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THE THERAPEUTIC ALLIANCE, RUPTURES, AND SESSION-BY-SESSION FEEDBACK

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A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology, validated by the University of Oxford

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Abstract

The therapeutic alliance has consistently been found to be predictive of good outcome across a number of different therapeutic modalities and in a number of different intervention types. Ruptures in the therapeutic alliance are critical points in therapy for exploration and change. Resolving ruptures in the therapeutic alliance can lead to a stronger therapeutic alliance and improved outcome, and unresolved ruptures in the therapeutic alliance have been linked to poor outcome and drop-out. Session-by-session feedback on the therapeutic alliance is an integral part of the most successful feedback systems known to improve outcome. Little is known regarding how this may be used within the rupture resolution process.

The review paper systematically evaluates the link between the therapeutic alliance and outcome in group interventions. Two types of group interventions were reviewed: CBT groups, and psychotherapy groups. A significant relationship between the therapeutic alliance and outcome in group interventions was found, although there were major methodological flaws in the studies reviewed.

The empirical paper employed a task analytic design to develop a model for how session-by-session feedback on the therapeutic alliance could be used to inform the rupture resolution process. Experts were interviewed to develop a theoretical model. This was then combined with an empirical model developed through analysis of the in-session performance of a therapist and four of their individual patients. This model shared similarities with

existing models of rupture resolution, however noticeable differences were found. These are discussed, alongside limitations of the study and implications for clinical practice and future research.

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Paper A

The Link Between Therapeutic Alliance and Outcome in Group Therapy Interventions: A Systematic Review of the Evidence.

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Paper A Abstract

Objective: The current study systematically reviews evidence for the link between the therapeutic alliance (between patient and therapist) and outcome in group therapy interventions. **Method:** Literature searches were conducted to identify studies where the therapeutic alliance and a pre-determined measure of outcome were measured and analysed. **Results:** Seventeen studies met inclusion criteria. The results suggest that there is a link between therapeutic alliance (between patient and therapist) and the outcome of group interventions. **Conclusions:** While the results support the existence of a therapeutic alliance-outcome link in group interventions, further research in this area is needed. Particularly the development and validation of a specific tool to assess therapeutic alliance in a group setting.

Keywords: Therapeutic Alliance; Working Alliance; Helping Alliance; Group Interventions; Outcome.

Introduction

Mental illness is the largest single burden of disease in the UK. It is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health, and increased health-risk behaviour. There is not only a human and social cost, but an economic one too, amounting to £105 billion per year in England (RCP, 2010). It is therefore of considerable importance that interventions both clinically and cost effective are provided. Over the last twenty years, there has been an increase in research supporting both the efficacy and economic benefits of group therapies. Empirical evidence generally attests to lower costs and equivalent effectiveness of group therapies compared to individual therapy (Tucker & Oei, 2007). This has contributed to the promotion of their implementation in public health services and clinical practice (Lenzo, Gargano, Mucciardi, Lo Verso, & Quattropani, 2014).

Group Psychotherapy

Group psychotherapy can be defined as a specialised treatment conducted by a professionally trained leader who assesses and selects individuals. These individuals come together as a group to address their individual psychological problems (Spitz & Sptiz, 1999).

There is a firm empirical foundation supporting the effectiveness of group psychotherapy in reducing symptom distress and improving interpersonal functioning (Bednar & Kaul, 1994; Burlingame, Ellsworth, Richardson, & Cox, 2000; Burlingame, Fuhriman, & Mosier, 2003; Fuhriman & Burlingame, 1994). Furthermore, there is evidence that it may be of equivalent benefit to patients as individual therapy. Tschuschke (1999) summarised 22 controlled studies published between 1973 and 1999 that compared group and individual therapy. Eleven studies reported no difference between the two formats, six found group therapy to be more effective, and five found individual therapies to be more effective. Burlingame, MacKenzie, and Strauss (2004) summarised the findings from 107 individual studies and 14 meta-analyses that investigated the effectiveness of group psychotherapy.

They reported that for the majority of patient populations, including those with mood disorders, panic disorder, social phobia, bulimia nervosa and older adult populations, gains in group treatment significantly exceeded those in wait list controls. A significant effect for in-patient group psychotherapy was demonstrated by Kosters, Burlingame, Nachtigall and Strauss (2006) in a meta-analysis of 70 studies of inpatient groups between 1980 and 2004. The existing research therefore indicates that group therapy is a beneficial and cost effective treatment.

Outcome

Although there are many goals of psychological therapy, primary among them is the amelioration of psychiatric disorders, and social, emotional, cognitive and behavioural difficulties (Weissman, Markowitz, & Klerman, 2000). Previous reviews of the outcome of group psychotherapy have classified outcome as a reduction in symptom distress or an improvement in interpersonal functioning (Burlingame, McClendon, & Alonso, 2011). This definition will be used for the present review.

Little is known about the forces that influence the outcome of group interventions. Burlingame et al. (2004) attempted to synthesise the various different factors that might impact on the outcome of group interventions. They hypothesise five different components that are common across group interventions. The first of these is 'formal change theory', which relates to the mechanisms of change contained within the theoretical underpinnings of the intervention (for example, cognitive restructuring in a CBT group). The second is group process, which reflects the fact that the therapeutic environment is a potent source of patient change. Client characteristics and structural factors (such as number and length of sessions) have also been identified as related to positive therapeutic outcome. Finally, and centrally, the group leader is understood to have a significant impact on the outcome of group interventions.

Therapeutic Alliance

The therapeutic alliance is a construct that has been developed to conceptualise how well the patient and the therapist are working together. Regardless of the therapeutic approach, a good alliance means that patients and therapists are working well together towards the goals of therapy. The roots of the therapeutic alliance lie in psychoanalytic therapy. Sterba (1934) first introduced the term 'alliance' to develop the idea that a patient has a rational, observing capacity with which the therapist can form an alliance against the irrational forces of the patient's transference and defences (Muran & Barber, 2011).

Bordin (1979) further developed this theory, and saw the therapeutic alliance as a framework for all types of interpersonal change, regardless of the theory underlying the specific psychotherapeutic intervention. Bordin's theory aimed to account for how clinical theory (e.g. psychoanalysis, cognitive behavioural therapy, gestalt therapy) is translated into clinical change process (Muran & Barber, 2011). Bordin (1979) proposed that agreement on the goals for therapy, collaboration on the tasks of therapy, and the affective bond between patient and therapist are the three central elements of the therapeutic alliance. This definition of the therapeutic alliance has been the most broadly utilised within the field of psychotherapy research, and underpins many of the measures designed to measure the therapeutic alliance.

Optimal therapeutic alliance is achieved when patient and therapist share beliefs with regard to the goals of the treatment and view the methods used to achieve these as efficacious and relevant. This necessitates a personal relationship of confidence, where the patient believes in the therapist's ability to help, and the therapist is confident in the patient's resources. It is believed a strong therapeutic alliance enables the patient to accept, follow, and invest in the various components of the therapy, facilitating positive change (Muran & Barber, 2011).

Therapeutic Alliance and Outcome

Individual therapy. The predictive role of the therapeutic alliance in individual therapy is well established in empirical research. A significant relationship between therapeutic alliance and outcome has been evidenced by several meta-analyses (Hovarth & Bedi, 2002; Martin, Garske, & Davis, 2000). It is thought to account for approximately 7% of the variance in outcome (Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012). This is greater than other treatment variables, such as therapist adherence to treatment manual and therapist competence (Webb, DeRubeis, & Barber, 2010). There is also evidence that poor therapeutic alliance is correlated with unilateral termination by the patient (Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Couples and family therapy. The role of the therapeutic alliance has received limited theoretical and empirical attention in couples and family therapy (CFT; Friedlander, Escudero, Heatherington, & Diamond, 2011). However, in a recent meta-analysis of 24 studies investigating therapeutic alliance in CFT, the association between alliance and outcome was found to be statistically significant with an effect size of 0.26 (Friedlander et al. 2011). This is very similar to the 0.275 found within individual psychotherapy (Fluckiger et al., 2012), suggesting that the link between therapeutic alliance and outcome extends beyond one-to-one therapy.

Group interventions. The findings from both individual psychotherapy and CFT underscore the importance of examining therapeutic alliance in group interventions. This modality may be a particularly efficient way of delivering mental health services, particularly given the paucity of psychological resources (Johnson, Penn, Bauer, Meyer, & Evans, 2008).

Most clinicians and researchers agree that group therapy and individual therapy are two distinct treatment modalities with related, but different, mechanisms of change (Gillaspy,

Wright, Campbell, Stokes, & Adinoff, 2002). Central to these differences is the fact that group therapy offers multiple relationships (member to member, therapist to member, member to group, therapist to group), which combine to create a therapeutic environment with multiple therapeutic agents. (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005).

With this distinction in mind, the therapeutic alliance can be divided into two dimensions when discussed in the context of group psychotherapy (Gillaspy et al., 2002). The first dimension is the specific client-therapist relationship for each individual group member. This is often referred to as the individual alliance, and the majority of research has focused on this dimension (Johnson et al., 2008).

The second dimension can be defined as group alliance, and represents the relationship between an individual and the entire group. This dimension takes into account the complexity of relationships in a group setting. Group alliance may be particularly important in group therapy, as clients in group therapy often rate interpersonal factors, such as how focused other group members are on others compared to themselves, as important (Holmes & Kivlighan, 2008).

Due to the fact that the complex group situation includes numerous possibilities for mutative interactions and relationships, clinical literature initially attributed a less central role to the group therapist than to the individual therapist (Lorentzen, Sexton, & Høglend, 2004). However, Burlingame et al. (2004) argue that the group leader plays a pivotal role within the group setting. Numerous mechanisms of change, including structural factors (the number and length of sessions), formal change theory (the specific technical elements of an intervention), and group processes need to be managed and integrated within a group setting in order for the intervention to be effective (Burlingame et al., 2004). The group leader is the central force in this management and integration. This therefore suggests that the therapeutic alliance

between a group member and the therapist plays an important role in the outcome of group psychotherapy. Given this fact, and the relative paucity of research investigating group alliance, the current review will focus on the link between patient-therapist alliance and outcome.

Therapeutic Alliance and Cohesion

Cohesion has been defined as "the attractiveness of the group to its members" (Piper & Ogrodniczuk, 2010). It is generally thought to relate to the 'togetherness' of the group, and the sense of belonging or being valued that is felt by its members. Budman, Soldz, Demby, Feldstein, Springer and Davis (1989) found that therapeutic alliance and group cohesion were closely related. They highlighted the importance of working together towards a common goal, in addition to a sense of bonding in both constructs. Both cohesion and therapeutic alliance were strongly related to reduced symptomology. Marziali et al. (1997) also found significant correlations between cohesion and therapeutic alliance, and although both predicted outcome in a randomised controlled trial for borderline personality disorder, the therapeutic alliance with the group leader accounted for more outcome variance than cohesion.

Over the last two decades numerous studies have identified that although the therapeutic alliance may share some of the variance with cohesion, it also has an independent, positive relationship to outcome in group psychotherapy (Lorentzen, Bakali, Hersoug, Hagtvet, Ruud, & Høglend, 2011). A recent study used confirmatory factor analyses to compare the Working Alliance Inventory – Short Form (Tracey & Kokotovic, 1989) with the Therapeutic Factors Inventory, subscale Cohesiveness (Lese & MacNair-Semands, 2000) and the Group Climate Questionnaire (MacKenzie, 1981). This study suggested that the patient-therapist alliance constituted a distinct process in the group, alongside although separate from

member-group cohesion (Bakali, Baldwin, & Lorentzen, 2009). For this reason, the link between patient-therapist alliance and outcome will be reviewed.

Rationale for Review

Over the last 20 years there has been growing interest in the role therapeutic alliance may play in the outcome of group interventions. The difficulties in establishing a coherent definition and operationalisation of cohesion, in addition to the growing evidence for an alliance-outcome link in other treatment modalities have contributed to this growth. As there are no previous reviews of this area, and given the relationship between therapeutic alliance and outcome in other settings, a systematic review and critical appraisal of current research is therefore timely.

Aim of Current Review

This is the first paper to systematically review the relationship between therapeutic alliance and a pre-determined measure of outcome in group interventions. The current review aims to summarise and systematically evaluate the current literature. Clinical and research implications will also be discussed.

Method

Search Strategy

Relevant studies were identified in January 2015 by systematically searching the following databases: CINAHL, EMBASE, Medline, and PsycINFO. Search terms were grouped into three main areas – therapeutic alliance-related, outcome-related, and group therapy-related – and were systematically combined. The complete search strategy is presented in Appendix B.

Figure 1 presents the process of study selection. The initial search identified 455 studies. Two hundred and seventy-four duplicates were removed. Secondary searches involved scanning publication reference lists, accessing online citations and manual searches of other relevant journals. An additional six studies were identified through this process. A total of 187 studies were systematically screened according to the inclusion criteria of the current review.

Inclusion Criteria

Searches were restricted to peer-reviewed journals published in English. Quantitative studies only were eligible for inclusion. Studies were eligible for inclusion if the therapeutic alliance was conceptualised as 'therapeutic alliance', 'working alliance', or 'helping alliance'. Studies were required to analyse the link between these constructs and a pre-determined measure of outcome. Studies were required to detail a psychological intervention delivered in a group format to an adult (18-65 years) population. The abstracts of the 187 studies identified were screened. One-hundred and fifty eight studies were excluded as they did not meet the inclusion criteria (e.g. 72 did not formally measure therapeutic alliance, 23 investigated therapist characteristics and their impact on therapeutic alliance). The full text of the remaining 29 articles was screened, and a further 12 articles excluded. This process yielded 17 articles eligible for inclusion in the current systematic review.

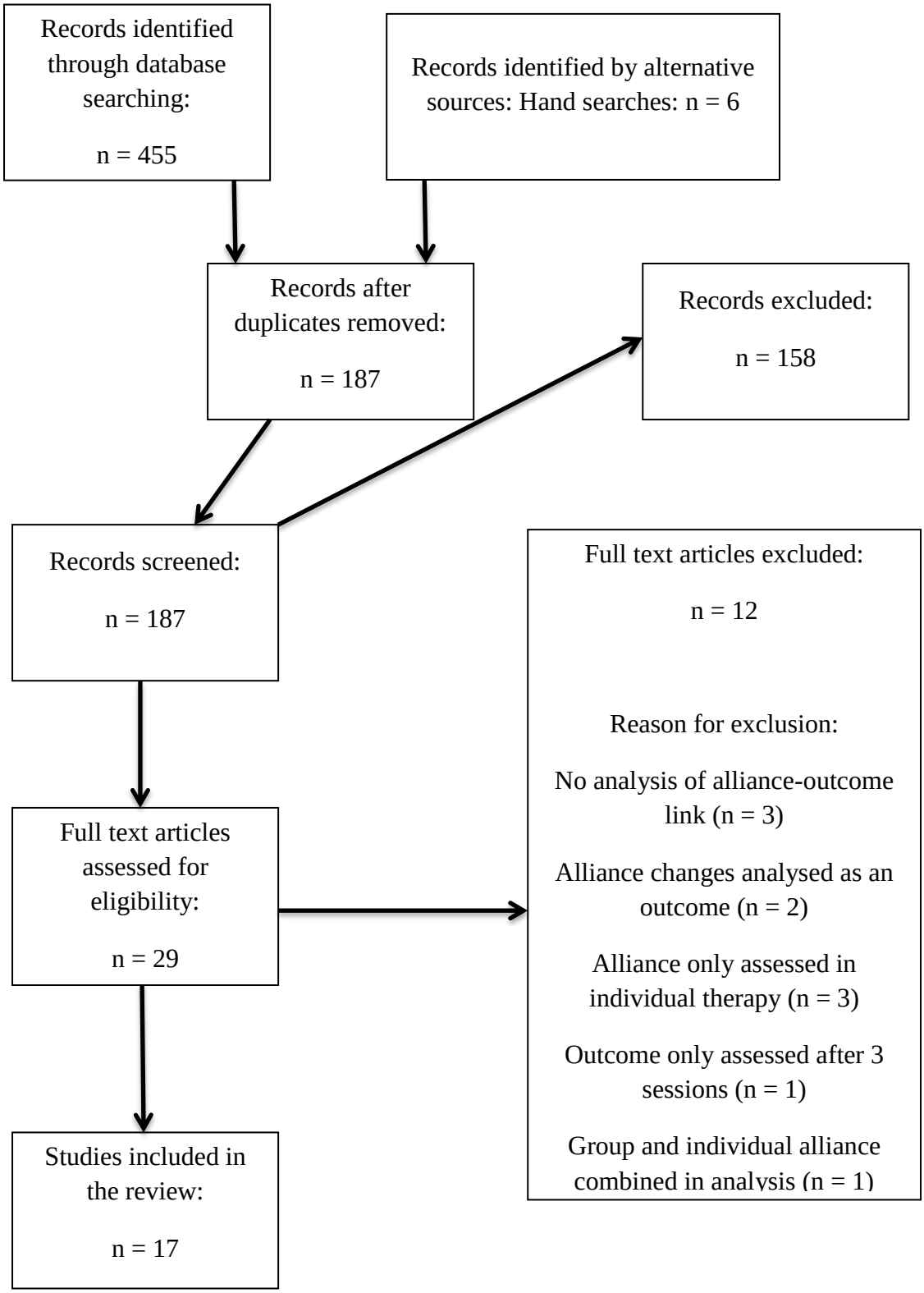

Figure 1. A flow diagram of the study selection process.

Procedure

The structure and content of this review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses document (PRISMA; Liberati et al., 2009). Downs and Black's (1998) checklist was utilised to assess the quality of reporting and the internal and external validity of studies. The researcher independently reviewed the included articles using a data extraction form (Appendix C) to standardise the approach to data extraction and appraisal. As other factors are investigated in these studies, only the results pertaining to therapeutic alliance and outcome were reviewed.

Table 1. Study Characteristics

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Bourgeois, Sabourin, & Wright (1990)	Quasi-experimental design Canada	N = 63 heterosexual couples Mean age 38.5 (range 22-66) 100% Caucasian	Domestic violence	CBT based couples survival program	CAS TAS Patient & Therapist 3rd session	DAS PPCL MHS PSI	Hierarchical multiple regression analysis	Therapeutic Alliance (TA) of males accounted for 8% of variance on PPCL, 7% of variance on DAS, and 5% of variance on MHS TA of females accounted for 5% of variance on DAS
Marziali, Munroe-Blum, & McCleary (1999)	RCT Canada	N = 38 (N = 16 provided full data set)	Personality disorder	Interpersonal Group Psychotherapy	GAS Patient Session 3 (or closest point) Session 8 (or closest point)	SAS BDI SCL-90 OBI	Exploratory Regression Analyses	Early TA did not account for outcome at 12 or 24 months At 12 month follow up, late TA accounted for 32% of variance on SCL-90, 23% of variance on SAS, and 17% of variance on BDI.

