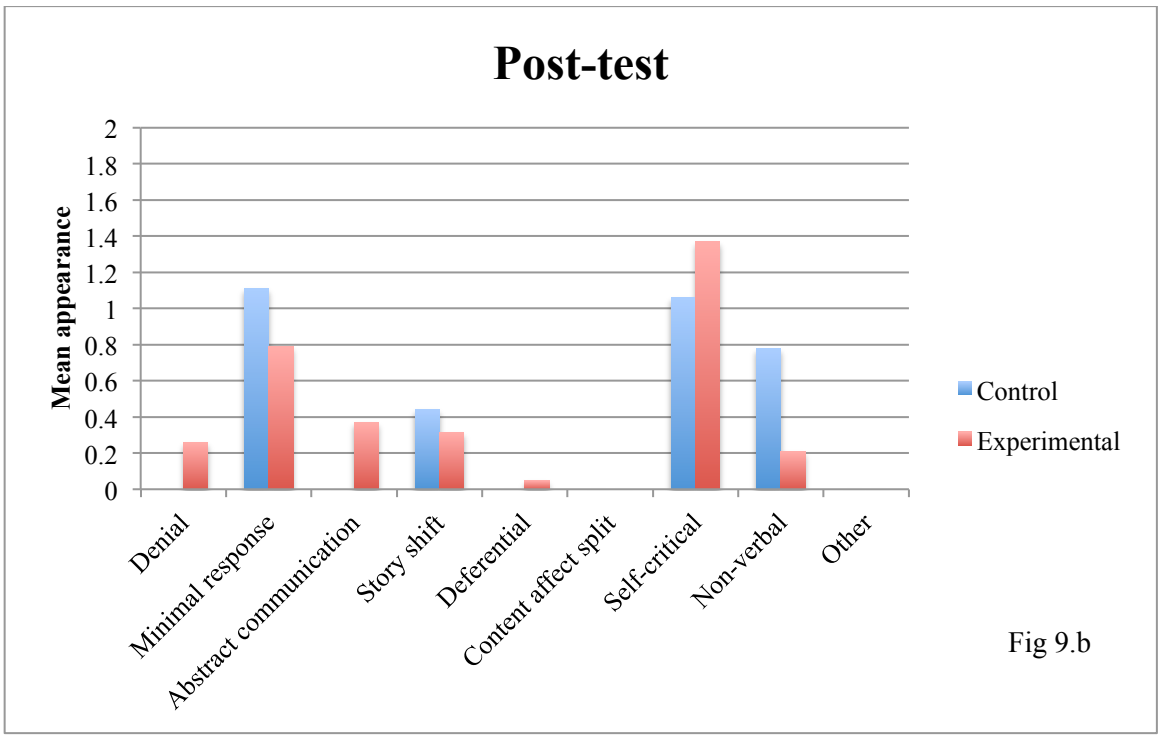


Fig 9.b

Appendix 4

Figure 9: Categories of resolution strategies according to group and time