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
								At 24 month follow up TA accounted for 64% of variance on BDI, 50% of variance on SCL-90, and 12% of variance on SAS.
Brown & O'Leary (2000)	RCT USA	N = 70 married heterosexual couples Mean age: Males 38 (SD 8.99) Females 35 (SD 8.35) 97% Caucasian, 2% African American, 1% Hispanic	Domestic violence	Conjoint or gender specific group CBT	WAI-O Session 1	DAS MCTS PMTW	Hierarchical regression analysis	TA of males accounted for 25% of variance in mild psychological aggression, 12% of variance in mild physical aggression, 8% of variance in severe psychological aggression and 7% of variance in severe physical aggression

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Gillaspy, Wright, Campbell, Stokes, & Adinoff (2002)	Quasi-experimental design USA	N = 66 100% male Mean age 45.41 (SD 8.49) 55% African American, 41% Caucasian, 4% Hispanic	Substance misuse	Group Psychotherapy	GAS Patient 4th & 8th Sessions	BDI OQ-45 InDUC	Hierarchical Multiple Regression Analyses	Patient-rated TA significantly predicted 9% of variance in OQ-45 scores No significant associations between TA and BDI or inventory of drug use consequences
Woody & Adessky (2002)	Longitudinal Study USA	N = 53 26 female, 27 male Mean age 33.2 (range 18-54) 91% Caucasian, 4% Asian American, 4% African American	Social Anxiety	Group CBT	WAI Patient Every session	SPAI QOLI Behavioural Assessment SISST	Growth curve modelling	TA not a significant predictor of outcome

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Taft, Murphy, King, Musser, & DeDeyn (2003)	Longitudinal Study USA	N = 107 domestically violent males Mean age 36.22 (SD 8.89) 45.8% 'minority status'	Domestic violence	Group CBT	WAI Patient & therapist Early – sessions 3 & 5 Late – sessions 11 and 13	CTS MMEA	Hierarchical linear modelling	Patient WAI scores not predictive of outcome Therapist WAI ratings significantly predicted changes in psychological abuse, physical abuse, and emotional abuse
Van Andel, Erdman, Karsdorp, Appels, & Trijsburg (2003)	Sample taken from RCT Netherlands	N = 47 90.5% male, 9.5% female Mean age 53 (SD 7.78, range 40-68)	Cardiac recovery	Group CBT	HAQ-II Patient and therapist Sessions 5 & 10	Vital Exhaustion QLMI STAI Blood Pressure Heart Rate	Hierarchical Regression	TA predicted post treatment systolic blood pressure TA predicted post treatment quality of life

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Abouguendia, Joyce, Piper, & Ogrodniczuk (2004)*	Sample taken from RCT Canada	N = 107 Mean age 43 (SD 10.3, 19-67) 77% female, 23% male 90% Caucasian	Complicated grief	Interpretive Group Psychotherapy Or Supportive Group Therapy	Scale developed by Piper et al. (1995) Patient and therapist Every session	15 measures reduced through factor analysis to: General symptoms Grief symptoms Target objectives/life dissatisfaction	Hierarchical linear modelling	At both individual and group levels TA directly associated with benefit on all 3 outcomes Patient-rated TA accounted for 12% of variation at the individual level, and 18-30% of variation at the group level Therapist-rated TA accounted for 5% of variation in outcome on target objectives/life dissatisfaction

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Lorentzen, Sexton, & Hoglend (2004)	Cohort study Location not provided	N = 12 50% male, 50% female Mean Age 35 (range 21-54)	Mixed presentations	Group Analysis	Scale developed by Piper et al. (1995) Patient and therapist Every session	IIP SCL-90	SAS Procedure Mixed	Therapist's rating of early TA a positive predictor of improvement on SCL-90
Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce (2005)*	Sample taken from RCT Canada	N = 107 Mean age 43 (SD 10.3, 19-67) 77% female, 23% male 90% Caucasian	Complicated grief	Interpretive Group Psychotherapy Or Supportive Group Therapy	Scale developed by Piper et al. (1995) Patient and therapist Every session	15 measures reduced through factor analysis to: General symptoms Grief symptoms Target objectives/life dissatisfaction	Correlation	Patient-rated TA significantly related to outcome in general symptoms, grief symptoms and target objectives/life dissatisfaction Therapist-rated TA not significantly related to outcome

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Constantino, Manber, Ong, Kuo, Huang, & Arnow (2007)	Longitudinal Study USA	N = 100 (N = 49 provided full data set) 54.7% female, 45.3% male 88.7% Caucasian	Insomnia	Group CBT-I	GTSR Patient Session 1	Sleep Wake Diaries ISI ACRS	Simultaneous Linear Regression	TA not predictive of outcome
Joyce, Piper, & Ogrodniczuk (2007)*	Sample taken from RCT Canada	N = 107 Mean age 43 (SD 10.3, 19-67) 77% female, 23% male 90% Caucasian	Complicated grief	Interpretive Group Psychotherapy Or Supportive Group Therapy	Scale developed by Piper et al. (1995) Patient and therapist Every session	15 measures reduced through factor analysis to: General symptoms Grief symptoms Target objectives/life dissatisfaction	Hierarchical Multiple Regression Analysis	Patient-rated TA directly associated with all outcomes Therapist-rated TA directly associated with target objectives/life dissatisfaction Patient-rated TA a significant predictor of outcome in grief symptoms and target objectives/life dissatisfaction

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Crowe & Greyner (2008)	Longitudinal Study Location not provided	N = 46 (N = 30 provided full data set) 57% female, 43% male Mean age 47.77 (24-65)	Depression	Supportive Expressive Dynamic Psychotherapy	CALPAS-G Patient Session 6	BDI	Pearson's Correlation Analyses	Patient-rated TA not associated with changes in depressive symptoms
Lindgren, Barber, & Sandahl (2008)	Sample taken from psychodynamic arm of RCT Sweden	N = 40 (N = 18 treatment completers) 72.5% female, 27.5% male Mean age 44.0 (SD 9.77, 24-59)	Depression	Group Psychotherapy	CALPAS-G Patient Sessions 3, 5, 8, 12 & 15	CPRS-S-A IIP RSQ	Multivariate Regression Analyses	Mean patient-rated TA significantly predictive of decreases in anxiety and global symptoms, but not in depression

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Mortberg (2014)	Sample taken from RCT Location not stated	N = 26 Mean age 34.8 (SD 6.2) No other demographic information provided	Social anxiety disorder	Intensive Group CBT	WAI-SF Patient Session 3	SIAS	Correlation Analysis	No significant correlation between total alliance score and outcome Significant positive correlation between goals subscale of WAI and outcome
Jasper, Weise, Conrad, Andersson, Hiller, & Klienstauber (2014)	Sample taken from RCT Germany	N = 62 (N = 26 provided full data set)	Tinnitus	Group CBT	WAI Short Form Patient Sessions 2, 5, & 9	THI	Bivariate correlation	Significant moderate correlation between bond subscale of WAI and outcome

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
Lenzo, Gargano, Mucciardi, Lo Verson, & Quattropani (2014)	Single Case Naturalistic Design Italy	N = 7 57% male, 43% female Age range 18-24 No further demographic information provided	Relational difficulties	Psychodynamic Group Therapy	CALPAS-G Patient Monthly	SCL-90 OQ-45	Correlation Analysis (Spearman's rho)	Initial phase: Patient Commitment subscale (PC) of CALPAS-G significantly associated with SCL-90 and OQ-45 Central phase: Working Strategy Consensus subscale (WSC) significantly associated with OQ-45 Group Understanding and Involvement subscale (GUI) significantly associated with SCL-90 and OQ-45 Final Phase: PC subscale significantly associated with

Study	Design & Location	Sample	Targeted Problem	Intervention	Alliance Measure, Respondents, and Time Points	Outcome Measure(s)	Analysis	Alliance-Outcome Link
								OQ-45 GUI subscale significantly associated with OQ-45 WSC subscale significantly associated with SCL-90 and OQ-45

Note. Therapeutic Alliance Measures: CALPAS-G = California Psychotherapy Alliance Scale – Group; CAS = Couples Therapeutic Alliance Scale; GAS = Group Alliance Scale; GTAS = Group Therapy Alliance Scale; GTSR = Group Therapy Session Report; HAQ-II = Helping Alliance Questionnaire-II; TAS = Therapist Alliance Scale; WAI = Working Alliance Inventory; WAI-SF = Working Alliance Inventory – Short Form; WAI-O = Working Alliance Inventory – Observer. Outcome Measures: ACRS = Assignment Compliance Rating Scale; BDI = Beck Depression Inventory; CPRS-S-A = Comprehensive Psychopathological Rating Scale – Self Affective; CTS = Conflict Tactics Scale; DAS = Dyadic Adjustment Scale; InDUC = Inventory of Drug Use Consequences; IPP = Inventory of Interpersonal Problems; ISI = Insomnia Severity Index; MCTS = Modified Conflict Tactics Scale; MHS = Marital Happiness Scale; MMEA = Multidimensional Measure of Emotional Abuse; OBI = Objective Behavioural Index; OQ-45 = Outcome Questionnaire-45; PMTW = Psychological Maltreatment of Women Scale; PPCL = Potential Problem Checklist; PSI = Problem Solving Inventory; QLMI = Quality of Life after Myocardial Infarction; QOLI = Quality of Life Inventory; RSQ = Relationship Scales Questionnaire; SAS = Social Adjustment Scale; SCL-90 = Symptom Checklist-90; SIAS = Social Interaction Anxiety Scale; SISST = Social Interaction Self Statement Test; SPAI = Social Phobia and Anxiety Scale; STAI = State-Trait Anxiety Scale; THI = Tinnitus Handicap Inventory.

* These three studies analysed data from the same set of participants

Results

Characteristics of Studies

See Table 1 for a summary of study characteristics. These will be discussed in more depth, following which a summary of the studies' findings will be provided. Studies were divided into those describing a cognitive behavioural group intervention, and those describing a group psychotherapy intervention. Results were further organised by strength of the relationship between therapeutic alliance and outcome reported.

Intervention type. All studies included some analysis of the link between therapeutic alliance and the outcome of group therapy. In eight of the studies the group intervention was a group version of cognitive behavioural therapy. In nine of the studies the group intervention was a form of group psychotherapy. These interventions included group analysis, interpersonal group psychotherapy, interpretative group therapy, supportive group therapy and supportive expressive dynamic psychotherapy.

Conceptualisation of the alliance. Nine studies measured the therapeutic alliance from the perspective of the patient. Seven studies measured the therapeutic alliance from the perspective of both the patient, and the therapist. One study used only an observer rating of the therapeutic alliance. All studies investigated individual group members' alliance with the therapist, with two studies also investigating the alliance of the group as a whole, and subgroups to the therapist. One study also investigated the alliance of individual group members to the group as whole.

Alliance measure. Three studies measured the therapeutic alliance using the California Psychotherapy Alliance Scales – Group patient version (CALPAS-G; Gaston & Marmar, 1993). This is a 12-item self-report measure assessing the strength of the

members to therapist alliance in a group. The measure comprises four scales: The Patient Working Capacity (PWC) scale, which reflects the patient's ability to work actively in treatment and form a working alliance with the therapist; the Patient Commitment (PC) scale, which reflects the patient's attitude toward the therapist and therapy, the Working Strategy Consensus (WSC) scale, which reflects the degree of agreement between the patient and the therapist about how to proceed in therapy; and the Therapy Understanding and Involvement (TUI) scale, which reflects the patient's perception of the therapist's empathic understanding of their difficulties.

Two studies used the Group Alliance Scale (GAS), developed by Pinsof and Catherall (1986). This measure is based on a systems framework for understanding the quality of the bond that develops in therapy, regardless of whether the structure is individual, couple, family, or group. The therapeutic alliance is conceptualised as existing on three levels of interpersonal exchange: 1) the individual alliance (individual and therapist); 2) the whole system alliance (all members of the group and the therapist); and 3) the subsystem alliance (subgroups and the therapist). One study used the couple's version of this measure.

Five studies used versions of the Working Alliance Inventory (Horvath & Greenberg, 1989). This is a trans-theoretical measure of the alliance between patient and therapist. It consists of the three sub-components of the alliance identified by Bordin (1979). The main measure contains 12 items for each subscale rated on a seven point Likert scale. Two studies used the Short Form version (WAI-SF; Tracey & Kokotovic, 1989), one study used the therapist-rated version (Horvath & Greenberg, 1989), and one study used the observer version (Horvath & Greenberg, 1989).

Four studies used a measure developed by Piper, Hassan, Joyce, and McCallum, (1995), which comprises of four items rated on a seven point Likert scale. The items focus on 1) talking about important private material, 2) feeling understood by the therapist, 3) understanding and working with what the therapist said, and 4) feeling the session enhanced understanding. These scores are averaged giving a total alliance score.

One study used the Helping Alliance Questionnaire II (Luborsky, Barber, Siqueland, Johnson, Najavits, & Frank, 1996). This measure is based on a two factor model of the therapeutic alliance, and differentiates between Type I and Type II therapeutic alliance. Type I refers to experiencing the therapist as warm, helping, and supportive. Type II refers to the collaborative aspect of the relationship. It has 19 items, with patient and therapist versions.

One study used the Group Therapy Session Report (Liebenthal, 1980). This is an 8-item measure that directly assesses the patient's expectations of therapist behaviour in an effort to capture the perceived quality of the therapeutic alliance. It is split into two subscales, 1) therapist affiliation; and 2) critical confrontation.

Finally, one study used the Therapist Alliance Scale. No reference was provided for this measure, however the study reported that consisted of items reflecting goal, task, and bond, specifically from the therapist's perspective.

Target Problem. A wide range of problems were targeted by the group interventions described in the studies. Four interventions targeted depression or anxiety. Three interventions targeted domestic violence. Three interventions targeted health problems, such as, insomnia, tinnitus, or cardiac symptoms. Three interventions targeted complicated grief. The remaining interventions targeted personality disorder symptoms, relational difficulties, substance misuse, or 'mixed presentations'.

Group CBT Findings

Alliance as predictive of outcome. Four studies found therapeutic alliance to be predictive of outcome in group CBT interventions using regression analyses. Three of these studies (Bourgeois, Sabourin, & Wright, 1990; Brown & O'Leary, 2000; Taft, Murphy, King, Musser, & DeDeyn, 2003) investigated the link between therapeutic alliance and a reduction in domestic violence. These interventions all took the form of group CBT, delivered through weekly sessions lasting for between two and three hours.

All three studies found that therapeutic alliance was predictive of a reduction in abusive behaviour following treatment. Two studies (Bourgeois et al., 1990, Brown & O'Leary, 2000) found that the therapeutic alliance as rated by the male partner in the couple was most predictive of a reduction in abusive behaviour. Brown and O'Leary (2000) found that this predicted a decrease in post-treatment mild and severe psychological aggression, and physical aggression. Bourgeois et al. (1990) found that this accounted for 8% of the outcome on a measure of couple agreement and disagreement (PPCL; Patterson, 1976), 7% of the variance in outcome on a measure of marital satisfaction (DAS; Spanier, 1976), and 5% of the variance on an outcome measuring marital happiness (MHS; Azrin, Naster, & Jones, 1973).

In contrast, Taft et al. (2003) found that patient-rated therapeutic alliance was not predictive of outcome. They found that it was 'late' therapist-rated therapeutic alliance (an average of the scores from the 11^{th} and 13^{th} sessions) that significantly predicted change in abusive behaviour on the Conflict Tactics Scale (CTS; Straus, 1979) and the Multi-dimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999). Bourgeois et al. (1990) also found therapist-rated therapeutic alliance to be predictive of outcome, but significantly less so than that of patients.

Common to the studies that found patient-rated therapeutic alliance predictive of outcome was the fact that the abusive member of the relationships' therapeutic alliance (the male in all instances) was most predictive of outcome. Bourgeois et al. (1990) found that female rated therapeutic alliance accounted for only 5% of the variance on a marital satisfaction outcome (DAS; Spanier, 1976). Brown and O'Leary (2000) found that female rated therapeutic alliance was not predictive of any reduction in abusive behaviour.

Van Andel, Erdman, Karsdorp, Appels, and Trijsburg (2003) investigated the link between both patient and therapist-rated therapeutic alliance with the reduction in coronary risk factors in a group CBT intervention. The intervention consisted of 12 weekly two hour sessions followed by four monthly sessions. The outcomes of interest were vital exhaustion, quality of life assessed by the Quality of Life after Myocardial Infarction Questionnaire (QMLI; Hillers, Guyatt, Oldridge, Crowe, Willan, & Griffith, 1994), anxiety as assessed by the Stait-Trait Anxiety Inventory (STAI; Van der Ploeg, Defares, Spielberger, 1980), systolic blood pressure, and heart rate. They found a significant negative correlation between systolic blood pressure and patient-rated therapeutic alliance, and a significant positive correlation between quality of life and patient-rated therapeutic alliance. No correlations between therapist-rated therapeutic alliance and outcome were found.

Correlation between alliance and outcome. Two studies (Jasper, Weise, Conrad, Andersson, Hiller, & Klienstauber, 2014; Mortberg, 2014) reported correlations between therapeutic alliance and outcome using correlational analyses.

Mortberg (2014) investigated the relationship between patient-rated therapeutic alliance and a reduction in social anxiety symptoms as reported on the Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998). This was following sixteen prolonged

treatment sessions delivered over a three week period. Jasper et al. (2014) investigated the relationship between therapeutic alliance and psychological distress associated with tinnitus, as measured on the Tinnitus Handicap Inventory (Newman, Jacobson, & Spitzer, 1996). This was following ten weekly sessions of group CBT.

Neither study found a correlation between total alliance score and outcome. However, both studies found a correlation between a subscale of versions of the WAI (Tracey & Kokotovic, 1989; Horvath & Greenberg, 1989) and outcome. Mortberg (2014) found a significant positive correlation between agreement on goals and reduction in social anxiety symptoms. Jasper et al. (2014) found that the bond subscale was significantly correlated with reduced psychological distress associated with tinnitus.

No alliance-outcome link. Two studies found no link between patient-rated therapeutic alliance and outcome (Constantino, Manber, Ong, Kuo, Huang, & Arnow, 2007; Woody & Adessky, 2002). Woody and Adessky (2002) found no link between therapeutic alliance and reduction in social phobia symptoms following a group CBT intervention. Constantino et al. (2007) found no link between first session therapeutic alliance and reduction in insomnia symptoms following seven 90 minute sessions of group CBT-Insomnia.

Group Psychotherapy Findings

Alliance as predictive of outcome. In total six studies found therapeutic alliance to be predictive of outcome in group psychotherapy formats using regression analyses. Three studies (Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002; Lindgren, Barber, & Sandahl, 2008; Marziali, Munroe-Blum, & McCleary, 1999) found patient-rated therapeutic alliance to be most predictive of outcome.

Marziali et al. (1999) found that patient-rated 'late' therapeutic alliance (assessed at session eight or the closest available time-point) predicted significant proportions of variance in increased social adjustment, decreased behavioural dysfunction and psychological distress at both 12 month and 24 month follow up. This was after a 30 session interpersonal group psychotherapy intervention for patients who met the criteria for borderline personality disorder. No predictive relationship was found between patient-rated 'early' alliance (assessed at session eight or the closest available time-point) and outcome.

Gillaspy et al. (2002) found that patient-rated therapeutic alliance was predictive of reduced psychological distress and improved general functioning following a group psychotherapy intervention for drug addiction. This intervention consisted of nine hour-long sessions, alongside several other interventions which were not analysed. Lingdren et al. (2008) found that mean scores of patient-rated therapeutic alliance across 18 sessions of group psychotherapy for depression were predictive of decreases in anxiety and global psychological symptoms. Furthermore, group alliance was found to explain 50-55% of variance in these outcomes. Despite this, patient-rated therapeutic alliance was not found to be predictive of changes in depressive symptomology, the primary target of the intervention.

Lorentzen et al. (2004) found that it was therapist-rated, rather than patient-rated therapeutic alliance that was predictive of outcome. In contrast to Marziali et al. (1999), they found that it was alliance at the 'early' stage, assessed between sessions three and eight of a two year group analytic intervention that was predictive. They found this 'early' therapist-rated therapeutic alliance was predictive of improvements in psychological distress. In addition to this, a high level of concordance between patient

and therapist ratings of the therapeutic alliance over the first fifteen sessions was found to predict improvements in interpersonal functioning.

A series of three studies (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Joyce, Piper, & Ogrodniczuk, 2007; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005) reported on the link between both patient and therapist-rated therapeutic alliance and outcome in a randomised controlled trial of two interventions for complicated grief. The interventions studied were interpretive group psychotherapy and supportive group therapy, and data from the same group of participants was analysed in each of these studies.

Two of these studies (Abouguendia et al., 2004; Joyce et al., 2007) found therapeutic alliance to be predictive of improvements in general psychiatric symptoms, grief symptoms, and life satisfaction. Unlike the studies detailed above, both patient-rated and therapist-rated therapeutic alliance were found to be significant predictors of outcome. Patient-rated therapeutic alliance accounted for approximately 12% of variance in the outcome of individuals, and approximately 18-30% of variance in aggregate outcome of the group as a whole.

Therapist-rated therapeutic alliance accounted for 5% of the variance in individual improvements in life satisfaction, however did not predict the aggregate outcome of the group as a whole. Abouguendia et al. (2004) also reported that patient-rated therapeutic alliance played a mediating role in the relationship between patient expectancy and positive outcome. Similar to Lorentzen et al. (2004), in a further analysis of this data Joyce et al. (2007) found high levels of agreement between therapist-rated and patient-rated therapeutic alliance.

Correlation between alliance and outcome. Two studies reported correlations between therapeutic alliance and outcome in group psychotherapy formats using correlational analyses. Piper et al. (2005) carried out further analyses on data collected by Abouguendia et al. (2004). They report that 'early' patient-rated therapeutic alliance was significantly related to favourable outcome for both general symptoms and grief symptoms, and approaching significance for a patient's target objectives and life satisfaction. Positive change in patient-rated therapeutic alliance over time was directly related to favourable outcome on all three measures. The combination of initial patient-rated therapeutic alliance, and the pattern of therapeutic alliance growth resulted in effect sizes of .34 and .37, which accounted for 12-14% of the variance in overall outcome. The therapist-rated change in therapeutic alliance over time was not directly related to any of the three outcome factors.

Lenzo, Gargano, Mucciardi, Lo Verson, and Quattropani (2004) investigated the relationship between patient-rated therapeutic alliance and outcome in psychodynamic group therapy for patients experiencing relational difficulties. They found that in the initial phase of therapy, the Patient Commitment scale of the California Psychotherapy Alliance Scales – Group Version (CALPAS-G; Gaston & Marmar, 1993) was significantly associated with symptomatic improvement and psychological wellbeing. During the central phase of therapy, the Working Strategy Consensus scale of the CALPAS-G was significantly associated with improvements in psychological wellbeing. In addition, the Group Understanding and Involvement scale was significantly associated with symptomatic improvement and psychological wellbeing. In the final phase of therapy there were strong negative correlations between the Patient Commitment scale and psychological wellbeing, the Working Strategy scale and both symptomatic

improvement and psychological wellbeing, and the Understanding and Involvement scale and psychological wellbeing.

No alliance-outcome link. One study found no link between therapeutic alliance and outcome in a group psychotherapy format. Crowe and Greyner (2008) investigated the link between patient-rated therapeutic alliance and outcome in supportive expressive dynamic psychotherapy for major depression. The intervention consisted of 16 weekly manualised sessions, each lasting 90 minutes. Patient-rated therapeutic alliance was not associated with any changes in depressive symptomology.

Critique

The extent to which the findings from the studies detailed above can be generalised and used to inform clinical practice is dependent on the internal and external validity of the research. Internal validity concerns the extent to which the relationship between therapeutic alliance and outcome described by the studies can be confidently stated, or whether this may be due to confounding or external factors. External validity considers the extent to which the relationship between therapeutic alliance and outcome can be generalised beyond the participants included in the studies to other individuals, or in other clinical settings. This review will now consider these aspects of the studies described.

Participant Demographics

All participants were recruited from high-income countries. No studies were found in cultures other than western cultures, therefore the findings of the studies reviewed may not be generalisable to non-western cultures or low and middle-income countries. The sample in eight of the selected studies was higher than 88% Caucasian. Eight studies did not state the ethnic composition of their sample. Therefore it is unclear

whether the findings regarding the relationship between therapeutic alliance and outcome are generalisable to group interventions with non-Caucasian patients.

Study Design and Methodology

Sample size. The majority of studies were limited by a small sample size (e.g. n = 7, Lenzo et al., 2014; n = 12, Lorentzen et al., 2004). This was further compounded by high rates of attrition of up to 55% (Lindgren et al., 2008) and limited participants completing a full data set for analysis, in some cases as low as 42% (Marziali et al., 1999). This limits the statistical power of the analyses conducted, and increases the chance of making a type II error. Two studies provided no information on drop-outs (Abouguendia et al., 2004; Brown & O'Leary, 2000). The small sample sizes were acknowledged in the majority of studies, however only one study described a post-hoc power calculation (Lorentzen et al., 2004), reporting that a sample size of 20 to 22 participants would have been necessary to detect a significant impact of patient-rated therapeutic alliance.

Alliance measures. A total of 11 different measures of therapeutic alliance were used within the studies. Five studies (Brown & O'Leary, 2000; Jasper et al., 2014; Mortberg, 2014; Taft et al., 2003; Woody & Adessky, 2002) used versions of the WAI (Horvath & Greenberg, 1989), which is well validated for use in individual therapy, but is not validated for use in groups. However, four of these studies (Brown & O'Leary, 2000; Jasper et al., 2014; Mortberg, 2014; Taft et al., 2003) calculated Cronbach's alpha for their studies, with scores of between 0.87 and 0.98. This demonstrated 'good' to 'excellent' internal consistency for this measure in each study. This procedure was common across all studies, with the exception of Van Andel et al. (2003) and Lenzo et al. (2014), which reduces the confidence that can be attached to their findings.

It was common for therapeutic alliance measures designed for individual therapy to be adapted for use in a group therapy setting. In two studies this involved either observers coding participants' therapeutic alliance with two therapists as a composite score (Brown & O'Leary, 2000) or the wording of a measure being changed to "my therapists" rather than the original "my therapist" (Taft et al., 2003). This procedure oversimplifies the nature of the therapeutic alliance construct, and the potential implications of this are not discussed.

Timing of alliance assessment. There was a degree of variation in the timing of the assessment of the therapeutic alliance between studies. Some studies assessed the therapeutic alliance following every session (Abouguendia et al., 2004; Joyce et al., 2007; Lorentzen et al., 2004; Piper et al., 2005; Woody & Adessky, 2002), others at only one time point early in the intervention (Bourgeois et al., 1990; Brown & O'Leary, 2000; Constantino et al., 2007). The remaining studies assessed the therapeutic alliance at least twice during the intervention, with some significantly more frequently (Lenzo et al., 2014; Lingdren et al., 2008; Marziali et al., 1999). Those studies that only assessed the therapeutic alliance once are limited in the extent to which they can explain the impact of the therapeutic alliance on the outcome of a group intervention. The therapeutic alliance has been conceptualised as a dynamic, rather than a static phenomenon (Kivlighan & Shaughnessy, 1995). Different individuals and groups might take different amounts of time to negotiate the therapeutic alliance, and through only assessing the therapeutic alliance at a single time-point, early in therapy, this fact is neglected.

Outcome measures. Thirty-five different outcome measures were employed across the 17 studies. All studies used self-report measures of outcome. This reduces the risk of researcher bias, but also increases the risk of respondent bias. Only three studies

(Lenzo et al., 2014; Van Andel et al., 2003, Woody & Adessky, 2002) supplemented these with clinician or observer rated outcome measures.

Follow-up. Fourteen studies did not collect any follow up data on outcome. Where therapeutic alliance was found to be predictive of outcome, it is unclear whether the outcome was maintained following the group intervention. It is also unclear whether therapeutic alliance may have predicted a change in outcome that became evident in the period of time following the intervention. Of the three studies that did collect follow up data (Gillaspy et al., 2002; Marziali et al., 1999; Taft et al., 2003), all found some relationship between therapeutic alliance and outcome at follow-up. However, the follow-up period in the Gillaspy et al. (2002) study was only a period of thirty days, which may not be sufficient to ascertain whether the outcomes were maintained long-term.

Confounding variables. Confounding variables were present in a number of studies, which limits their internal validity. Both the Woody and Adessky (2002) and the Lingdren et al. (2008) studies reported inconsistency of the structure of their interventions, with some participants within the same conditions receiving different intensities of treatment. In addition, in the Woody and Adessky (2002) study an unspecified number of participants were assessed over three to four sessions by the group facilitators, and consequently may have started to form a therapeutic alliance prior to the intervention group. Seventy-six percent (n = 81) of participants in the Taft et al. (2003) study received a pre-group intervention as part of a clinical trial for motivational interviewing as a preparatory intervention. These factors were not controlled for in the analyses.

Gillaspy et al. (2002) acknowledged that the group intervention in which they investigated the link between therapeutic alliance and outcome was a small component of a much wider treatment program. This included CBT psychoeducation, a 12-step

intervention, and occupational therapy. There was no consideration of the impact that these interventions may have had on outcome. A similar confounding variable is present in the study by Jasper et al. (2014), where participants who were originally part of an active waiting list control group were later assigned to the group intervention. These participants were then included in the analysis of therapeutic alliance and outcome, not taking into consideration the fact that the active waiting list may have an independent impact on therapeutic alliance and/or outcome.

An unspecified number of participants in the Taft et al. (2002) study faced legal consequences for non-attendance, which could have impacted on both therapeutic alliance and outcome. Nine studies also investigated the link between cohesion and therapeutic alliance, or cohesion and outcome. Only one study (Van Andel et al., 2003) highlighted the possibility of 'halo effects'. This refers to the potential for attitudes towards the group as a whole, brought to mind by completing a cohesion measure, influencing participants' therapeutic alliance rating.

Ethical issues. Ethical approval was only cited in three studies (Constantino et al., 2007; Jasper et al., 2014; Lindgren et al., 2008). Nine studies reported that they obtained informed consent from participants, although this process was not clearly detailed in any study. No consideration on the benefits or adverse consequences of participating in the study, or the anonymity and confidentiality processes was described.

Discussion

The present review critically evaluated the available literature on the link between therapeutic alliance and outcome in group therapy, identifying 17 studies. Due to the design and methodological flaws in the majority of the studies, the findings that can be drawn from this review must be tentative. One of the most significant flaws of the

reviewed research that may limit the interpretation of findings is conceptualising the therapeutic alliance in a group setting as the same as therapeutic alliance in individual therapy. In general the reviewed studies did not focus on the second dimension of therapeutic alliance when it is considered in a group setting – the therapeutic alliance between the individual and the group as a whole. Only two studies (Gillaspy et al., 2002; Marziali et al., 1999) reported on the 'group alliance' dimension of therapeutic alliance in a group setting. Both studies found associations between this and outcome.

Fourteen studies (82%) demonstrated a link between therapeutic alliance and outcome. Of these studies, 10 reported therapeutic alliance was predictive of outcome, and four reported an association between therapeutic alliance and outcome. Three studies reported no link between therapeutic alliance and outcome. The studies reviewed therefore cautiously suggest that the link between therapeutic alliance and outcome in individual and couples therapy may also be present in group interventions across different treatment modalities for different populations.

However, the relative paucity of studies, and the methodological limitations of those that have been carried out make it difficult to draw direct comparisons. Within individual therapy, therapeutic alliance has been found to account for approximately 7% of the variance in outcome (Fluckiger et al., 2012). Therapeutic alliance was found to account for a wide range of variance in outcome in the studies reviewed here, ranging from 3% (Bourgeois et al., 1990) to 56% (Lindgren et al., 2008). Whilst several studies reported effect sizes between .23 and .24 (Joyce et al., 2007; Piper et al., 2005), comparable to the effect sizes stated in previous reviews of individual therapy (Horvath & Bedi, 2002, Horvath, Del Re, Fluckiger, & Symonds, 2011), these findings were not consistent across the studies.

The therapeutic alliance may be perceived very differently by the patient, the therapist, and an observer. Divergences have consistently been found between patient and therapist ratings of the therapeutic alliance (Castonguay, Constantino, & Grosse Holtforth, 2006). It has been demonstrated within individual therapy that patient ratings of the alliance are more predictive of good outcome that therapist ratings (Horvath & Bedi, 2002; Wampold, 2001).

There were mixed findings amongst the studies reviewed regarding this phenomenon. Of the six studies that demonstrated a link between therapeutic alliance and outcome, four found that patient ratings were more predictive of outcome (Abouguendia et al., 2004; Bourgeois et al., 1990; Joyce et al., 2007; Piper et al., 2005). Two found that therapist ratings of the therapeutic alliance were more predictive of outcome (Lorentzen et al., 2004; Taft et al., 2003). It must be noted that of the four studies that found patient ratings to be more predictive, three analysed the same set of data. Therefore it is not possible to draw conclusions regarding which rating of the therapeutic alliance is more predictive of outcome. What can be concluded is that as in individual therapy, divergences between patient and therapist ratings of therapeutic alliance are present in group interventions.

There has been much debate as to the role of therapeutic alliance across the course of therapy. One suggestion is that therapeutic alliance is a simple effect of the temporal progression of therapy, getting stronger over time, rather than a causal factor linked to outcome (Ardito & Rabellino, 2011). If this were true, then one would expect alliance ratings taken early in therapy to be weaker predictors of outcome than those taken at later stages. The findings of the current review do not support this conceptualisation of alliance in group therapy.

Horvath and Marx (1991) describe the course of the therapeutic alliance in good outcome cases as a series of developments, setbacks, and repairs. Horvath and Symonds (1991) argued that therapeutic alliance ratings during early and late phases of successful therapy were stronger predictors of outcome that those obtained during the middle phase of therapy. They suggested that during the first phase of successful therapy, adequate levels of collaboration and confidence are facilitated, with agreements on the goals of therapy and how these are to be achieved. This leads to high levels of therapeutic alliance. In the middle phase of therapy, the therapist begins to challenge dysfunctional thoughts, affects, and behaviour patterns, with the goal of affecting change. This is argued to be perceived by the patient as a reduction in support and empathy, which may in turn weaken the therapeutic alliance. In the late stages of therapy, it is necessary for this weakening to be repaired in order for therapy to be successful.

Of the studies that measured 'early' therapeutic alliance (within the first four sessions), only one (Marziali et al., 1999) found no relationship with outcome. Only one study reviewed measured therapeutic alliance at a designated 'middle phase' of therapy, and this showed no difference in terms of the link with outcome than therapeutic alliance ratings taken at designated 'early' or 'late' phases within the study. The two studies that specifically investigated 'late' therapeutic alliance (Gillaspy et al., 2002; Marziali et al., 1999) both found this to be predictive of positive outcome. The findings therefore provide tentative support for the applicability of the model proposed by Horvath and Symonds (1991), emphasising the important of both 'early' and 'late' therapeutic alliance to group interventions.

There has been some discussion within the literature surrounding differences between the levels of therapeutic alliance established in CBT and psychotherapy. During the late 1980s, some authors found no difference between the levels of therapeutic

alliance in individual psychotherapy and individual CBT (Marmer, Weiss, & Gaston, 1989). However, later studies provided evidence of higher levels of observer rated therapeutic alliance in individual CBT compared to psychotherapy (Raue, Goldfried, & Barkham, 1997; Spinhoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007). In the present study, no difference was found between the levels of therapeutic alliance in CBT groups and group psychotherapy. This may be due to the fact the majority of the studies relied on patient or therapist-rated therapeutic alliance, with only one study employing observer ratings.

In the three studies that directly reported the link between the strength of the therapeutic alliance and a reduction depressive symptomology (Crowe & Greyner, 2007; Gillaspy et al., 2002; Lingdren et al., 2008), no relationship was found. This is in stark contrast to previous findings that therapeutic alliance predicted change in depressive symptomology in both individual CBT and psychotherapy (Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Klien et al., 2003). A potential reason for this could be that the role of the therapeutic alliance is influenced by the presence of the multiple relational demands in group therapy that are not as prevalent in individual therapy.

Implications for Clinical Practice and Research

The findings of this review suggest that patient and therapist agreement on the tasks and goals, in addition to establishing a strong affective bond are important factors to attend to in group interventions. It may be necessary to attend to these as early as the first session. This is particularly true for male participants in domestic violence interventions. Alliance enhancing techniques could be incorporated into clinical training in group work to capitalise on the link between strong therapeutic alliance and positive outcomes in groups. This may include developing personal attributes such as flexibility and openness, and developing techniques such as reflection, and exploration. These factors have

consistently been found to positively impact on the therapeutic alliance (Ackerman & Hilsenroth, 2003).

Of the four studies that investigated the link between components of the therapeutic alliance and a pre-determined outcome, two identified the strength of the affective bond as being significantly correlated with outcome (Constantino et al., 2007; Jasper et al., 2014). One study identified a significant correlation between agreement on the goals for therapy and outcome (Mortberg, 2014). One study (Lenzo et al., 2014) found each component of the therapeutic alliance to be significantly related with outcome at some stage during therapy. Further studies investigating the various components of the therapeutic alliance and their relationship to outcome may provide more guidance to clinicians on which aspect of the alliance needs attending to most.

Further investigation into the link between therapeutic alliance and outcome in group interventions is needed. The development of a validated tool to measure therapeutic alliance between both the patient and the therapist, and between the patient and the group as a whole in group interventions would address some of the methodological limitations of the evidence currently available. Further research into the link between therapeutic alliance and outcome using such a measure is warranted. Future research should also measure therapeutic alliance across the course of therapy, rather than at one time-point, to further explore the dynamic nature of the therapeutic alliance in a group setting.

Limitations of Review

The limited diversity in the samples of the reviewed studies has been discussed. This review could have been strengthened by searching non-English language journals and databases to identify non-English language research. Positive publication bias may

have been reduced through the inclusion of unpublished papers and non-peer reviewed journals. As the first review of the available literature, it is also limited by the small number of studies that have been conducted at this time. Although drawing on the evidence available at the time of writing, this review is further limited by the fact that the link between therapeutic alliance and outcome was not the sole focus of the majority of studies included. This limited the amount of discussion given to this topic within the studies selected.

References

Abouguendia, M., Joyce, A. S., Piper, W. E., & Ogrodniczuk, J. S. (2004). Alliance as a mediator of expectancy effects in short-term group psychotherapy. *Group Dynamics: Theory, Research, and Practice, 8,* 3-12. http://dx.doi.org/10.1037/1089-2699.8.1.3

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33. http://dx.doi.org/10.1016/S0272-7358(02)00146-0

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology, 2,* 1-10. http://dx.doi.org/10.3389/fpsyg.2011.00270

Bakali, J. V., Baldwin, S. A., & Lorentzen, S. (2009). Modeling group process constructs at three stages in group psychotherapy. *Psychotherapy Research, 19,* 332-343. http://dx.doi.org/10.1080/10503300902894430

Barber, J. P., Connolly, M. B., Crits-Cristoph, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68,* 1027–1032. http://dx.doi.org/10.1037/0022-006X.68.6.1027

Bednar, R. L., & Kaul, T. J. (1994). Experiential group research: Can the canon fire? In M. J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 631-663). New York: NY, Wiley.

Bourgeois, L., Sabourin, S., & Wright, J. (1990). Predictive validity of therapeutic alliance in group marital therapy. *Journal of Consulting and Clinical Psychology, 58,* 608-613. http://dx.doi.org/10.1037/0022-006X.58.5.608

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology, 68,* 340-345. http://dx.doi.org/10.1037/0022-006X.68.2.340

Budman, S. H., Soldz, S., Demby, A., Feldstein, M., Springer, T., & Davis, M. S. (1989). Cohesion, alliance and outcome in group psychotherapy. *Psychiatry, 52,* 339-350. Retrieved from http://www.hindawi.com/journals/psychiatry/

Burlingame, G. M., Ellsworth, J. R., Richardson, E. J., & Cox, J. C. (2000). How effective is group psychotherapy: A review and synthesis of treatment outcomes. *Ricerche Sui Gruppi, 10,* 7–35.

Burlingame, G. M., Fuhriman, A., & Johnson, J. (2002). Cohesion in group psychotherapy. In J. Norcross (Ed.*), A guide to psychotherapy relationships that work* (pp. 71-88). Oxford: Oxford University Press. http://dx.doi.org/10.1521/ijgp.52.4.555.45523

Burlingame, G. M., Fuhriman, A., & Mosier, J. (2003). The differential effectiveness of group psychotherapy: A meta-analytic perspective. *Group Dynamics: Theory, Research, and Practice, 7,* 3-12. http://dx.doi.org/10.1037/1089-2699.7.1.3

Burlingame, G. M., MacKenzie, K. R., & Strauss, B. (2004). Small group treatment: Evidence for effectiveness and mechanisms of change. In M. J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 647-696). New York: NY, Wiley.

Burlingame, G., McClendon, D. T., & Alonso, J. (2011). Group cohesion. In J. Norcross (Ed.), *A guide to psychotherapy relationships that work* (pp. 71-88). Oxford: Oxford University Press. http://dx.doi.org/10.1093/acprof:oso/9780199737208.003.0005

Constantino, M. J., Manber, R., Ong, J., Kuo, T. F., Huang, J. S., & Arnow, B. A. (2007). Patient expectations and therapeutic alliance as predictors of outcome in group cognitive-behavioral therapy for insomnia. *Behavioral Sleep Medicine, 5*, 210-228. http://dx.doi.org/10.1080/15402000701263932

Crowe, T. P., & Grenyer, B. F. (2008). Is therapist alliance or whole group cohesion more influential in group psychotherapy outcomes*? Clinical Psychology & Psychotherapy, 15,* 239-246. http://dx.doi.org/10.1002/cpp.583

Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology and Community Health, 52*, 377-384. http://dx.doi.org/10.1136/jech.52.6.377

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59,* 10-17. http://dx.doi.org/10.1037/a0025749

Friedlander, M. L., Escudero, V., Heatherington, L., & Diamond, G. M. (2011). Alliance in couple and family therapy. *Psychotherapy, 48,* 25-33. http://dx.doi.org/10.1037/a0022060

Fuhriman, A., & Burlingame, G. M. (1994). Group psychotherapy: Research and practice. In A. Fuhriman, & G. M. Burlingame (Eds.), *Handbook of group psychotherapy: An empirical and clinical synthesis* (pp. 3-40). London: John Wiley & Sons.

Gaston, L., & Marmar, C. (1994). The california psychotherapy alliance scales. in A. O. Horvath & L. S. Greenberg (Eds.) *The working alliance: Theory, research and practice* (pp. 85-108). London: John Wiley and Sons.

Gillaspy, J. A., Wright, A. R., Campbell, C., Stokes, S., & Adinoff, B. (2002). Group alliance and cohesion as predictors of drug and alcohol abuse treatment outcomes. *Psychotherapy Research, 12,* 213-229. http://dx.doi.org/10.1093/ptr/12.2.213

Hillers, T. K., Guyatt, G. H., Oldridge, N., Crowe, J., Willan, A., Griffith, L., & Feeny, D. (1994). Quality of life after myocardial infarction. *Journal of Clinical Epidemiology, 47,* 1287-1296. http://dx.doi.org/10.1016/0895-4356(94)90134-1

Holmes, S. E., & Kivlighan, Jr D. M. (2000). Comparison of therapeutic factors in group and individual treatment processes. *Journal of Counseling Psychology, 47,* 478–484. http://dx.doi.org/10.1037/0022-0167.47.4.478

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J.C. Norcross (Ed.), *Psychotherapy relationships that work.* (pp. 25-69). New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9-16. http://dx.doi.org/10.1037/a0022186

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-238. http://dx.doi.org/10.1037/0022-0167.36.2.223

Horvath, O. A., & Marx, R. W. (1991). The development and decay of the working alliance during time-limited counselling. *Canadian Journal of Counselling, 24,* 240-259. Retrieved from http://www.editlib.org/j/ISSN-0828-3893/

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149. http://dx.doi.org/10.1037/0022-0167.38.2.139

Jasper, K., Weise, C., Conrad, I., Andersson, G., Hiller, W., & Kleinstaeuber, M. (2014). Internet-based guided self-help versus group cognitive behavioral therapy for chronic tinnitus: a randomized controlled trial. *Psychotherapy and*

Psychosomatics, 83, 234-246. http://dx.doi.org/10.1159/000360705

Johnson, J. E., Burlingame, G. M., Olsen, J. A., Davies, D. R., & Gleave, R. L. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of Counseling Psychology, 52,* 310-321. http://dx.doi.org/10.1037/0022-0167.52.3.310

Johnson, D. P., Penn, D. L., Bauer, D. J., Meyer, P., & Evans, E. (2008). Predictors of the therapeutic alliance in group therapy for individuals with treatment-resistant auditory hallucinations. *British Journal of Clinical Psychology*, *47,* 171-184. http://dx.doi.org/10.1348/014466507X241604

Joyce, A. S., Piper, W. E., & Ogrodniczuk, J. S. (2007). Therapeutic alliance and cohesion variables as predictors of outcome in short-term group psychotherapy. *International Journal of Group Psychotherapy, 57,* 269-296. http://dx.doi.org/10.1521/ijgp.2007.57.3.269

Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., ... & Keller, M. B. (2003). Therapeutic alliance in depression treatment: controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology, 71,* 997-1006. http://dx.doi.org/10.1037/0022-006X.71.6.997

Kösters, M., Burlingame, G. M., Nachtigall, C., & Strauss, B. (2006). A meta-analytic review of the effectiveness of inpatient group psychotherapy. *Group Dynamics:*

Theory, Research, and Practice, 10, 146-163. http://dx.doi.org/10.1037/1089-2699.10.2.146

Lenzo, V., Gargano, M., Mucciardi, M., Lo Verso, G., & Quattropani, M. (2014). Clinical efficacy and the therapeutic alliance in a time-limited group therapy for young adults. *Research in Psychotherapy: Psychopathology, Process, and Outcome, 17,* 9-20. doi: 10.7411/RP.2013.015

Lese, K. P., & MacNair-Semands, R. R. (2000). The therapeutic factors inventory: Development of a scale. *Group, 24,* 303-317. http://dx.doi.org/10.1023/A:1026616626780

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., ... & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *Annals of Internal Medicine, 151*, 1-65. http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00136

Liebenthal, D. M. (1980). *The experience of patients in group psychotherapy*. Chicago: Northwestern University.

Lindgren, A., Barber, J. P., & Sandahl, C. (2008). Alliance to the group-as-a-whole as a predictor of outcome in psychodynamic group therapy. *International Journal of Group Psychotherapy, 58,* 163-184. http://dx.doi.org/10.1521/ijgp.2008.58.2.163

Lorentzen, S., Bakali, J. V., Hersoug, A. G., Hagtvet, K. A., Ruud, T., & Høglend, P. (2012). Psychodynamic group psychotherapy: Impact of group length and

therapist professional characteristics on development of therapeutic alliance. *Clinical Psychology & Psychotherapy, 19,* 420-433.

http://dx.doi.org/10.1002/cpp.758

Lorentzen, S., Sexton, H. C., & Høglend, P. (2004). Therapeutic alliance, cohesion and outcome in a long-term analytic group. A preliminary study. *Nordic Journal of Psychiatry, 58,* 33-40.

http://dx.doi.org/10.1080/08039480310000770

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance questionnaire (HAq-II): psychometric properties. *The Journal of Psychotherapy Practice and Research, 5,* 260-271.

Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=407188

MacKenzie, K. R. (1981). Measurement of group climate. *International Journal of Group Psychotherapy, 31,* 287-295. Retrieved from http://guilfordjournals.com/loi/ijgp

Marmer, C. R., Weiss, D., & Gaston, L. (1989). Towards the validation of the California therapeutic alliance rating system. *Psychological Assessment, 1,* 46-52.

http://dx.doi.org/10.1037/1040-3590.1.1.46

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

http://dx.doi.org/10.1037/0022-006X.68.3.438

Marziali, E., Munroe-Blum, H., & McCleary, L. (1999). The contribution of group cohesion and group alliance to the outcome of group psychotherapy. *International*

Journal of Group Psychotherapy, 47, 475-497 http://dx.doi.org/10.1080/10503309912331332841

Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36,* 455-470. http://dx.doi.org/10.1016/S0005-7967(97)10031-6

Mortberg, E. (2014). Working alliance in individual and group cognitive therapy for social anxiety disorder. *Psychiatry Research, 220,* 716-718. http://dx.doi.org/10.1016/j.psychres.2014.07.004

Muran, J. C., & Barber, J. P. (Eds.). (2011). *The therapeutic alliance: An evidence-based guide to practice.* London: The Guilford Press.

Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the tinnitus handicap inventory. *Archives of Otolaryngology–Head & Neck Surgery, 122,* 143-148. http://dx.doi.org/10.1001/archotol.1996.01890140029007

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple, and individual scales. *Journal of marital and Family Therapy, 12,* 137-151. http://dx.doi.org/10.1111/j.1752-0606.1986.tb01631.x

Piper, W. E., Boroto, D. R., Joyce, A. S., McCallum, M., & Azim, H. F. (1995). Pattern of alliance and outcome in short-term individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 32,* 639-647. http://dx.doi.org/10.1037/0033-3204.32.4.639

Piper, W. E., & Ogrodniczuk, J. S. (2010). The therapeutic alliance in group therapy. In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance. An evidence-based guide to practice,* (pp. 263-282). London: The Guildford Press.

Piper, W. E., Ogrodniczuk, J. S., Lamarche, C., Hilscher, T., & Joyce, A. S. (2005). Level of alliance, pattern of alliance, and outcome in short–term group therapy. *International Journal of Group Psychotherapy, 55,* 527-550. http://dx.doi.org/10.1521/ijgp.2005.55.4.527

Raue, P. J., Goldfried, M. R., & Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 65,* 582-587. http://dx.doi.org/10.1037/0022-006X.65.4.582

Royal College of Psychiatrists (2010). No health without public health. *Position Statement PS4/2010.*

Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice & Research, 7,* 126-143. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=407188

Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 75,* 104-115. http://dx.doi.org/10.1037/0022-006X.75.1.104

Spitz, H. I., & Spitz, S. T. (1999). *A pragmatic approach to group psychotherapy*. London: Psychology Press.

Sterba, R. (1934). The fate of the ego in analytic therapy. *The International Journal of Psychoanalysis, 15,* 117-126. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1745-8315

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of consulting and clinical psychology, 71,* 812-820. http://dx.doi.org/10.1037/0022-006X.71.4.812

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Journal of Consulting and Clinical Psychology, 1,* 207-210. http://dx.doi.org/10.1037/1040-3590.1.3.207

Tschuschke, V. (1999). Gruppentherapie versus einzeltherapie. Gleich wirksam. *Gruppenpsychotherapie und Gruppendynamik, 35,* 257-274.

Tschuschke, V., & Dies, R. R. (1997). The contribution of feedback to outcome in long-term group psychotherapy. *Group, 21,* 3-15. http://dx.doi.org/10.1007/BF02872750

Tucker, M., & Oei, T. P. (2007). Is group more cost effective than individual cognitive behaviour therapy? The evidence is not solid yet. *Behavioural and Cognitive Psychotherapy, 35,* 77-91. http://dx.doi.org/10.1017/S1352465806003134

Van Andel, P., Erdman, R. A., Karsdorp, P. A., Appels, A., & Trijsburg, R. W. (2003). Group cohesion and working alliance: Prediction of treatment outcome in cardiac

patients receiving cognitive behavioral group psychotherapy. *Psychotherapy and Psychosomatics, 72,* 141-149. http://dx.doi.org/10.1159/000069733

Van der Ploeg, H. M., & Defares, P. B. (1980). ZBV: a Dutch-language adaptation of the Spielberger state-trait anxiety inventory. *Swets & Zeitlinger NedTPsychologie, 35,* 243-249.

Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78,* 200-211. http://dx.doi.org/10.1037/a0018912

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). IPT for Late-Life Depression. *Comprehensive Guide to Interpersonal Psychotherapy,* 213-222.

Woody, S. R., & Adessky, R. S. (2003). Therapeutic alliance, group cohesion, and homework compliance during cognitive-behavioral group treatment of social phobia. *Behavior Therapy, 33,* 5-27. http://dx.doi.org/10.1016/S0005-7894(02)80003-X

Paper B

Resolving Ruptures in the Therapeutic Alliance Using Session-by-Session Feedback – A Task Analytic Study

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Paper B Abstract

Objective: This study aimed to develop an explanatory model of how session-by-session feedback may be used to facilitate the identification of ruptures and aid the process of rupture resolution. **Method:** A task-analytic design was employed. Participants were five experts in the field of the therapeutic alliance and/or session-by-session feedback. They were interviewed to develop a theoretical model of how this therapeutic task might be achieved. Five patients receiving integrative therapy from one of two therapists also took part in the study. An analysis of selected sessions led to the development of an empirical model of in-session performance of this therapeutic task. The two models were then combined to produce a rational-empirical model. **Results:** A rational-empirical model of rupture resolution using session-by-session feedback was developed. **Conclusions:** Results suggest that session-by-session feedback can be used to identify ruptures and aid in the process of rupture resolution. The patient contribution to this process is crucial in its success. Limitations of the study, clinical implications, and suggestions for further research are discussed.

Keywords: Task analysis; session-by-session feedback; therapeutic alliance, ruptures.

Introduction

The Therapeutic Alliance

The concept of the therapeutic alliance has its roots in psychoanalytic literature (Sterba, 1934). Zetzel (1956) used the term to refer to a patient's ability to use the healthy part of their ego to work with the analyst to accomplish the therapeutic tasks. Luborsky (1976) attempted to extend the concept of the therapeutic alliance beyond its psychodynamic roots. He suggested two types of alliance, the first being the extent to which the client perceived the therapist as being a potent source of help, providing a warm, supporting and caring relationship. The second type of alliance referred to the client's investment in the therapeutic process itself.

Bordin (1979) proposed a conceptualisation of the therapeutic alliance that was applicable regardless of therapeutic orientation. This comprises of agreement between the client and therapist on the therapeutic goals, consensus on the tasks that make up therapy, and the bond between the client and therapist. A strong therapeutic alliance suggests that the therapist and patient are working purposefully and collaboratively towards the agreed goals of therapy (Muran & Barber, 2010). This conceptualisation has been used as the basis for a number of widely used therapeutic alliance measures, and for this reason will be used within the present study. The therapeutic alliance has been found to be a robust predictor of treatment outcome across a range of different treatments (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000).

Ruptures in the Therapeutic Alliance

A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between a client and their therapist (Safran, Muran, & Eubanks-Carter, 2001). Ruptures can vary in intensity, duration, and frequency according

to the particular therapist-client dyad. For example, a rupture may consist of a minor tension that the client or therapist may be only vaguely aware of, or a major breakdown in understanding, communication and collaboration. Safran, Muran, and Eubanks-Carter (2011) suggest that ruptures can be seen as patient behaviours and/or communications that indicate critical points in therapy for exploration. Ruptures frequently occur when therapists unintentionally participate in maladaptive interpersonal cycles. This can confirm a patient's dysfunctional interpersonal schemas, or generalised representations of self-other interactions (Safran, 1990).

Researchers have demonstrated that clients report ruptures in 19% to 42% of sessions, and therapists report ruptures in 43% to 56% of sessions (Safran et al., 2011). These figures rise to between 41% to 100% of sessions when ruptures are identified by trained observers (Safran et al., 2011).

Unresolved ruptures have been shown to be predictive of treatment drop-out, and higher rupture intensity has been found to be associated with poorer outcomes in psychological wellbeing and interpersonal relationships. (Muran, Safran, Gorman, Samstag, Eubanks-Carter, & Winston, 2009; Muran, Safran, Samstag, & Winston, 2005). Recognising and resolving ruptures may play a significant role in treatment retention and positive outcome (Muran et al., 2009). Furthermore, a therapy focusing primarily on rupture repair was found to be more effective than either CBT or psychodynamic therapy at keeping clients engaged in treatment when other therapies had failed (Muran et al., 2005).

Repairing Ruptures in the Therapeutic Alliance

Given the prevalence of ruptures and their association with dropout and outcome, investigation into how ruptures are repaired is a crucial area for research. Distinct models

of rupture repair processes have been developed using quantitative and qualitative methodologies for integrative therapy (Safran & Muran, 2001), cognitive-behavioural therapy (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008), cognitive-analytic therapy (Bennett, Parry, & Ryle, 2006) and emotion focussed couples therapy (Swank & Wittenborn, 2013). With the exception of the CBT model, findings from these studies emphasise the value of therapists openly acknowledging and exploring ruptures, rather than avoiding or ignoring them. All highlight the importance of the therapist maintaining an open and non-defensive stance. A further commonality between these models is linking the rupture process to broader patterns of interaction.

A limitation of existing models is that they presuppose that the therapist has become aware of a rupture. However, discrepancies between therapist and client reporting of ruptures, and also of the quality of the alliance have consistently been reported, with the latter's ratings of the quality of the alliance found to be more predictive of outcome (Wampold, 2001; Horvath & Bedi, 2002; Castonguay, Constantino, & Holforth, 2006). One way of assisting therapists in accurately assessing a patient's view of the therapeutic alliance is by systematically measuring the alliance during therapy. This process is a key element in efforts to improve psychotherapy outcomes through sessional outcome monitoring, or 'feedback informed therapy' (Lambert, 2010).

Session-by-Session Feedback on the Therapeutic Alliance

Session-by-session feedback derived from client-completed outcome and process questionnaires has been shown to improve outcome (e.g. psychological dysfunction, interpersonal relationships, and social role performance) in a significant body of high quality research (Lambert, Hansen, & Finch, 2001; Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen, & Goates, 2002; Shimokawa, Lambert, & Smart, 2010). This is particularly the case for clients who are not progressing as would be expected in therapy

(based on statistical models of progress in good outcome cases), where giving the questionnaire-based feedback to therapists results in reduced client deterioration and drop-out (Lambert et al., 2001).

The two feedback systems that have been most extensively researched incorporate monitoring of the therapeutic alliance alongside monitoring of client psychological problems. Lambert's feedback system based on the Outcome Questionnaire-45 measures (e.g. Lambert at al., 2001) incorporates an assessment tool for patients who are not progressing. This Assessment for Signal Clients (ASC) is designed to identify a number of common barriers to therapeutic progress. Problems in the therapeutic alliance are a prime focus. Interventions suggested include 'discuss[ing] the therapeutic alliance with the patient', 'give[ing] and ask[ing] for feedback on the relationship', and 'discuss[ing] therapist and therapeutic style match' (Lambert, Whipple, Harmon, Shimokawa, Slade, & Christofferson, 2004). The addition of this tool to the OQ feedback system led to an improvement in patient outcome in all studies (Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003).

The Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005) also utilises feedback on the therapeutic alliance, using the Session Rating Scale (SRS; Duncan et al., 2003), an ultra-brief measure of the therapeutic alliance. Through combining this with feedback on outcome, the effect size of treatment was doubled in some studies, and client retention and cost-effectiveness was improved (Miller, Duncan, Sorrell, & Brown, 2005). Formal assessment of the therapeutic alliance is, then, central to the two most empirically supported methods for delivering session-by-session feedback to the therapist. However, it is currently unclear how therapists use this information to improve outcome. Furthermore, researchers have

not yet developed an empirically based model for how formal feedback on the therapeutic alliance contributes to rupture resolution.

Aims of the Present Study

As has been discussed, there is overlap between session-by-session feedback on the therapeutic alliance, and resolving ruptures in the therapeutic alliance. Despite this there is no research into how feedback on the therapeutic alliance contributes to the resolution of ruptures. The aim of this study is to develop a model detailing how sessional feedback on the therapeutic alliance (in the form of client completed alliance measures shared with the therapist) may inform therapists of potential ruptures and enable attempts at resolution.

Research Questions

(1) How do experts believe session-by-session feedback on the therapeutic alliance can be used in the rupture resolution process?

(2) How is session-by-session feedback on the therapeutic alliance used in the rupture resolution process in clinical practice?

(3) What model of rupture resolution using session-by-session feedback can be arrived at if the expert model is combined with an empirical model based on observation?

Method

Design

The study employed a qualitative task analytic design.

The task analytic approach (Greenberg, 2007) is well established in the field of psychotherapy research and was used in the development of the existing research based models of rupture resolution. The approach consists of a qualitative analysis of theoretical

hypothesising regarding how a specific therapeutic task may be achieved, resulting in a *rational model*. This is followed by a qualitative analysis of actual clinical performances of the therapeutic task in question, resulting in the *empirical model*. These two models are then combined, providing a new model grounded in theoretical understanding and empirical observation – *the rational-empirical model*. Further information on the task analytic methodology is provided in Appendix D.

Participants

Two therapists were recruited from a private psychotherapy practice. Five individuals who were referred to the service and subsequently started individual treatment agreed to participate in the present study. Four participants received treatment from the first therapist, and one participant received treatment from the second therapist. Table 1 provides demographic information of the five participants:

Table 1. *Demographic Characteristics of Participants*

Participant Number	Therapist	Age	Sex	Ethnicity	Occupation	CORE at start of therapy	Presenting Problem
1	Therapist 1	30	Male	White British	Solicitor	19 (moderate)	Depression & Anxiety
2	Therapist 1	24	Female	British Asian	Medical Student	9	Complex Grief
3	Therapist 1	23	Female	White British	University Student	23 (moderate-severe)	Relational Difficulties; Depression
4	Therapist 2	29	Male	White British	Sales	5	Depression & Anxiety
5	Therapist 1	34	Male	White British	IT	12 (mild)	Depression

Therapist one is a qualified clinical psychologist, and is trained in Gestalt Therapy and Experiential Dynamic Therapy. Therapist one also teaches on clinical psychology training programs on the therapeutic alliance and session-by-session feedback. Therapist two is a qualified clinical psychologist.

Experts were identified through a review of the current literature to ascertain individuals with relevant publications in the fields of either session-by-session feedback and/or rupture resolution. This was followed by a discussion with the research supervisors. Six experts were identified and approached via e-mail. Five agreed to be interviewed as part of the present study. Details of their credentials as experts in these fields can be found in Appendix E.

Inclusion criteria. Client participants had to be between 18 and 65, and had to be able to give informed consent for participation in the current study. To be eligible for inclusion in the present study, client participants had to complete a Session Rating Scale (SRS; Duncan et al., 2003) in each therapy session, in addition to a Post Session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1991) immediately following each session.

Exclusion criteria. Participants were excluded from the current study if they had a diagnosis of a learning disability, schizophrenia, reported comorbid alcohol or illicit substance use, or had experienced a recent head injury.

Measures

Session rating scale. The Session Rating Scale (SRS; Duncan et al., 2003; Appendix F) is an ultra-brief therapeutic alliance measure designed specifically for session-by-session use. The measure consists of four 10cm visual analogue scales that each address a separate construct of the therapeutic alliance – the relationship, agreement

on goals, agreement on approach or method, and perception of the session as a whole. The SRS has been found to have similar test-retest reliability, internal consistency and concurrent validity with other validated measures of the therapeutic alliance (Duncan et al., 2003). Specific details regarding reliability and validity are contained within Appendix F.

Post session questionnaire. The Post Session Questionnaire (PSQ; Muran et al., 1991; Appendix G) is a measure designed to highlight any difficulties in the therapeutic relationship that may have been present during a therapy session. There is no psychometric data available for this measure at the time of writing. Sections A and D of the patient version of the measure were chosen for the current study, as they directly enquire about tension or conflict in the therapeutic alliance.

Rupture marker coding form. A rupture marker coding form (Appendix H) was developed by the researcher to code for the presence of ruptures and rupture repair when listening to the audio-recordings of therapy sessions. This was based on previous qualitative research on rupture 'markers' by Samstag, Muran, & Safran (2003) and Bennett, Parry, & Ryle (2006).

Interview schedule. A semi-structured interview schedule (Appendix I) was designed, and used to guide the interviews with experts. The schedule was developed to incorporate both 'experience and behaviour' questions, and also 'knowledge based' questions (Patton, 1990). This schedule was audited and approved by the research supervisors.

Procedure

Rational model. Experts were identified following a discussion with the researcher's supervisors, and approached via e-mail. Five experts were sent an

information sheet further detailing the aims, methodology, definitions used in the study (Appendix J) and gave consent to take part in the study.

Interviews were conducted via Skype, and recorded. Interviews took the form of semi-structured interviews aiming to develop a step-by-step model for how session-by-session feedback on the therapeutic alliance could be used in the rupture resolution process. Each interview was transcribed by the researcher.

Empirical model. Following referral to the private psychotherapy service, individuals were sent an information sheet regarding the current study (Appendix K). Informed consent (Appendix L) was obtained by the treating therapist at the first appointment. All sessions were audio recorded. As per standard practice at the private psychotherapy practice, the SRS was introduced roughly ten minutes before the end of each session, and as intended by its developers (Duncan et al., 2003) used as a tool to review the session. Following the end of each session, each participant completed a PSQ in the absence of the therapist, and stored it in a designated box outside of the therapy room.

Selection of sessions for analysis. PSQs were analysed, and any sessions where the participant had endorsed items indicating any degree of tension or conflict in the relationship, or feeling as though they were holding back were identified for inclusion in the analysis. Audio-recordings of these sessions were listened to, to ascertain the presence or absence of an unrepaired rupture prior to the administration and discussion of the SRS. These were identified through the use of the previously described coding form. Where these were present the rupture was transcribed. The subsequent administration and discussion of the SRS was also transcribed, and coded for either the successful or unsuccessful resolution of this rupture.

Data Analysis

Research question one. To answer the research question of 'how do experts believe session-by-session feedback on the therapeutic alliance can be used in the rupture resolution process?' the transcripts of the interviews with the experts were analysed using a grounded theory approach. Excerpts of the interviews are provided in Appendix M. A grounded theory approach was chosen because it provides systematic guidance on analysing qualitative data to construct an explanatory theoretical framework (Charmaz, 2014). Grounded theory is described as the qualitative design of choice when a theory is not currently available to explain a process (Creswell, 2007).

The data was initially coded line-by-line, using gerunds to define implicit meanings and actions, and to suggest emergent links between processes in the data. In vivo codes were used in the instances where it was important to preserve participants' meanings of their views and actions in the coding itself. Following the initial coding, focused coding was employed, using the most significant and frequent initial codes to categorise the data. Axial coding was used to relate categories to subcategories, and give coherence to the emerging analysis. Theoretical coding was then used to specify possible relationships between categories developed through focused coding. The coding scheme with supporting quotes is provided in Appendix N. The grounded theory approach led to the development of the rational model. This is a hypothetical model of how ruptures in the therapeutic alliance may be resolved using session-by-session feedback on the alliance.

Research question two. To answer the research question 'how is session-by-session feedback on the therapeutic alliance used in the rupture resolution process in clinical practice?' selected transcripts of the feedback process from therapy sessions were analysed using a grounded theory approach. Initially, the transcripts of three examples of

the SRS being introduced and discussed in therapy sessions leading to the resolution of a rupture were analysed. Examples of transcripts of ruptures, and the feedback process are provided in Appendix O. Through this analysis, an initial empirical model of how ruptures in the therapeutic alliance were repaired using feedback was developed.

The transcripts of two examples of the SRS being introduced and discussed in therapy sessions that did not lead to the resolution of a rupture were then analysed. These were compared to the initial empirical model. Any components contained within both examples that did not distinguish successful use of feedback from the unsuccessful use of feedback were removed. This process resulted in the final empirical model of how ruptures in the therapeutic alliance were repaired using feedback. The coding scheme and supporting extracts from transcriptions of therapy sessions is provided in Appendix P.

Research question three. To answer the question 'what model of rupture resolution using session-by-session feedback can be arrived at if the expert model is combined with an empirical model based on observation?' the rational and empirical models were synthesised. The final empirical model was compared with the rational model for corroboration, elaboration and modification. Changes were made in the rational model to accurately reflect actual client-therapist performances, resulting in a first 'rational-empirical' model. This is a synthesised model including both the theoretical description by experts in the field, and what was observed in practice.

Examples of feedback leading to the resolution of a rupture, and examples of feedback that did not lead to the resolution of a rupture were compared with the first rational-empirical model. Changes were made to the model after each comparison using the principles outlined above. This iterative comparison continued until further examples yielded no further discoveries, and saturation was reached.

Quality Checks

Credibility. A range of credibility checks were carried out throughout the present study. In the development of the rational model, emergent themes from individual transcripts were discussed with the research supervisors. After the development of the rational model, this was sent to all participants who had been interviewed for their feedback (Appendix Q). During the development of the empirical model, and the synthesis of the rational and empirical models, regular meetings were held with the research supervisors to discuss the emerging analysis of the data.

Triangulation. In the current study triangulation is achieved in a number of ways. During the rational analysis, the researcher triangulated his own theoretical speculation of how session-by-session feedback may contribute to the resolution of ruptures with that of experts in the field. During the empirical analysis, ruptures and their resolution were identified through both the use of the PSQ, containing both qualitative and quantitative data, and also through a detailed qualitative analysis of session transcripts.