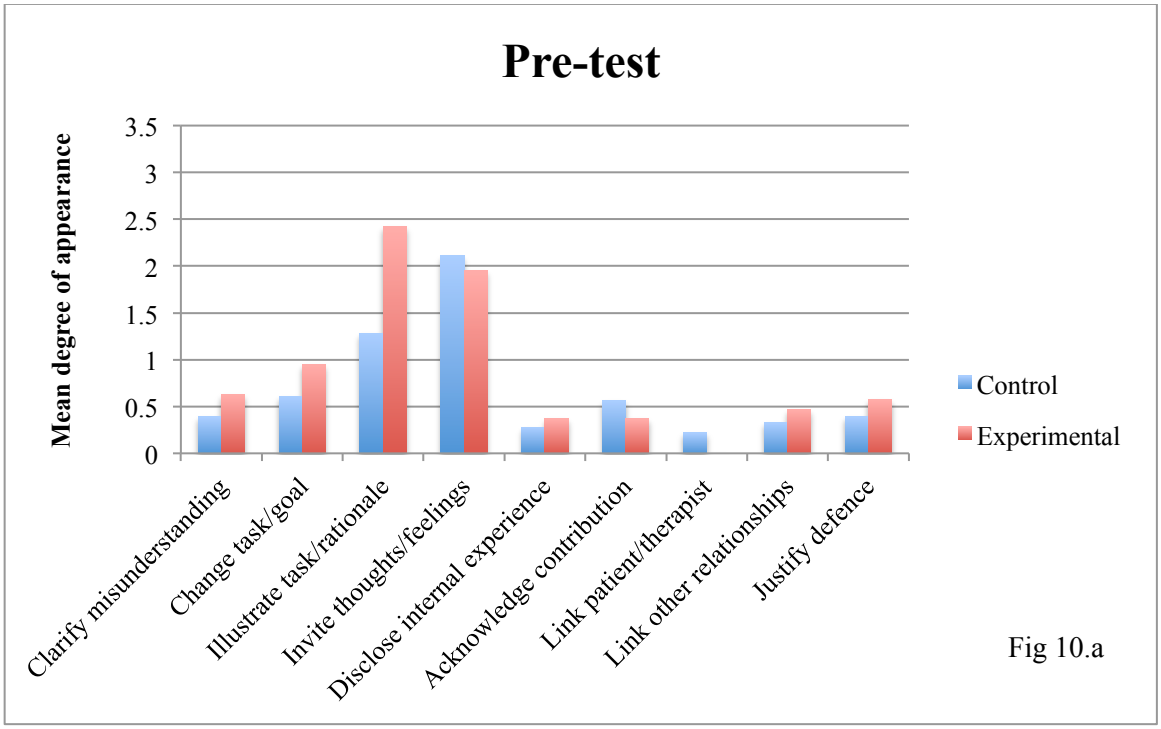


Fig 10.a

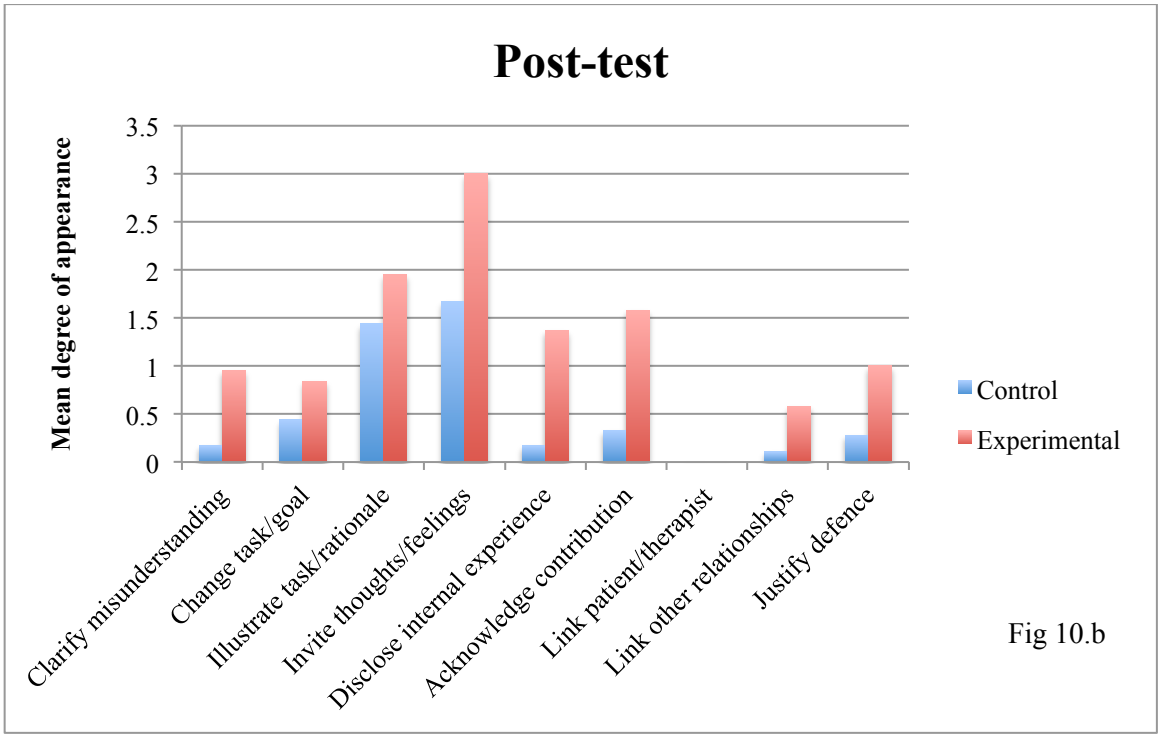
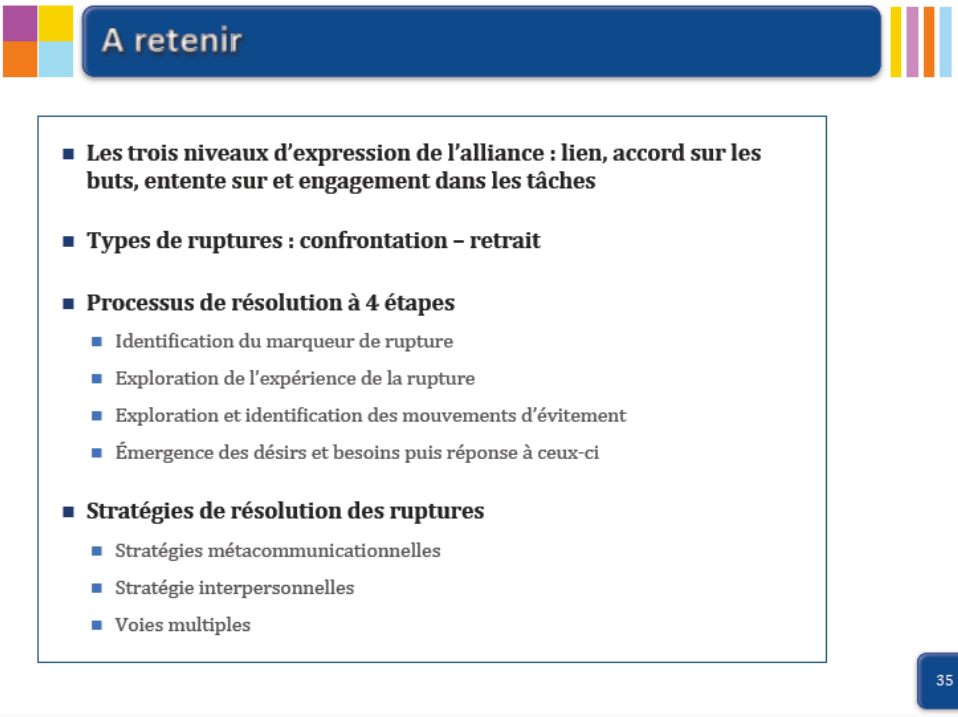