Coherence and transparency. The ways in which simple systems of classification evolved into more sophisticated coding, and then into clearly defined concepts and explanations for the data collected should be made clear. The current study therefore aims to present its data and findings in a coherent and transparent manner. This will be evaluated in the discussion.

Reflexivity. Personal and intellectual biases were explored at the outset of this project through a bracketing interview conducted with a member of a qualitative research group. Excerpts of this are provided in Appendix R. These issues were kept in mind throughout the research process in regular supervision with the research supervisors, and

by keeping a reflective diary to record notes during the analysis. Excerpts of this are provided in Appendix S.

Transferability. The present study will aim to be sufficiently detailed for the reader to judge whether the findings apply in similar settings (Mays & Pope, 2000). The transferability of the findings of the present study will be addressed in the discussion.

Ethical Considerations

The research was approved by the Oxford Doctoral Course in Clinical Psychology Research Sub-Committee (Appendix T), and the Central University Research Ethics Committee (reference number MSD-IDREC-C1-2014-214; Appendix U). Recordings of experts, participants, and any related transcripts were stored on an encrypted, password protected memory stick. Data was anonymised using participant numbers, and any identifying personal information was changed during the transcription process. Hard copies of consent forms, questionnaires, and transcripts will be stored in a locked cabinet at the private psychotherapy practice. All data will be destroyed after a period of five years.

Results

The Rational Model

The rational model was developed through interviews with five experts to answer the research question, 'how do experts believe session-by-session feedback on the therapeutic alliance can be used in the rupture resolution process?' The model is presented in Figure 1 overleaf. It is then described, using selected quotes to illustrate the various stages. Table 2 provides information regarding which elements of the rational model were contributed to by each expert.

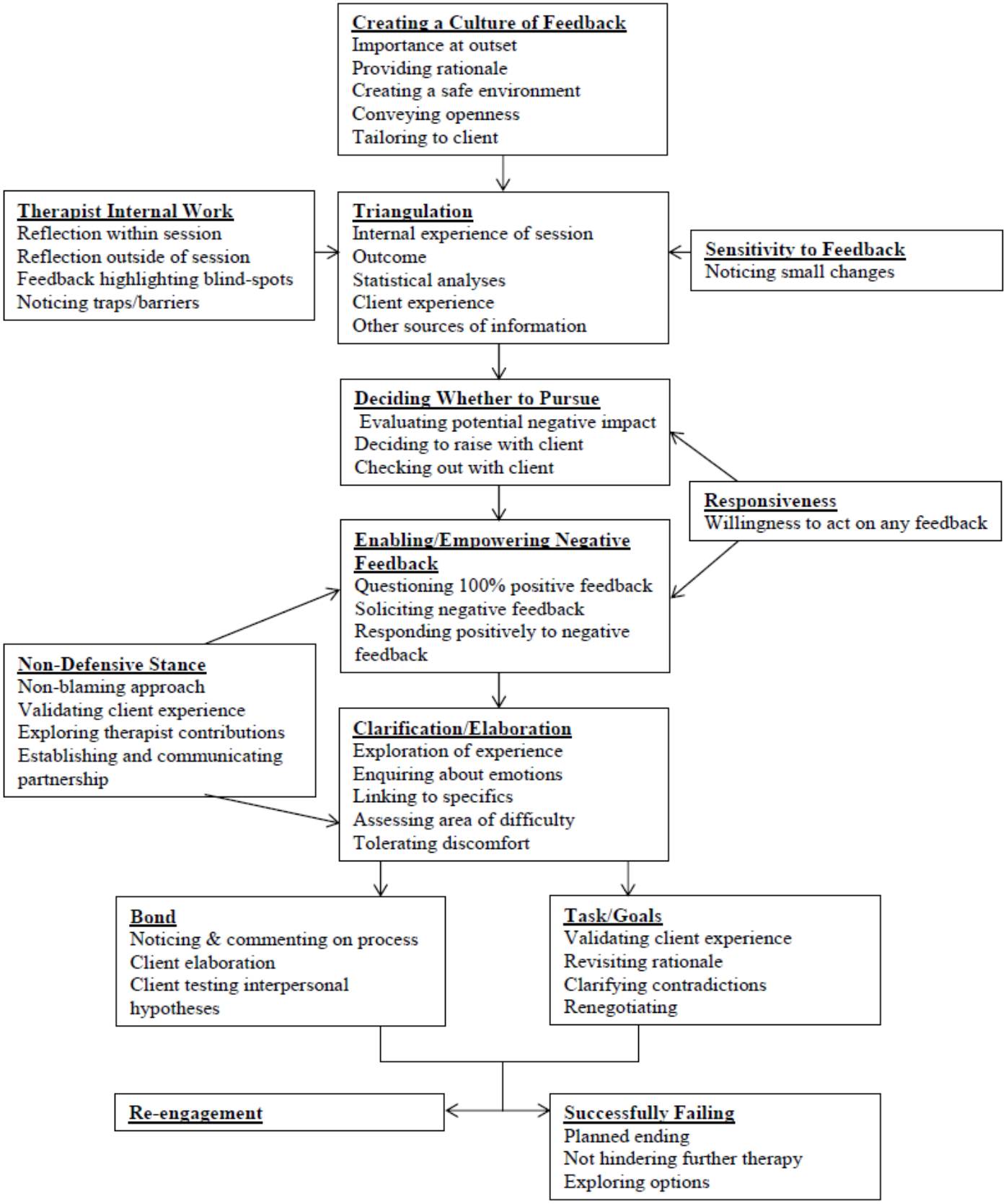

Figure 1. The Rational Model

Table 2. *Prevalence of themes in expert interviews*

Element of Rational Model	Scott Miller	Mike Lambert	Jeremy Safran	David Green	Rolf Holmqvist
Creating a Culture of Feedback	x		x	x	
Triangulation	x	x	x	x	x
Therapist Internal Work	x	x	x	x	x
Sensitivity to Feedback	x	x	x	x	x
Deciding to Pursue or Not	x	x	x	x	x
Enabling/Empowering Negative Feedback	x	x	x	x	x
Clarification/Elaboration	x	x	x	x	x
Non-Defensive Stance	x	x	x	x	
Bond		x	x		x
Task/Goals		x		x	
Re-engagement	x		x	x	x
Successfully Failing	x			x	

Creating a Culture of Feedback

All experts emphasised the importance of creating a culture of feedback from the very outset of therapy. This process begins with providing a rationale for feedback, and creating a safe environment in which feedback on the therapeutic alliance can be given by the client, and discussed:

> *"I think it's about providing a stage, where clients can give you very small, detailed feedback about what might be different or changed" [Scott Miller, line 159]*

It was hypothesised that this could be through conveying openness to feedback, and tailoring the feedback process to the client's wishes and needs:

> *"If there is something, to feel as though even if they're grasping for the words to just convey what feels a bit different, or a bit wrong, that they'll be listened to, and we can have an interesting exploratory conversation" [David Green, line 59]*

Triangulation

Once the patient has completed the feedback measure, the next step identified by the experts was the 'triangulation' of this data with other sources of information. This might be with patient reported outcome, the therapist's own experience of the session, and the patient's verbal report of how the session went:

> *"There's three different sources of information. There's what the patient verbalises in the session, there's what they score on the measure, and then there's I guess it's like the clinician's observations or intuitive sense of what's going on in the session… So it's kind of a triangulation process" [Jeremy Safran, line 409]*

In the cases where further sources of information were available (e.g. additional measures or statistical analyses of previous outcome and alliance scores), these would also be employed within the triangulation process.

Therapist Internal Work & Sensitivity to Feedback

Informing the triangulation process is the internal work of the therapist, and sensitivity to the feedback provided by the patient. All experts commented on the need for the therapist to notice, and reflect on their own in-session responses. This provides a vital source of information against which to compare the patient feedback to:

> *"I guess I'd have to look inside… try to look inside and being honest about what I am feeling, what I am thinking… reflection on what's really happening with me, in relation to them" [Mike Lambert, line 15]*

It also brings into awareness the aspects of the patient experience that the therapist may be blind to. When receiving this feedback, it is also crucial that the therapist is sensitive to the smallest of changes, as these can represent significant communications from the patient:

> *"You can end up with, I don't know, 3mm of difference on a 10cm line, and it launches into a conversation" [David Green, line 37]*

Deciding Whether to Pursue

The triangulation of the feedback, in combination with their internal work and sensitivity to small changes, aids the therapist in deciding whether to pursue the feedback further. As part of this decision making process, the therapist evaluates the potential negative impact that pursuing the feedback may have:

"One issue is if there's a problem in the alliance and you try to begin addressing it with the patient, and the patient is not willing to talk about what's going on in the relationship, then that has certain implications" [Jeremy Safran, line 115]

Once the decision has been made to further explore patient feedback, the first step is to check out the patient's perception of the feedback, and whether they feel it accurately represents their experience of the session.

Enabling/Empowering Negative Feedback

Once the therapist has decided to continue with a more focused discussion of the patient's feedback, then any negative feedback on the measure should be responded to in a positive way. This process helps further feedback to emerge, both in the moment and throughout the remainder of the therapy:

"I will say, 'I'm really glad that you made the mark the way you did, and I want you to know this is exactly what you need to do, and the next time you experience it, don't wait until I give you the form, you can tell me right then'" [Scott Miller, line 295]

Overwhelmingly positive feedback should be respectfully questioned. This process should be informed by both a responsive, and a non-defensive stance on the part of the therapist:

"I am listening, it's not a one way partnership, that it's two way, and that if they have further, what feels like negative, or damaging, or unhelpful aspects of the relationship, that they can bring it up again in the future, and that it's ok for them to have the feelings they have, it's ok for them not to please me" [Mike Lambert, line 33]

Clarification/Elaboration

Once the feedback has been raised with the patient, the aim of the therapist is to facilitate clarification of, and elaboration on the patient's experience. Central to this process

is enquiring about the emotional experience of the patient, and attempting to link their feedback to specific points within the session:

> *"The second thing I'm going to say is 'can you tell me what led to that lower piece, was there a moment during the visit… what was going on at the time? What words were used, what actions took place that led to that?" [Scott Miller, line 286]*

Throughout this step, the therapist will be attempting to assess the area in which the difficulty in the therapeutic alliance may lie. It is important that the therapist is able to tolerate the discomfort that might be inherent in exploring the rupture experience:

> *"So I wouldn't be too eager to resolve the rupture, I mean that's really what makes a good therapist, the ability to stay in a tense situation as long as the patient can have some use of it" [Rolf Holmqvist, line 165]*

Bond

If it emerges through clarification and elaboration that the difficulties are related to the bond between the patient and therapist, then the therapist should comment on process, and seek further elaboration from the patient. Following further discussion of this, it is hoped that the patient would then test out any interpersonal hypotheses:

> *"I might say something like… I wonder if you're afraid I'll be judging you… I'd want to put myself into the equation… I'd hope they would go inside, and try to figure out, for example, what their fantasies were about me… I would hope she would be able to reflect and say, 'yeah, I really am afraid you'll not like me, if I tell the truth, or something, and I'd hope if we discussed it then they'd take a risk of doing what, you know, take a risk and test out whether I withdraw from them" [Mike Lambert, line 433]*

Task/Goals

If it emerges through clarification and elaboration that the difficulties are related to agreement on task or goals, then the therapist would address this by initially validating the patient's experience, and re-visiting the rationale for the task or goals. Any contradictions that emerge through elaboration should be clarified, and if necessary the task or goals should be jointly re-negotiated:

> *"I mean, people should be the architects of their own therapy shouldn't they?... That line, the heroic client, that's where the engine of change lies… If they want to point the engine in a different direction, then it's best to respond" [David Green, line 443]*

Re-Engagement

As a result of this process, all the experts identified that they would look for re-engagement on the part of the patient as a marker that the rupture had been successfully resolved:

> *"If she didn't choose to show up, if she didn't come because it was so frightening to her and I wasn't able to be supportive enough, I'd know it hadn't worked. So checking out engagement with the process" [Mike Lambert, line 409]*

Successful Failure

One possible outcome of this process suggested by experts was coming to a mutual agreement that the therapy was not a good fit, without the patient dropping out. Through the feedback process this could be discussed, and other options discussed without jeopardising the utility of any future therapy the client may pursue at a later date.

> *"Planned ending, that's honey to my ears, because we know that more effective therapists have more planned terminations, I consider this a successful failure. I*

didn't help this particular person, but I didn't get in their way" [Scott Miller, line 386]

The Empirical Model

Session selection. Twenty-three sessions identified through PSQ scores as potentially containing ruptures in the therapeutic alliance were listened to by the researcher. Eight sessions were judged to contain the presence of a clear unrepaired rupture prior to the administration of the SRS. In six of these sessions the rupture was judged to have been repaired during feedback. In two of these sessions, the rupture was judged to have remained unrepaired during the feedback process. This process was audited by the researcher's supervisor. The first three examples of repaired ruptures and the two examples of unrepaired ruptures were selected for the development of the empirical model (Greenberg, 2007).

In addition, as experts identified the importance of *creating a culture of feedback* during the very first session, the introduction of the feedback measure in the first session of three participants was analysed. One participant was not included in this analysis, as they dropped out of therapy following the first session. That session was therefore not considered an appropriate example of the measure being introduced.

The empirical model was therefore developed through analysis of eight actual in-session performances by clients and therapists to answer the research question, 'how is session-by-session feedback on the therapeutic alliance actually used in the rupture resolution process in practice?' This model is presented in Figure 2 overleaf. The model is then described, using selected quotes to illustrate the various stages. Table 3 details which sessions contributed to each aspect of the empirical model.

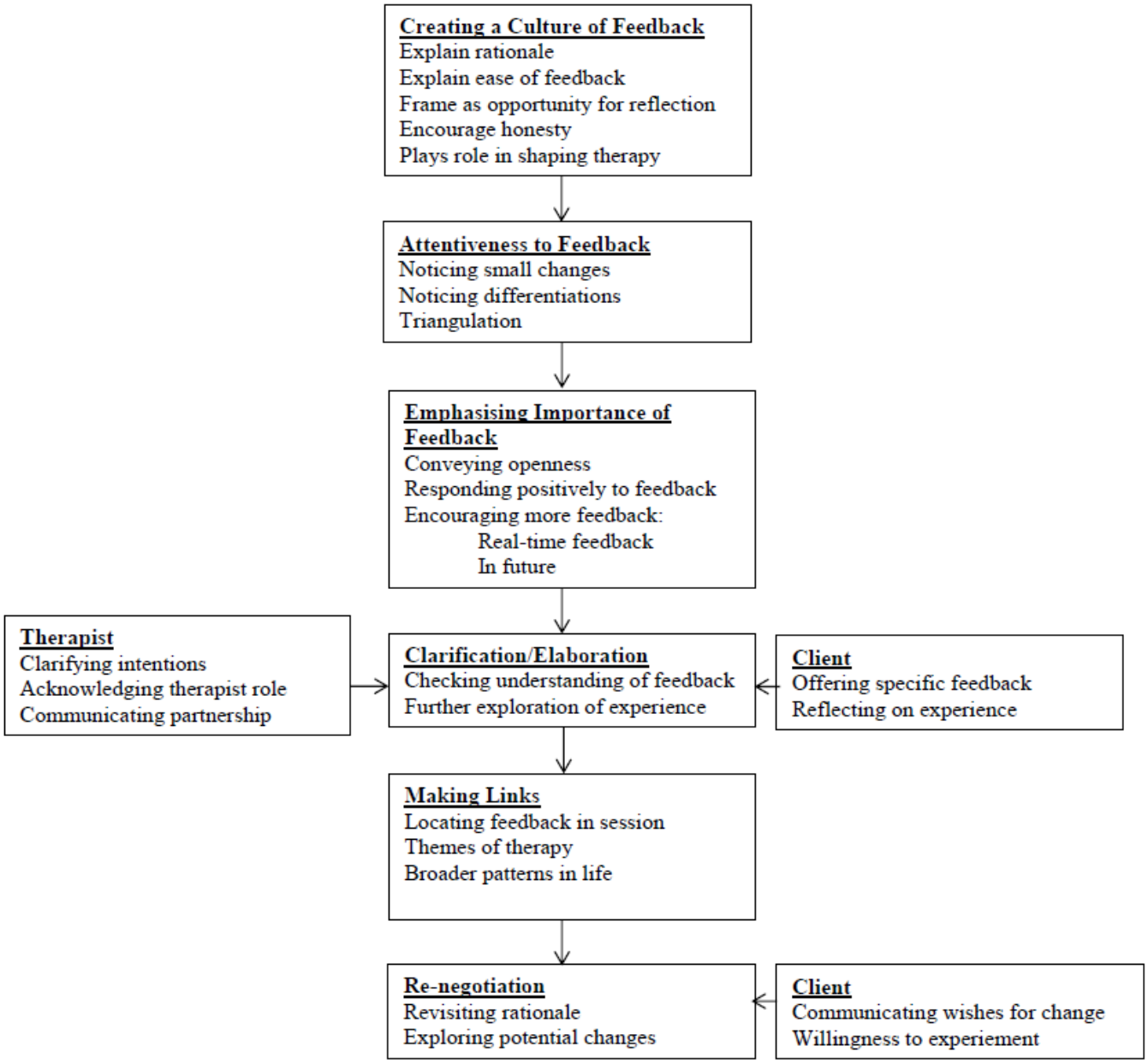

Figure 2. The Empirical Model

Table 3. *Prevalence of themes in session analyses*

Category	Participant 1 Session 1	Participant 3 Session 1	Participant 5 Session 1	Participant 3 Session 2 (Repaired Rupture)	Participant 3 Session 8 (Repaired Rupture)	Participant 1 Session 5 (Repaired Rupture)	*Participant 2 Session 1 (Unrepaired Rupture)*	*Participant 5 Session 3 (Unrepaired Rupture)*
Creating a culture of feedback	X	X	X	X	X	X	X	Not present
Attentiveness to feedback	Not analysed (NA)	NA	NA	X	X	X	X	Not present
Emphasising importance of feedback	NA	NA	NA	X	X	X	X	Not present
Clarification/elaboration	NA	NA	NA	X	X	X	X	Not present
Therapist contribution	NA	NA	NA	X	X	X	Not present	X
Client contribution	NA	NA	NA	X	X	X	Not present	Not present
Acknowledging therapist role	NA	NA	NA	X	X	Not present	X	Not present
Making links	NA	NA	NA	X	X	X	Not present	X
Renegotiation	NA	NA	NA	X	X	X	Not present	Not present
Client Contribution to Renegotiation	NA	NA	NA	X	X	X	Not present	Not present

Creating a Culture of Feedback

The creation of a culture of feedback occurred in the first session, either at the start of the session when the feedback measure is being introduced, or at the end of the first session when it is administered for the first time. The rationale for completing the measure was explained by the therapist:

> *"T: Yeah, so, erm, it's based on a lot of research showing that this is like a safety net, that can help us get back on track if things aren't working… It's about your experience of the session, so again we know that how you feel about the session, whether you feel understood, whether you feel we worked on the right things… Whether you feel that we worked in a useful way… This is really critical to the success of therapy" [Participant 1, session 1, line 18]*[1]

The feedback is framed as an opportunity for reflection:

> *"T: That gives you a chance to take a bit of a step back, break eye-contact with me as it were, just think about 'how was it for me', this session, and then we can have a a bit of a conversation about that" [Participant 5, session 1, line 5]*

Honesty is encouraged, and the potential for the feedback to shape the future of therapy is highlighted:

> *"T: Then really hopefully be absolutely as honest as you can about that experience, and then we can have a little conversation about you know, what I can learn from that… and then where we might go next" [Participant 3, session 1, line 12]*

[1]Therapist quotes are indicated by "T:"
Patient quotes are indicated by "P:"

Attentiveness to Feedback

The next step in the model is therapist attentiveness to the feedback that is provided by the client. This includes comparison with previous feedback offered by the client, and noticing any changes:

> *"T: Kind of less sure about today's session than you were about last time?" [Participant 3, session 2, line 20]*

Another step in this process is noticing whether there are any differentiations between the various subscales on the alliance measure:

> *"T: Yep, erm, a little bit less for the goals and topics, was there anything in that was er, that you were kind of picking up?" [Participant 1, session 5, line 10]*

Emphasising Importance of Feedback

Once the feedback has been raised with the client, the first step is to emphasise its importance. This is done in a number of ways by the therapist, firstly by conveying openness to the feedback, and responding positively:

> *"T: Well thank you so much, you've given me a lot of really helpful sort of feedback and pointers, and understanding to feel what it's been like in this conversation" [Participant 3, session 2, line 344]*

The therapist can then take this opportunity to reinforce the feedback process, encouraging both future feedback at the end of each session, and also 'real-time' feedback during the session itself:

> *"T: So if I kind of paraphrase something in a way that doesn't feel right, just, you know, please let me know" [Participant 3, session 8, line 193]*

Clarification/Elaboration

Once the importance of feedback has been emphasised, and reinforced, the specific feedback offered can be clarified and elaborated upon. The therapist should first check that they have correctly understood the feedback offered:

> *"T: So it felt a little bit like erm, being under pressure to do something that you weren't sure it was there, anyway?" [Participant 3, session 2, line 215]*

Once understanding has been established, feedback can be further explored:

> *"T: What might have helped pull that back further across to the right, erm, what could I have done that would have helped us, help you, focus more on what you wanted, or do it in a way that felt better for you?" [Participant 3, session 2, line 32]*

Therapist Contribution

During the process of clarification and elaboration, it is important that the therapist is aware of their own role in the experience of the client. It may be necessary for the therapist to clarify his/her own intentions:

> *"T: So not that I'm thinking I'm definitely right when I'm saying it's something, but I'm saying <u>it seems like</u> this…" [Participant 3, session 8, line 83]*

It is also important that the therapist acknowledges the role that they may have played in a rupture:

> *"T: Ok, so when I'm asking about feelings it feels a bit like a test, or a, or a hoop that you've got to jump through or something like that?" [Participant 3, session 2, line 198]*

Acknowledging their role allows the therapist to help communicate to the client that they are in a partnership, working collaboratively towards the goals of therapy:

> *"T: Because obviously we're both responsible for this" [Participant 3, session 2, line 54]*

Client Contribution

In order for clarification and elaboration of the rupture experience to take place, it is necessary for the client to offer specific feedback on their experience to alert the therapist to aspects of their experience that they may not have been aware of:

> *"P: I think I'm finding the paraphrasing a bit hard… Because I am very keen to, I'm always at great pains to work out what I'm saying, whether I'm being understood or misunderstood, and when somebody paraphrases it back even slightly differently to me, how I think about it… I start wondering if I've said the right thing" [Participant 3, session 8, line 56]*

Once the more specific feedback has been given the client is enabled through further discussion to reflect on their experience in more detail:

> *"P: Being able to, being able to feel things is something that will come… It's just that it… This week isn't a good week to be trying to concentrate too much on feeling… It is, I have replaced feeling with things a huge amount… I feel the step we're trying to make… With me being able to feel things in my body… Is sort of actually, I need to engage with that I think" [Participant 3, session 2, line 105]*

Making Links

Through the process of clarification, the therapist is able to contextualise the feedback offered. This involves the therapist locating the feedback in specific moments within the session:

> *"T: And you know, we kind of focussed on your feelings, particularly anger today, and how was that for you? Cause I'm kind of thinking, you know, you noticed the connection with your headache getting bigger… As we went more and more into it, and it kind of felt like stickier and stickier, because sort of, er… Like very hard for you to accept… Having really angry feelings, or thoughts" [Participant 1, session 5, line 38]*

The feedback can also be linked to the general themes of the therapy, or to broader themes in the client's life and experience:

> *"T: Right, right, so there's something about how easy it is to be over-accommodating… And you're noticing that outside here, and also in here" [Participant 3, session 8, line 153]*

Re-negotiation

The culmination of the feedback process is negotiation of how to incorporate the client's feedback into the therapy as it progresses. This displays responsiveness to feedback, and ensures the client remains engaged in the therapeutic process. It may be necessary to revisit the rationale for the task or goals of therapy:

> *"T: OK, so I was seeing us like we're in a workshop together, and kind of like working towards what might be emerging and what might be important" [Participant 3, session 8, line 80]*

An important final step is exploring potential changes that might be made within the therapy, directly as a result of the feedback from the client:

> *"T: So would it be helpful for us to make more space to go, to work through that… That's something we can definitely play with here if you want to" [Participant 3, session 2, line 261]*

It is crucial that this is a collaborative process, during which the client is able to communicate their wishes for change, or demonstrate a commitment to experimenting with suggestions:

> "*T: Just maybe something to*
>
> *P: Yeah,*
>
> *T: Play with a little bit in your mind, and see if anything comes up*
>
> *P: Will do*
>
> *T: And perhaps talk to other people about it and see what they think*
>
> *P: OK, yeah" [Participant 1, session 5, line 80]*

The Rational-Empirical Synthesis

To answer the question 'what model of rupture resolution using session-by-session feedback can be arrived at if the expert model is combined with an empirical model based on observation?' the rational and empirical models were synthesised.

Several differences were evident between the rational model (figure 1) and the empirical model (figure 2). These represent differences between theoretical speculation regarding the process of rupture resolution using session-by-session feedback, and the observable performance of this task in a clinical setting. A summary of these is presented below.

Triangulation of the feedback received on the therapeutic alliance with other sources of information was hypothesised by experts to be a distinct step in the rupture resolution process. Although triangulation of feedback was observed within clinical practice, this was as a component of a separate step described as *attentiveness to feedback.* Therapist *sensitivity* as suggested by experts was also incorporated into this step.

Experts hypothesised that *enabling and empowering negative feedback* would form an important and unique step in the use of session-by-session feedback in the rupture resolution process. However, in clinical practice, there was no distinction in the way the therapist responded to positive and negative feedback. This theoretical step was replaced in actual performances by a more general step of *emphasising the importance of feedback*.

The step of *clarification and elaboration* was present both in the hypothesised and the observed steps of rupture resolution. However, distinct *therapist* and *client* contributions emerged from an analysis of actual performance. Furthermore, *linking to specifics,* hypothesised by experts to be part of *clarification and elaboration*, formed part of a distinct step in actual performances – *making links*.

Contrary to what was suggested by experts, the analysis of in-session performance revealed the same approach was taken regardless of whether difficulties were reported with agreements on *goals and task*, or *bond*. This step was defined as *re-negotiation*, and a clear *client* contribution was evident in resolved ruptures.

Client contributions, both at the stage of *clarification and elaboration,* and *re-negotiation* were universally present in all six successful examples of session-by-session feedback being used to repair ruptures in the therapeutic alliance. They were absent in all three examples of the unsuccessful attempts.

With the exception of *therapist internal work* and *deciding to pursue or not*, all stages of the rational-empirical model were observed in each example of actual in-session performance of clients and therapists. It was not possible to observe therapist internal work, or therapist evaluation of the potential negative impact of addressing the rupture through audio-recordings.

The three remaining examples of session-by-session feedback being used to repair ruptures in the therapeutic alliance were iteratively compared with the first rational-empirical model. Changes to the first rational-empirical model were made to accurately reflect further actual client-therapist in-session performances. Saturation was not achieved due to the limited number of sessions identified by PSQs as potentially containing ruptures.

The final rational-empirical model arrived at through the synthesis of the rational and empirical models is presented overleaf in figure 3.

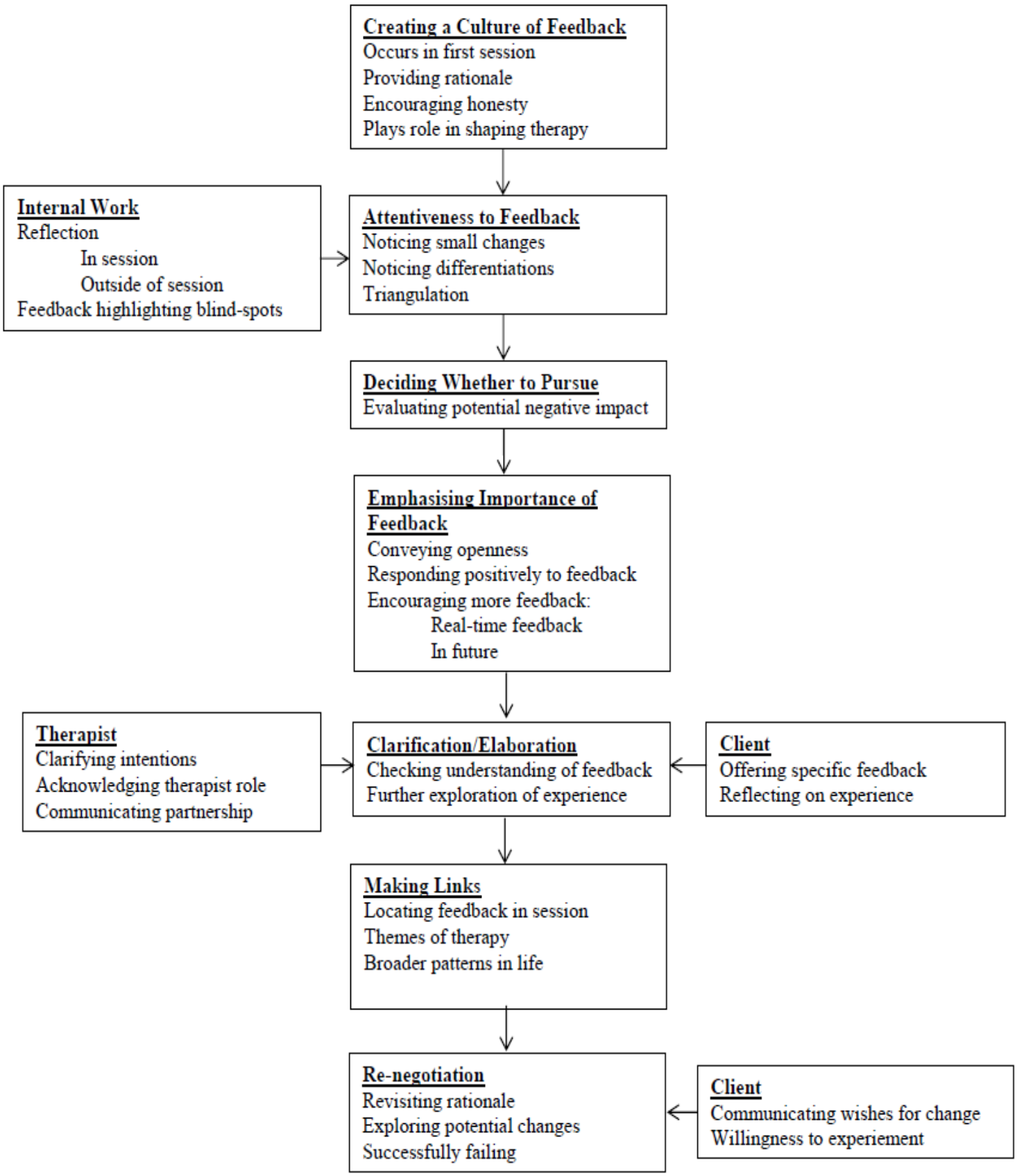

Figure 3. Final Rational-Empirical Model

Discussion

As findings of each phase of this study have been described in the results section, they will not be restated again here.

The Findings in Relation to Clinical and Empirical Literature

Session-by-session feedback. One criticism regularly raised regarding session-by-session feedback on the therapeutic alliance is the concern regarding demand characteristics. It has been argued that the presence of the therapist exerts pressure on the client to respond positively (Anker, Duncan, & Sparks, 2009; Reese, Toland, Slone, & Nosworthy, 2010). Whilst it was clear that participants consistently rated the therapeutic alliance as strong on the SRS, the final model provides guidance for how to negotiate this. *Creating a culture of feedback*, *attentiveness* to small changes and differentiations, and *emphasising the importance of feedback* all serve to ensure the utility of feedback in highlighting ruptures in the therapeutic alliance.

Ruptures in the therapeutic alliance. Safran et al. (2011) state that ruptures can range from a minor tension that one or both of the dyad may not be aware of, to major breakdowns in understanding, communication and collaboration. This wide range of rupture characterisations were present within the ruptures analysed within the study. It also supports the assertion of Safran et al. (2011) that ruptures in the therapeutic alliance are critical points for exploration and change in therapy. The important role session-by-session feedback on the therapeutic alliance can play in this has been demonstrated by the current study. Muran et al. (2009) found that recognition and resolution of ruptures may play a significant role in treatment retention and outcome. Although an analysis of this was outside of the scope of the study, the presence of an unrepaired rupture was confirmed in the initial session following which one participant dropped out of therapy.

Existing models of rupture-resolution. The final rational-empirical model shares similarities with the existing models of rupture-repair developed through task analytic studies, (Aspland et al., 2008; Bennett et al., 2006; Safran & Muran, 2001; Swank & Wittenborn, 2013 – figures of these are presented in Appendix V), although there are also notable differences. The similarities and differences between the rational-empirical model, and each existing model will now be briefly discussed.

The CBT model (Aspland et al., 2008) identifies the importance of *internal work* by the therapist, *making links*, and *renegotiation*. The CAT model (Bennet et al., 2006) includes stages analogous to *making links, clarification/elaboration*, and *re-negotiation*. The EFT model (Swank & Wittenborn, 2013) includes the steps that incorporate *emphasising the importance of feedback*, *clarification/elaboration*, *therapist contribution*, and *renegotiation*. Finally, the integrative therapy model (Safran & Muran, 2001) incorporates *clarification/elaboration*, and both *therapist* and *client contributions*.

The significant difference between the final model and existing models of rupture resolution is how a rupture is identified. All the models previous described rely on the therapist internally recognising a rupture. In the final model, this recognition is achieved through direct feedback from the client on a sessional measure. This is then considered alongside the therapist's internal experience of the session, and triangulated with other sources of information such as outcome. This unique feature of the model explains why steps such as *creating a culture of feedback*, and *attentiveness to feedback* are not contained within existing models. It is possible that the ruptures identified within this study may not have been resolved if session-by-session feedback had not been employed.

Covert client processes. One of the key revisions made to the rational model after observation of in-session performance was the inclusion of client contributions. Clients have

been found to consistently hide negative reactions in both brief therapy, and longer term therapy (Hill, Thompson, Cogar, & Denman, 1993). It is perhaps unsurprising then that the *client contribution* to both the *clarification and elaboration* step, and the *renegotiation* step, was present in all six ruptures repaired during feedback, and absent in both ruptures that were unrepaired during feedback. This suggests that client contributions are key to the final model. This finding could be explained by the fact that therapists have been found to be inaccurate in identifying when clients are hiding their experience of negative therapeutic reactions (Hill, Thompson, & Corbett, 1992).

These negative therapeutic reactions are often covert processes. Hill et al. (1993) found that 64% of clients left something unsaid during therapy sessions, and the majority of these were negative in content. In a grounded theory study into client deference in therapy, Rennie (1994) highlighted 'concern about the therapist's approach' as an area in which clients were reluctant to voice concerns. This was compounded by a 'fear of criticising the therapist' (Rennie, 1994). Through the use of a feedback measure such as the SRS, and by *creating a culture of feedback*, *emphasising the importance of feedback*, and *acknowledging the therapist's role* in any rupture it may be possible for these covert processes to be named, and discussed. From the results of this study, this would appear to help facilitate repairs to ruptures in the therapeutic alliance. Furthermore this process may bring more ruptures into the awareness of the therapist, which increases the chance of successfully repairing ruptures throughout therapy.

Methodological Critique

Coherence and transparency. The researcher endeavoured to present the data and findings in a coherent and transparent manner. During the development of the rational and empirical models, quotes from transcripts were provided to illustrate the location of themes

within the data. Further examples of quotes supporting each theme and sub-theme can be found in Appendices N and P.

Transferability. There were several limitations to the current study with regards to transferability. At present, the final model developed can only be considered specific to the environment in which it was developed (Greenberg, 2007). This is the resolution of ruptures using session-by-session feedback on the therapeutic alliance in integrative therapy. It is unclear whether the same steps would need to be taken by therapists working in other therapeutic modalities to achieve the same outcome. Only one therapist was involved in the four patient-therapist dyads analysed. This raises the possibility that the model represents an idiosyncratic way of working, rather than a transferrable process that could be employed by other therapists.

Confounding variables. It was not possible to observe the presence or absence of two of the steps in the final model – *therapist internal work*, and *deciding to pursue or not*. These are best conceptualised as internal processes that take place within the therapist. It was outside of the scope of the study to investigate these. In future work Interpersonal Process Recall (Kagan, 1984) could be used to clarify the importance of these steps in the current model.

A significant limitation of the current study was the lack of sensitivity provided by the PSQ. Fifty-seven point five percent of PSQs indicated no conflict or tension within the session. Of those that did indicate any tension or conflict, this was often reported as only minor. This perhaps should not be surprising, as previous studies have shown that clients report ruptures in only 19% to 42% of sessions. Significantly, the participant being treated by the second therapist recruited into the study reported no difficulties in the therapeutic alliance following every session. This precluded the use of these sessions in the empirical analysis.

The limited data available for analysis means that saturation was not achieved for the final model. Further comparisons with resolved or unresolved ruptures during the feedback process may have resulted in changes to the final model. However, given the overlap described above between the present model and existing models of rupture resolution, it can be hypothesised that these changes would be minor.

Reflexivity. During the course of this study my original way of thinking evolved in a number of ways as I engaged with the data. On initial listening to the therapy sessions where a potential rupture was indicated, the presence of a rupture appeared obvious to me. I originally questioned how such an experienced therapist, clearly well versed in the use of a relational model, could not attend to it in the moment. It was only after repeated and detailed listening that the complexity of the participant's communications became apparent. Many participants, even when prompted to discuss their experience as part of the feedback process gave an overwhelmingly positive view of the session, despite there clearly being periods of disengagement.

Prior to starting the study, perhaps due to my limited experience using the SRS, I naively envisaged it being used openly and honestly by all respondents. I imagined participants would be happy for the opportunity to raise difficulties that had not been addressed during the session. However, after listening to the sessions identified for analysis, the skill involved in creating an environment where negative feedback could be given, even after it was directly solicited, became apparent. This was further evidenced by the reluctance of many participants to offer negative feedback on the PSQ, despite knowing the treating therapist would not see it.

Clinical implications. This study can be considered an "essential, substantial, but preliminary contribution" (Harper, 1994, p.281) to the understanding of how session-by-

session feedback may be used to inform the repair ruptures in the therapeutic alliance. It must be noted that the second phase of the task analytic approach, the verification of the present model, was outside of the scope of this study. Therefore, the present model represents hypothesis generation, and is not intended as a direct guide for clinical practice.

Despite this, both the rational model and the rational-empirical model resulting from this research make clinically, theoretically and empirically grounded preliminary contributions to the fields of session-by-session feedback and rupture resolution. Given that therapists experience difficulty in avoiding engaging in negative complimentary interactions (Safran & Muran, 2000), and also in identifying ruptures (Eames & Roth, 2000), this research has implications for both training and supervision.

As repairing ruptures in the therapeutic alliance has been found to be predictive of improved outcome (Strauss et al., 2006), creating an environment where the client feels able to offer negative feedback is essential. This is particularly pertinent as clients are often reluctant to provide insights into their internal experiences of therapy (Hill et al., 1992). The current study suggests that training in the sophisticated and nuanced use of feedback measures may help therapists facilitate this process. When training therapists, the routine collection of therapeutic alliance data could be used for both educational purposes, and competence assessment. Alongside this process, a supervisory focus on therapeutic alliance concepts and techniques could aid the development of clinicians skilled at using and interpreting session-by-session feedback.

Future Research

Following this study's development of a preliminary model of rupture resolution using session-by-session feedback, the next phase within the task analytic approach is the 'verification phase' (Greenberg, 2007). This phase tests how well the model described in this

study describes the nature of further examples of rupture resolution using session-by-session feedback. In addition to this, it also investigates how well the model predicts outcome (Greenberg, 2007). Furthermore, the model developed in the present study should be compared with actual rupture resolution performances by other therapists. This would help ensure that the model developed did not represent an idiosyncratic description of one therapist's performance, rather a universal set of steps applicable to a number of different approaches.

Conclusion

This study provided a preliminary task analytic comparison of the hypotheses of experts in the fields of session-by-session feedback and rupture resolution, with actual clinical performance of the task of repairing a rupture in the therapeutic alliance using session-by-session feedback. The rational model, provided by experts was partially confirmed through observation of in-session performance. The most salient addition was the crucial role played by clients in the feedback and rupture resolution process.

References

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*, 693-704. http://dx.doi.org/10.1037/a0016062

Aspland, H., Llewelyn, S., Hardy, G. E., Barkham, M., & Stiles, W. (2008). Alliance ruptures and rupture resolution in cognitive–behavior therapy: A preliminary task analysis. *Psychotherapy Research, 18*, 699-710. http://dx.doi.org/10.1080/10503300802291463

Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 395-418. http://dx.doi.org/10.1348/147608305X58355

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16,* 252-260. http://dx.doi.org/10.1037/h0085885

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, 43*, 271-279. http://dx.doi.org/10.1037/0033-3204.43.3.271

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage.

Creswell, J. W. (2007). *Qualitative enquiry and research design: Choosing among five approaches.* London: Sage

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*, 3-12. Retrieved from http://journalbrieftherapy.com/

Eames, W., & Roth, A. (2000). Patient attachment orientation and the early working alliance – a study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10,* 421-434. Retrieved from http://www.tandfonline.com/toc/tpsr20/current#.VaOVLk3JCUk

Harper, H. (1994). The resolution of client confrontation challenges in exploratory psychotherapy: Developing the new paradigm in psychotherapy research. *Unpublished Doctoral Thesis, University of Sheffield.*

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology, 40,* 278-287. Retrieved from http://www.apa.org/pubs/journals/cou/

Hill, C., Thompson, B., & Corbett, M. (1992). The impact of therapist ability to perceive displayed and hidden client reactions on immediate outcome in first sessions of brief therapy. *Psychotherapy Research, 2,* 143-155. Retrieved from http://www.tandfonline.com/toc/tpsr20/current#.VaOVLk3JCUk

Horvath, A. O., and Bedi, R. P. (2002). The Alliance. In J.C. Norcross (Ed.), *Psychotherapy relationships that work.* (pp. 25-69). New York, NY: Oxford University Press.

Kagan, N. (1984). Influencing human interaction: Interpersonal process recall (IPR) stimulated by videotape. *O. Zuber-Skerritt, Video in Higher Education, 3,* 93-107.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. New York, NY: American Psychological Association.

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*, 159-172. http://dx.doi.org/10.1037/0022-006X.69.2.159

Lambert, M. J., Whipple, J. L., Harmon, C., Shimokawa, K., Slade, K., & Christofferson, C. (2004). Clinical support tools manual. Provo, UT: Department of Psychology, Brigham Young University.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology & Psychotherapy, 9*, 91-103. http://dx.doi.org/10.1002/cpp.324

Luborsky, L. (1976). Helping alliances in psychotherapy. *Successful Psychotherapy, 3*, 92-116.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450. http://dx.doi.org/10.1037/0022-006X.68.3.438

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *BMJ: British Medical Journal, 320*, 50-62. Retrieved from http://www.bmj.com/

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*, 199-208. http://dx.doi.org/10.1002/jclp.20111

Muran, J. C., & Barber, J. P. (2010). *The therapeutic alliance: An evidence-based approach to practice and training*. New York, NY: Guilford.