Fig 10.b

Appendix 5


En résumé
Comment restaurer l'alliance thérapeutique lorsque celle-ci est menacée?


A retenir
Les trois niveaux d'expression de l'alliance : lien, accord sur les buts, entente sur et engagement dans les tâches
Types de ruptures : confrontation – retrait
Processus de résolution à 4 étapes
Identification du marqueur de rupture
Exploration de l'expérience de la rupture
Exploration et identification des mouvements d'évitement
Émergence des désirs et besoins puis réponse à ceux-ci
Stratégies de résolution des ruptures
Stratégies métacommunicationnelles
Stratégie interpersonnelles
Voies multiples
35

Marqueurs de ruptures

RETRAIT

- Déni
- Réponse minimale
- Communication abstraite
- Changements de sujets, digressions
- Complaisance, apaisement
- Incongruence
- Autocritique / désespoir

CONFRONTATION

- Plaintes, critiques sur le thérapeute
- Rejet de la formulation / interprétation d'une manière non collaborative
- Plaintes, critiques au sujet des activités de la thérapie
- Plaintes, critiques au sujet du setting thérapeutique
- Plaintes, inquiétudes au sujet des progrès
- Défense de ses pensées, de ses opinions divergentes
- Tentatives directes d'exprimer une pression ou un contrôle sur le thérapeute

36

Stratégies de résolution

- Clarification d'un malentendu
- Changement des tâches ou des objectifs
- Explication, justification, illustration des tâches
- Expression, exploration des pensées ou sentiments concernant le thérapeute ou un aspect de la thérapie
- Révélation de soi : expression par le thérapeute de son expérience interne de la relation
- Reconnaissance explicite de la contribution du thérapeute au problème
- Lien entre rupture et pattern interpersonnel entre patient et thérapeute
- Lien entre rupture et pattern relationnel du patient avec d'autres personnes
- Alliance avec la résistance, légitimation de la rupture dans son aspect adaptatif

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Conclusion

Comment restaurer l'alliance thérapeutique lorsque celle-ci est menacée?

Que m'avez-vous appris?

- **Concordance - alliance**
  - Le désaccord n'est peut-être pas un signe de rupture
  - Problème de la pseudo-alliance → rupture malgré concordance
- **Dynamique :**
  - Variabilité du niveau / profil d'alliance au fil des répliques
- **Retrait : probable nécessité d'être en tant que thérapeute le signalisateur de la rupture (au risque sinon d'être en désaccord avec soi-même)**
- **Ne pas mélanger accord sur la thérapie et accord sur les tâches**

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- **Ne pas hésiter à coupler la révélation de soi avec l'exploration des pensées du patients sur le thérapeute**
  - L'attaque contre le thérapeute offre toujours la possibilité d'une réaction de ce type qui permet de déboucher sur : (1) la clarification des malentendus, (2) un travail de métacommunication, (3) une option de travail sur l'interpersonnel
  - La révélation nécessite un engagement plus important → attention à ses propres évitements
- **Retrait : probable nécessité d'être en tant que thérapeute le signalisateur de la rupture (au risque sinon d'être en désaccord avec soi-même)**
- **Même quand la rupture est consommée, il y a toujours quelque chose à faire, pour que cette dernière soit une expérience utile, éventuellement correctrice.**

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