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 46*, 233-248. http://dx.doi.org/10.1037/a0016085

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. http://dx.doi.org/10.1037/0033-3204.42.4.532

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy: Theory, Research, Practice, Training, 47*, 616-630. http://dx.doi.org/10.1037/a0021182

Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology, 41,* 427-437. Retrieved from http://www.apa.org/pubs/journals/cou/

Samstag, L. W., Muran, J. C., Wachtel, A., Slade, A., Safran, J. D., & Winston, A. (2008). Evaluating negative process: A comparison of working alliance, interpersonal behavior, and narrative coherency among three psychotherapy outcome conditions. *American Journal of Psychotherapy, 62*, 165-194. Retrieved from http://www.ingentaconnect.com/content/afap/ajp

Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *The Journal of Psychotherapy Practice and Research, 7*, 126-143. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/journals/1745/

Safran, J. D. (1990). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review, 10*, 87-105. http://dx.doi.org/10.1016/0272-7358(90)90108-M

Safran, J. D., & Muran, J. C. (2001). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology, 56*, 233-243. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2044-8260

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80-87. http://dx.doi.org/10.1037/a0022140

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical*

Psychology, 78, 298-311. http://dx.doi.org/10.1037/a0019247

Sterba, R. (1934). The fate of the ego in analytic therapy. *The International Journal of Psychoanalysis, 15*, 117-126. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1745-8315

Swank, L. E., & Wittenborn, A. K. (2013). Repairing alliance ruptures in emotionally focused couple therapy: A preliminary task analysis. *The American Journal of Family Therapy, 41*, 389-402. http://dx.doi.org/10.1080/01926187.2012.726595

Wampold, B. E. (2001). General effects: The alliance as a case in point. The Great Psychotherapy Debate: Models, Methods and Findings (pp. 149-158). In L. N. Rice, & L. S. Greenberg, (Eds.). *Patterns of change: Intensive analysis of psychotherapy process*. London: Guilford Press.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology, 50*, 59-68. http://dx.doi.org/10.1037/0022-0167.50.1.59

Zetel, E. (1956). Current concepts of transference. *The International Journal of Psychoanalysis, 37*, 369-376. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1745-8315

Appendix A

Psychotherapy Research Instructions for Authors

Manuscript preparation

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- There is no word limit for articles but authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
  Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows:
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- Each manuscript should have 5 to 6 keywords .
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- Section headings should be concise.
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- Authors must adhere to SI units . Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

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- Description of the Journal's reference style.
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- Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

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Appendix B

EMBASE, MEDLINE, PsycINFO, & CINAHL Search Strategy

Evidence Services | library.nhs.uk

Search History

1. EMBASE, MEDLINE, PsycINFO, CINAHL; "therapeutic alliance".ti,ab; 7777 results.
2. EMBASE, MEDLINE, PsycINFO, CINAHL; "working alliance".ti,ab; 3122 results.
3. EMBASE, MEDLINE, PsycINFO, CINAHL; "helping alliance".ti,ab; 373 results.
4. EMBASE, MEDLINE, PsycINFO, CINAHL; group.ti,ab; 4849917 results.
5. EMBASE, MEDLINE, PsycINFO, CINAHL; outcome.ti,ab; 1741331 results.
6. EMBASE, MEDLINE, PsycINFO, CINAHL; 1 OR 2 OR 3; 10465 results.
7. EMBASE, MEDLINE, PsycINFO, CINAHL; 4 AND 5 AND 6; 455 results.
8. EMBASE,MEDLINE,PsycINFO,CINAHL; Duplicate filtered: [4 AND 5 AND 6]; 455 results.

Appendix C

Data Extraction Form

Citation
Study Design (incl. follow up time points) and Location
Sample (recruitment, method, sample size, attrition rates)
Group Demographics
Intervention(s)
Alliance Measure(s) (time point(s), respondent, direction)

Outcome Measure(s)
Findings & Method of Analysis (statistical and clinical significance/inclusion of moderating factors)
Limitations and Critical Appraisal (clear aims and research questions, clear definitions of terms, appropriateness of study design, sampling method and analyses, consideration of ethical procedures, validity and reliability of measures, frequency of alliance/outcome assessment, possibility of replication of intervention)
Key Implications/Relationship with Other Studies

Appendix D

Task Analytic Methodology

Theoretical Summary. An overall task analysis (Greenberg, 2007) comprises of two phases: a discovery oriented phase, and a validation oriented phase. The discovery oriented phase emphasises working within the context of discovery to build models (Rice & Greenberg, 1984). It employs both rational and empirical analyses to rigorously observe and categorise performance. The second phase is wholly empirical, and works within the context of justification, emphasising validation, hypothesis testing, group design, and statistical evaluation. The steps of each phase are outlined in Table 1 below. The current study will carry out the discovery phase of task analysis only.

Table 1

Steps of a Task Analysis

Phase	Step Description
Discovery	1. Specify the task
	2. Explicate the clinician's cognitive map
	3. Specify the task environment
	4. Construct the rational model
	5. Conduct empirical analysis
	6. Synthesise a rational-empirical model
	7. Explain the model: theoretical analysis
Validation	8. Validation of the components of the model
	9. Relating process to outcome

The steps of the discovery phase of a task analysis will briefly be described below, and related to the current study.

Step 1 – Specifying the Task

According to the task-analytic methodology, a precise behavioural description of the affective-cognitive problem is necessary. In the current study, the affective-cognitive problem to be investigated is a rupture in the therapeutic alliance between client and therapist. Precise behavioural markers of the problem must be defined. In the current study, the following definition of a rupture (Samstag, Muran, & Safran, 2003) will be used: "a complex interpersonal process between a patient and a therapist that is often subjectively experienced as a kind of tension within the therapeutic relationship…an emotional disconnection between patient and therapist creating a negative shift in the quality of the alliance" (p. 193).

Samstag et al. (2003) further delineate ruptures into 'withdrawal ruptures' and 'control ruptures'. Withdrawal ruptures represent a move by the patient away from the therapist, and are passive in nature. They can often be subtle in their manifestation, making them difficult for therapists to identify in the moment. Control ruptures describe a patient attacking or blaming the therapist, or the patient manipulating the therapist.

A rupture is considered to comprise of two components. The first of these is a misunderstanding event, which includes the 'immediate background' of the session, or the therapeutic task in which the dyad was engaged at the moment of the rupture. A misunderstanding event also includes a 'precipitant', or the way in which the therapist did something the patient did not need, or failed to provide what the patient needed (Samstag et al., 2003).

The second component of a rupture is a 'rupture marker' (Samstag et al., 2003), which is defined as, "expressions or indications of a patient's distress resulting from an emotional disconnection from the therapist" (p. 198). The patient behaviours that have been identified as rupture markers can be seen in Table 2 overleaf:

Table 2

Patient Marker Behaviours Found in Withdrawal and Control Rupture Episodes

Narrative Manner or Tone	Narrative Content
Long silence	Intellectualisation
Minimal response	Denial
Refusal to respond	Tangential, vague, or abstract narrative
Changing topic	Storytelling
Quiet voice	Talking about other people
Loud voice	Content of narrative mismatched with affective expression
Demanding, emphatic tone	Overly ingratiating comments
Whining tone	"Yes-ing" therapist then responding in contradictory way
Use of sarcasm or mocking tone	Self-critical statements
Coy or flirtatious manner (e.g. teasing)	Self-justifying statements

Heavy sighs	Helpless, manipulative behaviour (e.g. request that therapist call patient to remind about session)
Hisses through teeth	Passive-aggressive or threatening behaviour (e.g. patient making suicidal threats)
Interrupts and talks over therapist	Name dropping, use of obscure references or unusually sophisticated vocabulary
Disregards or dismisses therapist	Criticises therapist as a person
Directs therapist (e.g. "you should/must" or asking pointed questions)	Criticises therapist's competence
Mimics therapist	Questions relevance of therapist's interventions or treatment tasks
Talks directly to recording device	Doubts about being in therapy
Laughing at therapist	Complains about parameters of therapy (e.g. inconvenient session time)
Nervous laughter	Complains about lack of progress

Step 2 – Explicating the Clinician-Investigator's Cognitive Map

The second step of task analysis involves making explicit the perspectives and assumptions of the researcher before building a rational or empirical model. In the current

study this was completed through a bracketing interview, conducted with a member of a qualitative research group.

Step 3 – Specifying the Task Environment

The task-analytic methodology stipulates that the resolution of the task – in the current study the resolution of ruptures in the therapeutic alliance) will occur in a specific intervention context, and the final model of change will be specific to this environment. The purpose of specifying the task environment is to specify a standardised or controlled environment within which the performance variations of clients' and therapists' problem solving behaviour can be investigated. In the current study the task environment is individual integrative psychotherapy, which incorporates session-by-session feedback on the therapeutic alliance in the form of the SRS.

Step 4 – Constructing the Rational Model

Task analysis involves the undertaking of a rational analysis to produce a hypothetical model. During this process the researcher will conjecture as to how ruptures in the therapeutic alliance may be resolved once identified using session-by-session feedback on the therapeutic alliance. The rational model acts as a record against which any future observations will be checked. It is suggested that the rational model is constructed by engaging in a 'thought experiment', guided by the questions "how does the researcher think clients and therapists resolve this particular task", and "what essential steps must the client and therapist go through to resolve this problem".

The thought experiment should involve reflecting on clinical work completed with clients, asking "how would I resolve a problem like this", discussing with experts how they think clients and therapists might resolve the task of interest, and reviewing the relevant

literature regarding the task of interest. A rational model is then constructed as a first effort to capture the essence of what is thought to occur in the resolution of the affective-cognitive task. This acts as a baseline, and a hypothesis against which to evaluate what aspects of what is later observed are actually discoveries. In the current study, five experts were identified, and interviewed to develop the rational model.

Step 5 – The Empirical Analysis

The empirical analysis is the rigorous observation of samples of actual performance of clients and therapists who are working on resolving the affective-cognitive task of interest. The main procedure involves the selection of a number of resolved events and a description of the steps the client and therapist take to move from the marker to the resolved state. A diagram of the major components of this performance is sketched, using points at which the client's state changes in productive ways as anchor points for understanding the change process. In the current study, five participants were recruited, and the actual in-session process of resolving a rupture in the therapeutic alliance using session-by-session feedback was observed and described. This formed the first empirical model.

Step 6 – Synthesising a Rational Empirical Model

After the construction of the first empirical model, it is compared with the rational model for corroboration, elaboration, and modification. Changes are made in the rational model to accurately reflect actual client-therapist performances. This results in the first rational-empirical model, a synthesised diagram of a resolution performance. This represents an integration of what is actually observed with what was expected. The first rational-empirical model represents a theory, grounded in observation, which will acknowledge the theoretical assumptions from which it has arisen, and will demonstrate what has been newly

discovered. This model is then iteratively compared with further empirical models, until further in-session performance yield no further discoveries.

Step 7- Explaining the Model: Theoretical Analysis

This step involves considering what affective-cognitive psychological processes allow the client to move from one state to another to complete the task.

Uniqueness of Task Analysis

Task analysis is distinguishable from other qualitative inquiries in at least 4 important ways:

Purpose. The purpose of task analysis is the dynamic modelling of a change task, discerning the minimum number of distinct and essential steps in a task's resolution. Task analysis aims to describe a goal-directed performance as efficiently as possible. The discovery phase of a task analysis aims to model the process, rather than attempting to interpret meaning in a client's experience.

Use of theory. Task analysis dialectically makes use of both top-down (rational) and bottom up (empirical) modelling.

Nature of data collection. Task analysis relies on both what participants themselves are aware of, and also the systematic observation of a client's performance in a task. Therefore data for use in a task analysis may include both aspects of a change process - those that may be overt and are within the client's awareness, and those directly observed aspects that may be outside of the client's awareness.

Measurement development in the interest of prospective modelling. Models are developed in task analysis with the understanding that they must be amenable to

measurement and be empirically predictive of outcome. The creation of qualitative categories is contingent on their ultimately being codified in quantifiable terms. In addition to this, measurement criteria are constructed in parallel with the development of constructs (categories), such that identifying criteria actually impact the way in which constructs are conceptualised.

References

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research, 17,* 15-30. http://dx.doi.org/10.1080/10503300600720390

Samstag, L. W., Muran, J. C., & Safran, J. D. (2003). Defining and identifying alliance ruptures. In D. Charman (Ed.), *Core processes in brief psychodynamic psychotherapy* (pp.187-214). London: Routledge.

Appendix E

Expert Credentials

This appendix aims to summarise the relative qualifications of each expert identified as part of the rational analysis of the model. A brief description of their qualifications and publications will be provided, followed by pertinent examples of research they have contributed to.

Dr Jeremy Safran

Dr Safran has spent over 30 years playing a leading role in developing a 'second generation' of research on the therapeutic alliance. This investigates factors promoting a strong alliance, in addition to principles relevant to repairing strains or ruptures in the therapeutic alliance. He has conducted research using task analysis to develop models of rupture resolution in integrative therapy.

Selected publications:

Safran, J. D. (1993). Breaches in the therapeutic alliance: An arena for negotiating authentic relatedness. *Psychotherapy: Theory, Research, Practice, Training, 30,* 11-24. http://dx.doi.org/10.1037/0033-3204.30.1.11

Muran, J. C., **Safran, J. D**., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 46,* 233-248. http://dx.doi.org/10.1037/a0016085

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. http://dx.doi.org/10.1037/0033-3204.42.4.532

Muran, **Safran,** Samstag, Winston (1991). Client and therapist post-session questionnaires. Unpublished instruments, Beth Israel Medical Centre, New York.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology*, *56*, 233-243. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2044-8260

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80-87. http://dx.doi.org/10.1037/a0022140

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy: Theory, Research, Practice, Training, 38*, 406-412. http://dx.doi.org/10.1037/0033-3204.38.4.406

Samstag, L. W., Batchelder, S. T., Muran, J. C., **Safran, J. D.**, & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *The Journal of Psychotherapy Practice and Research, 7*, 126-143. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/journals/1745/

Samstag, L. W., Muran, J. C., Wachtel, A., Slade, A., **Safran, J. D.**, & Winston, A. (2008). Evaluating negative process: A comparison of working alliance, interpersonal behavior, and narrative coherency among three psychotherapy outcome conditions. *American Journal of Psychotherapy, 62*, 165-194. Retrieved from http://www.ingentaconnect.com/content/afap/ajp

Samstag, L. W., Muran, J. C., & **Safran, J. D.** (2003). Defining and identifying alliance ruptures. In D. Charman (Ed.), *Core processes in brief psychodynamic psychotherapy* (pp.187-214). London: Routledge.

Dr Scott Miller

Dr Miller was one of the co-developers The Partners for Change Outcome Management System (PCOMS), a client-directed, outcome-informed approach to therapy. He has written extensively on outcome informed therapy, and developed measures to track outcome and therapeutic alliance on a session-by-session basis. Specifically, Dr Miller was one of the developers of the Session Rating Scale (SRS), the tool used by therapists and participants within the present study to provide feedback on the therapeutic alliance.

Selected publications:

Duncan, B. L., **Miller, S. D.**, Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*, 3-12. Retrieved from http://journalbrieftherapy.com/

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, 91-100. Retrieved from http://journalbrieftherapy.com/

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*, 199-208. http://dx.doi.org/10.1002/jclp.20111

Dr Michael Lambert

Dr Lambert's has spent 30 years researching psychotherapy outcome, process, and the measurement of change. He has edited, authored, or co-authored nine academic research based books, and 40 book chapters. He has also published over 150 articles on treatment outcome. He is one of the developers of the OQ-System, which along PCOMS is one of the best researched and empirically supported feedback informed therapy systems.

Selected publications:

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*, 159-172. http://dx.doi.org/10.1037/0022-006X.69.2.159

Lambert, M. J. (2001). Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research. *Journal of Consulting and Clinical Psychology, 69*, 147-149. http://dx.doi.org/10.1037/0022-006X.69.2.147

Lambert, M. J., Harmon, C., Slade, K., Whipple, J. L., & Hawkins, E. J. (2005). Providing feedback to psychotherapists on their patients' progress: clinical results and practice suggestions. *Journal of Clinical Psychology*, *61*, 165-174. http://dx.doi.org/10.1002/jclp.20113

Lambert, M. J. & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In **M. J. Lambert** (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior*

change (pp. 139-193). New York, NY: Wiley.

Lambert, M. J., Whipple, J. L., Harmon, C., Shimokawa, K., Slade, K., & Christofferson, C. (2004). Clinical support tools manual. Provo, UT: Department of Psychology, Brigham Young University.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology & Psychotherapy, 9*, 91-103. http://dx.doi.org/10.1002/cpp.324

Shimokawa, K., **Lambert, M. J.**, & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*, 298-311. http://dx.doi.org/10.1037/a0019247

Wells, M. G., Burlingame, G. M., **Lambert, M. J.**, Hoag, M. J., & Hope, C. A. (1996). Conceptualization and measurement of patient change during psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire. *Psychotherapy: Theory, Research, Practice, Training, 33*, 275-295. http://dx.doi.org/10.1037/0033-3204.33.2.275

Whipple, J. L., **Lambert, M. J.**, Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal*

of Counseling Psychology, 50, 59-68.

http://dx.doi.org/10.1037/0022-0167.50.1.59

Dr David Green

Dr Green is a clinical psychologist with over 30 years' experience. Between 1998 and 2010 he was Clinical Director of the Clinical Psychology training programme at the University of Leeds. He is co-author of 'Maximising The Benefits of Psychotherapy: A Practice-Based Evidence Approach', a book investigating how practice-based evidence such as feedback directly from the client can be used to improve therapy outcome.

Selected publication:

Green, D., & Latchford, G. (2012). *Maximising the benefits of psychotherapy: A practice-based evidence approach*. London: John Wiley & Sons.

Dr Rolf Holmqvist

Dr Rolf Holmqvist is a professor in clinical psychology, clinical psychologist and psychotherapist. He has published 2 books and more than twenty articles, many focusing on the therapeutic alliance in psychological and psychiatric treatment.

Selected publications

Falkenström, F., Granstrom, F., & **Holmqvist, R.** (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology, 60,* 317-328.

http://dx.doi.org/10.1037/a0032258

Holmqvist, R., Hill, T., & Lang, A. (2007). Treatment alliance in residential treatment of criminal adolescents. *Child & youth care forum*, *36*, 163-178. Retrieved from http://www.springer.com/psychology/child+%26+school+psychology/journal/10566

Viklund, E., **Holmqvist, R.**, & Zetterqvist Nelson, K. (2010). Client-identified important events in psychotherapy: Interactional structures and practices. *Psychotherapy Research*, *20*, 151-164. Retrieved from http://www.tandfonline.com/toc/tpsr20/current#.VaOXT03JCUk

Falkenström, F., Granström, F., & **Holmqvist, R**. (2014). Working alliance predicts psychotherapy outcome even while controlling for prior symptom improvement. *Psychotherapy Research*, *24*, 146-159. Retrieved from http://www.tandfonline.com/toc/tpsr20/current#.VaOXT03JCUk

Holmqvist, R., Philips, B., & Barkham, M. (2015). Developing practice-based evidence: Benefits, challenges, and tensions. *Psychotherapy Research*, *25*, 20-31. Retrieved from http://www.tandfonline.com/toc/tpsr20/current#.VaOXT03JCUk

Appendix F

The Session Rating Scale

Session Rating Scale (SRS)

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	**Relationship** I———————————I	I felt heard, understood, and respected.
We did *not* work on or talk about what I wanted to work on and talk about.	**Goals and Topics** I———————————I	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	**Approach or Method** I———————————I	The therapist's approach is a good fit for me.
There was something missing in the session today.	**Overall** I———————————I	Overall, today's session was right for me.

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www.centerforclinicalexcellence.com
www.scottdmiller.com (with permission)

The SRS is an ultra-brief therapeutic alliance measure specifically for every session clinical use (Duncan et al., 2003). The measure consists of four 10cm visual analogue scales that each address a separate construct of the therapeutic alliance.

The SRS is scored by summing the marks made by the client measured to the nearest centimetre on each of the four lines, with a total possible score of 40. According to Duncan et al. (2003) any score lower than 36 overall, or 9 on any scale could be a cause for concern, and should prompt the therapist to ask the client to comment. An SRS score between 0-34 reflects a poor alliance, an SRS score between 35-38 reflects a fair alliance, and an SRS score between 39-40 reflects a good alliance.

Reliability

Duncan et al. (2003) found similar test-retest reliability, and internal consistency between the SRS and the Revised Helping Alliance Questionnaire (HAQ-II) (Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, et al., 1996), with a coefficient alpha (N=420) of .88 as a measure of internal consistency, and an overall test-retest reliability (Pearson's *r*) of .64.

Validity

Duncan et al. (2003) found concurrent validity between the SRS and the Revised Helping Alliance Questionnaire (Luborsky et al., 1996), with a correlation between the two meaures of .48 ($p<.01$). All correlations between SRS items and total HAQ-II scores were within a range of .39 to .44.

Construct Validity (Relationship to Outcome)

Duncan et al. (2003) found a correlation of .29 ($p<.01$) between SRS scores and the final administration of an outcome measure (Outcome Rating Scale). This indicated that the SRS functions in much the same way as other alliance measures.

References

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*, 3-12. Retrieved from http://journalbrieftherapy.com/

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance questionnaire (HAq-II): psychometric properties. *The Journal of Psychotherapy Practice and Research, 5*, 260-271. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/journals/1745/

Appendix G

The Post Session Questionnaire

POST SESSION QUESTIONNAIRE

Participant Number: Date:

SECTION A: Please circle the appropriate number.

1. How helpful or hindering for you was this session overall?

1 2 3 4 5 6 7 8 9

Extremely Hindering — Neutral — Extremely Helpful

2. To what extent are your presenting problems resolved?

1 2 3 4 5 6 7 8 9

Not at all — Moderately — Completely

SECTION B: Please circle the appropriate number.

1 a) Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your therapist during the session?

1 2 3 4 5

Not at — Occasionally — Constantly

b) If yes, please rate how tense or upset you felt about this during the session.

1 2 3 4 5

Mildly — Moderately — Extremely

2 a) To what extent did you find yourself and your therapist overly accommodating or overly protective of each other? Or to what extent did you feel you were making nice or smoothing things over? Or to what extent did you feel you were holding back or avoiding something?

1 2 3 4 5

Not at all Somewhat Very Much

b) If yes, please rate how tense or upset you felt about this during the session.

1 2 3 4 5

Mildly Moderately Extremely

3. Please describe the problem:

_____
_____
_____
_____
_____
_____
_____

4. To what extent was this problem addressed in this session?

1 2 3 4 5

Not at all Somewhat Very much

5. To what degree do you feel this problem was resolved by the end of the session?

1 2 3 4 5

Not at all Somewhat Very much

6. What do you think contributed to the resolution of the problem? Please describe:

_____
_____
_____
_____
_____
_____

Appendix H

Rupture Marker Coding Form

Coding Form

Participant Number: **Session Number:** **Coding From Number:**

Precipitant (way in which therapist did something the patient did not need, or failed to provide what was needed)

Rupture Markers: Expressions or indications of a patient's distress resulting from an emotional disconnection from the therapist

Narrative Manner or Tone	Time Point	Narrative Content	Time Point
Long silence/minimal response/refusal to respond		Intellectualisation	
Laughing at therapist/nervous laughter		Denial	
Directs therapist		Vague/tangential/abstract narrative	
Dismisses therapist		Storytelling	
Interrupts and talks over therapist		Talking about other people	
Mimics therapist		Content-affect mismatch	
Mocking tone/saracasm		Overly ingratiating comments	
Demanding tone		Yes-but	
Whining tone		Self-critical statements	
Flirtatious/coy		Self-justifying statements	
Heavy sighs		Helpless behaviour	
Quiet voice		Passive-aggressive behaviour (e.g. suicidal threats)	
Loud voice		Use of obscure vocabulary	
Changing topic		Criticises therapist	
Talks directly to recording device		Questions relevance of intervention/tasks	
		Doubts about being in therapy	
		Complaints about parameters of therapy	
		Complains about lack of progress	

Rupture Repair During Feedback:

Statement of Understanding	Time Point	Affective Shift	Time Point

Appendix I

Semi-Structured Interview Schedule

INTERVIEW SCHEDULE

What would be the first thing you would do if a rupture was identified using session-by-session feedback?

How would you address this with a client in the next session?

What would be the first step you would take?

What would be a necessary response from a client in order to move forward from this step?

What would you do if you did not receive this response from a client?

How would you know this step had been achieved?

What would immediately follow this step?

Summarising understanding – can I check that I've understood that right [offer understanding of previous points]?

How would a client know that the rupture had been resolved?

What would they be able to observe within the session?

How would a therapist know that that the rupture had been resolved?

What would they be able to observe within the session?

Appendix J

Information Sheet for Experts

Resolving Ruptures in the Therapeutic Alliance Identified Using Session-by-session Feedback

Background of Study

- Interest in the therapeutic alliance has grown over the past 30 years. The quality of the therapeutic alliance has been found to be a robust predictor of the outcome of therapy (Horvath et al., 2011).
- Ruptures in the therapeutic alliance can be seen as patient behaviours and/or communications that indicate critical points in therapy (Safran et al., 2011).
- The recognition and resolution of ruptures in the therapeutic alliance plays a significant role in both treatment retention and outcome (Muran et al., 2009).
- Session by session feedback has been shown to improve outcome in a significant body of high quality research (Lambert et al., 2001; Lambert et al., 2002; Shimokawa et al., 2010).
- The feedback systems with the most evidence incorporate systems for monitoring and tracking the therapeutic alliance (Lambert et al., 2001; Miller et al., 2006).
- The existing models of how ruptures in the therapeutic alliance are repaired have not provided a model for how session-by-session feedback may aid clinicians in the recognition and resolution of ruptures.

Aim of this Study

- To describe a model of how session-by-session feedback on the therapeutic alliance in the form of a client completed alliance measure may be used to recognise and repair ruptures.

Methodology – Task Analysis (Discovery Phase)

- Task analysis employs both rational and empirical analyses to rigorously observe and categorise performance.
- Initially a rational model is developed, in order to produce a hypothetical model of how ruptures might be resolved using session-by-session feedback.

- The rational model is developed through discussion with experts in the areas of rupture repair and session-by-session feedback, reflecting on clinical experience and theoretical understanding of the area of interest.
- An empirical model is then developed through the rigorous observation of samples of actual client and therapist performances.
- Through an iterative process these two models are combined into a rational-empirical model which can be used to generate hypotheses for future investigation.
- This approach has been used to investigate rupture repair in integrative therapy, cognitive behavioural therapy, and couples therapy.

Definitions & Measures

- Ruptures in the therapeutic alliance will be defined as 'a tension or breakdown in the collaborative relationship between client and therapist that can vary in intensity, duration, and frequency, according to the client-therapist dyad' (Safran et al., 2011).
- A post-session client completed questionnaire will be used to identify sessions containing ruptures in the therapeutic alliance.
- The measure used for session-by-session feedback on the therapeutic alliance will be the Session Rating Scale (SRS; Duncan et al., 2003). This is an ultra-brief therapeutic alliance measure designed specifically for every session clinical use.
- The SRS consists of four 10cm visual analogue scales that each address a separate construct of the therapeutic alliance (agreement on the goals of therapy, how these are to be achieved, the emotional bond between client and therapist), and also includes a perception of the session as a whole.

Objective of the Interview

- To develop a 'rational model' based on your experience and knowledge of rupture resolution and/or session-by-session feedback on the therapeutic alliance.
- This is an idealised model of how ruptures should be repaired using session-by-session feedback, and should identify each of the processes involved in reaching this resolution

Additional Information

- I am hoping to tape the interview to ensure I can review and revisit everything that has been said.
- I also hope to interview 4 other experts (Dr Mike Lambert, Dr Rolf Holmqvist, Dr David Green, Dr Scott Miller, Dr Jeremy Safran – DELETE AS APPOPRIATE) to aid in the development of the rational model.
- If you would like any further information regarding this study please do not hesitate to contact me at Christopher.laraway@hmc.ox.ac.uk

Appendix K

Participant Information Sheet

Christopher Laraway
Trainee Clinical Psychologist
Oxford Doctoral Course in Clinical Psychology
Isis Education Centre
Warneford Hospital
OX3 7JX

Resolving ruptures in the therapeutic alliance identified using session-by-session feedback

The therapeutic alliance describes the working relationship between a therapist and their client. It is thought to include agreement on the goals for therapy, the way in which these goals are to be achieved, and the emotional bond between the therapist and the client. Throughout the course of many different types of therapy, there may be times when therapists and clients disagree on these elements, or find the relationship in some way difficult. This study will help therapists understand how they can best monitor and improve their relationships with their clients.

You are being invited to take part in this study as you are starting treatment at Headington Psychotherapy.

Participation in the study will involve the audio-recording of each therapy session. A selected section of the recording may be written up by the researcher, and analysed in order to try and understand what was happening during this section.

If you have any questions that you would like to ask before deciding about taking part, you can either ask the therapist you will see, or alternatively you can speak directly to the researcher by e-mail, at Christopher.laraway@hmc.ox.ac.uk, or by telephone, on [redacted].

If you decide not to participate in this study, it will in no way impact on your treatment at Headington Psychotherapy. If you do give your consent to participate then you can withdraw at any time by e-mailing Christopher.laraway@hmc.ox.ac.uk at any time. This will not affect your treatment at Headington Psychotherapy.

This project has been reviewed by, and received ethics clearance through the University of Oxford Central University Research Ethics Committee.

Audio-recordings of therapy sessions will be listened to by the researcher (Christopher Laraway, Trainee Clinical Psychologist), a professional transcriber, and the supervisor involved in the study (Dr James Macdonald, Clinical Psychologist, and Dr Anne-Marie Daly, Clinical Psychologist) that is not acting as your therapist. Data will be stored electronically, and all data will be anonymised and password protected. Information will be stored for 5 years, and will be destroyed after this time. The

recordings of the therapy sessions will not be linked to any personal information such as your name, or date of birth.

The University of Oxford is committed to the dissemination of its research for the benefit of society and the economy and, in support of this commitment, has established an online archive of research materials. This archive includes digital copies of student theses successfully submitted as part of a University of Oxford postgraduate degree programme. Holding the archive online gives easy access for researchers to the full text of freely available theses, thereby increasing the likely impact and use of that research.

If you agree to participate in this project, the research will be written up as a thesis, with all personally identifying information anonymised. On successful submission of the thesis, it will deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published with restricted access, which means only individuals working within the field of psychology will have access.

Any therapy involves the discussion of sensitive issues. It is possible that you may feel uncomfortable with discussions of these issues being recorded, even though all recordings will be anonymised. You have the right to stop the recording of the sessions at any point, and can do this by speaking to your therapist.

If you have a concern about any aspect of this project, please speak to Christopher Laraway ([redacted]) or their supervisors Dr James Macdonald and Dr Anne-Marie Daly ([redacted]), who will do his/her best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how he/she intends to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the chair of the Research Ethics Committee at the University of Oxford (Chair, Medical Sciences Inter-Divisional Research Ethics Committee; Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD). The chair will seek to resolve the matter in a reasonably expeditious manner.

Appendix L

Consent Form

Christopher Laraway
Trainee Clinical Psychologist
Oxford Doctoral Course in Clinical Psychology
Isis Education Centre
Warneford Hospital
OX3 7JX

Name of Study: Resolving ruptures in the therapeutic alliance identified using session-by-session feedback

Researcher: Christopher Laraway, Trainee Clinical Psychologist
E-mail: Christopher.laraway@hmc.ox.ac.uk
Telephone: [redacted]

The purpose of the study is to help therapists understand how they can best monitor and improve their relationships with their clients.

I declare that:

- ☐ I have read the participant information sheet explaining the current study
- ☐ I have had the opportunity to ask questions about the study, and have received satisfactory answers to these questions, and any additional information if requited
- ☐ I understand that I may withdraw from the study at any time, without any penalty at any time by advising the researchers of my decision
- ☐ I understand that this study has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee
- ☐ I understand that personal data collected will be accessed by the researcher (Christopher Laraway) his two supervisors (Dr James Macdonald and Dr Anne-Marie Daly), a professional transcriber, and that this data will be anonymised and stored electronically, password protected, and destroyed after 5 years
- ☐ I understand that this research will be written up as a thesis, and that personal information will be anonymised, and the thesis will be available electronically to those studying relevant disciplines
- ☐ I agree to participate in this study, and for my therapy sessions to be audio-recorded
- ☐ I understand how to raise a concern and make a complaint

Participant: (Print Name) Therapist:

Signed:

Date:

Appendix M

Excerpts of Interview Transcripts

Extract from interview with Scott Miller:

SM: In our written literature we call this creating a culture of feedback. So, by contrast, I don't think that begging or pleading works. I think you have, because what we're looking for is such small, what's amazing is that clients are very forgiving, on the one side, we do make mistakes, they often take it and turn it to their benefit, so I think it's about providing a stage, where clients can give you very small, detailed feedback about what might be different or changed, what I don't think I know, really know yet, is do you have to do something about that feedback, or is the mere process of talking about it intensifies the engagement which leads to better outcomes.

CL: Yeah, ok, so, trying to convey how open you are to even the smallest of changes in order to provide the best possible therapeutic experience for the person opposite you?

SM: And in terms of very very small, nothing is too small to complain about. Therapy is the one place where you can still get the services tailored to you. I mean most of us by clothing off the rack, but this an opportunity to really have something that fits you, so I'm using lots of analogies to hopefully create an opportunity where clients can say something about small things that I can change. Of course, if it's something big, I would like to know, but my experience is that most of the time it's not something big, and the bigger challenge is that these difficulties build up over time and the client doesn't say things over time that are troubling, and then by the time they say something it is something big

CL: So kind of like a pressure cooker where you're hoping to let a little bit out as you go along, constantly attend to it rather than allowing it to become overwhelming and perhaps more explosive, and less manageable at that point?

SM: Yeah, that's right

CL: What would be a necessary response from a client in order to move forward from this?

SM: For me personally I'm looking for a head nod, engagement, as evidenced by questions, sometimes I brush through this material, for me I'm doing the SRS 5 times a day, for the client it's once a week, and so I would look for questions about, clarifications on their part, and then the time they take to fill it out

CL: Yeah

SM: Is it, for example with adolescents they draw a single line through all 4 questions, and to me this hints at disengagement, like I don't really care about this, and at this point I'm going to stop, and make a comment, like you filled that out really quickly, well yeah yeah, and then I'll say, me, I really am interested in this, would you take a look at it one more time, and answer the questions

CL: So it's a process that isn't necessarily linear, going straight from one to the other, it might need to be revisited, and there be a feedback loop within the setting the culture for feedback?

SM: There is. Now if the client scores perfectly, which we find is a hazard for beginners, so often times when teach people how to use it they'll come back a month later and say "I don't get any negative feedback". And they'll either blame the measure or the clients. You know, the clients are too afraid, or they're scared it isn't sensitive enough. And I always say you know the measure is working perfectly, and the clients have figured you out. They know that you can't take it, and so, usually there's a moment of shock, and I say what is it that's going to convince the people that you work with that you really do wanna know

CL: OK

SM: Once people have given a perfect score I find it very hard to undo, and I usually advise therapists not to even try, you know, because to say oh you know you're right, maybe it could be lower, in a way when we do that we're training the client according to the way we want it to be, the way we want it to be completed. And plus, if the client does, were they lying to begin with? It's a mess

CL: It muddies the water

SM: It's much better if I can get this stuff up front. If the client gives me perfect scores, and my gut tells me something different, then we now advise, I usually say, why don't you pick up the phone at the end of the day and call that client, just check in with them

CL: OK

Extract from interview with Michael Lambert:

ML: And, usually if I'm not especially happy to see somebody it's because they're difficult, and I feel inadequate, and when I feel inadequate then there's a little more dread about facing my limitations then, so I would try to own what my problem is by identifying within me what… but I don't think I necessarily need to discuss that with my patient, I can resolve it alone, so if, so then, I think you have get kind of specific, so if you're using the SRS, its just an item getting at say the task,

CL: Yeah

ML: So I think that requires a bit more elaboration on the part of the client if the task score is low on the srs, I think you need to dig into what part of the task is, you know, so if the patient finds the hour a bit boring, or a waste of time, or, erm, irrelevant, or painful, I mean you have to kind of get enough information on the task part, then I think you have to ask yourself how you can modify it, how you could be more responsive, so you probably have to check out, if you make modifications you'd probably need to check out if those modifications made a different. I think as therapists we're always checking it out, because we're always looking at our patients to see what's going on, but, erm I think we also know from Clara Hill's research that patients intentionally deceive us, so you can't always figure it out, they're trying to to give themselves away because they don't wanna be difficult

CL: Yeah, so, I guess from what I'm hearing part of the process you would go through would be deciding whether it's something you need to resolve personally through supervision or peer support,

that doesn't need to be explicitly discussed with the patient, or whether it's something that does need a conversation with the patient?

ML: Yeah

CL: And then would you take a different approach if it was say the task that was indicated, as opposed to the goals for the therapy, in trying to resolve that?

ML: Uh huh, yeah, because I think it's quite possible that I might see things in the client that, erm, like they might want to become better avoiders of, er, healthy coping strategies, they may wanna keep their unhealthy coping strategies, and they may not have an awareness of alternatives, or they might find it too difficult to do the alternatives. I may feel that they're, that's not going to be a very good long term solutions, so all of a sudden my goals can be ideal mental health, or my conception of how people should live, and their own idea might be continual avoidance of something is a really good strategy, so they want me to help them strengthen their ability to avoid, and, er, I might have a hard time accepting that as a worthy goal, or a goal I want to participate in very enthusiastically, and so that's really a goal disagreement, that'll have an impact on the bond, and on the way the hour is conducted, but it's primarily either me persuading them that that goal is gonna be detrimental and having them change their goal, or might be me having to give up on my ideal mental health conception, and it'll affect the hour because we'll probably wanna have a pretty serious conversation about that, in the hour, but it does seem to me like it's important for the end goal, for us to be on the same page

CL: So it would be checking your agreement on the goals, and I guess noticing if there was any difference between the client's goal and your goal?

ML: Yeah

CL: And that would be something that was explicitly discussed with the client?

ML: Yeah and those are kind of values conflicts that seem like they would be usual, or so, they seem like they have to be addressed

Appendix N

Rational Model Coding Scheme and Supporting Quotes

Category	Sub-category	Selected Quotes
Creating a culture of feedback	Importance at outset	"I think when you introduce the scale, this is where clients make a determination, in addition to your behaviour beforehand… I think you can increase the odds dramatically that the clients will give you feedback… So you say things like 'I'm not interested in perfect scores'" [Scott Miller, 140]
	Providing rationale	"What I say is there is no reason to leave here with shoes that pinch even a little, or with a suit that's too tight around the middle, we can sort those things out, we can talk about them, so let's make sure we have a suit that fits comfortably, and perfect for you when you leave. So setting the stage" [Scott Miller, 149]
	Creating safe environment	"We actually think it's a skill these clinicians possess. Somehow enabling, empowering, er, creating a safe space for clients to say, 'well, this didn't feel right, this wasn't right,' and then repairing that piece" [Scott Miller, 118]
	Conveying openness	"The message it conveys, the meta-communication of using a scale like this is, what it does, it says, 'come on, be responsive here, if there's something that's not going right for you let's grapple with it'" [David Green, 41]
	Tailoring to client	"I think it's about providing a stage, where clients can give you very small, detailed feedback about what might be different or changed" [Scott Miller, 159]
Triangulation	Internal experience of session	"It's just a piece of paper with four questions, it's silly on some level, but it can be something I can juxtapose to my own internal experience" [Scott Miller, 235]

	Outcome	"I hear clinicians say, 'well I like the SRS but I don't like the outcome scale'… I don't even know what kind of analogy I can put to that, it's like using the gas pedal without the brake. You can control the car by letting off the gas, but it's really helpful to have the second tool to say stop, so I use them in tandem." [Scott Miller, 82]
	Statistical analyses	"You can calculate a mean for that item, and you can calculate a standard deviation on the negative side of that item, and you can use that as a cut-off for if there's a problem with that" [Mike Lambert, 97]
	Client experience	"There's three different sources of information. There's what the patient verbalises in the session, there's what they score on the measure, and then there's I guess it's like the clinician's observations or intuitive sense of what's going on in the session… So it's kind of a triangulation process" [Jeremy Safran, 409]
	Other sources of information	"Well, we created what we call the assessment for signal cases, it has 40 items, and those are alliance outcomes" [Mike Lambert, 80]
Therapist internal work	Reflection within session	"I guess I'd have to look inside… try to look inside and being honest about what I am feeling, what I am thinking… reflection on what's really happening with me, in relation to them" [Mike Lambert, 15]
	Reflection outside of session	"I might have to talk to a supervisor, or a colleague about my less than positive feelings about my visits" [Mike Lambert, 113]
	Feedback highlighting blind spots	"And then that gives me something to work on, for myself, you know, that I'm tone deaf to this particular dimension of client experience, and if I'm tone deaf then I don't even hear it, I don't notice it" [Scott Miller, 510]
	Noticing traps/barriers	"I think it's quite possible that I might see things in the client that, erm, like they might want to become better avoiders" [Mike Lambert, 147]

Sensitivity to feedback		"It may not be anything big, in fact it might be something you don't even think is worth bringing up, because the rest of it was very good, and then, but what I say is 'there is no reason to leave here with shoes that pinch even just a little, or with a suit that's too tight around the middle, we can sort these things out, we can talk about them, so let's make sure we have a suit that fits comfortably, and is perfect for you when you leave'" [Scott Miller, 146] "And in terms of very very small, nothing is too small to complain about. Therapy is the one place where can still get the services tailored to you" [Scott Miller, 169] "You can end up with, I don't know, 3mm of difference on a 10cm line, and it launches into a conversation" [David Green, 37]
Deciding to pursue or not	Evaluating potential negative impact Deciding to raise with client Checking out with client	"One issue is if there's a problem in the alliance and you try to begin addressing it with the patient, and the patient is not willing to talk about what's going on in the relationship, then that has certain implications" [Jeremy Safran, 115] "You see the rupture in the patient's ratings, and the first decision is do you talk about it, or even show it?" [Rolf Holmqvist, 78] "I would probably say 'I notice that this particular mark is lower than the other three, I look to see whether the client agrees with that" [Scott Miller, 282]
Enabling/empowering negative feedback	Questioning 100% positive feedback Soliciting negative feedback	"I'm always, if you look at alliance ratings, on the WAI, you have seven as the top rating, and when I see that a patient rates seven on all items all the time, I'm very sceptical about this. You have to teach patients that they can score lower, and it's OK, you can think about that" [Rolf Holmqvist, 218] "I am listening, it's not a one way partnership, that it's two way, and that if they have further, what feels like negative, or damaging, or unhelpful aspects of the relationship, that they can bring it up again in the future, and that it's ok for them to

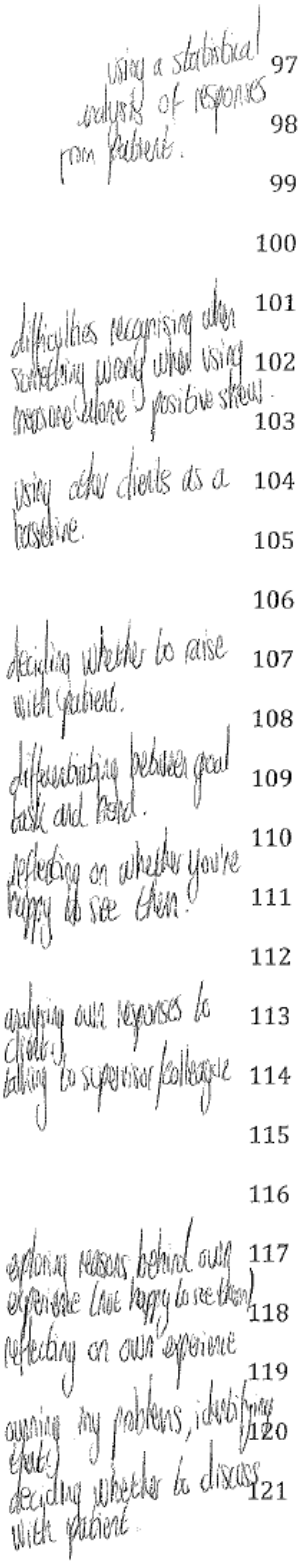
		have the feelings they have, it's ok for them not to please me" [Mike Lambert, 33]
	Responding positively to negative feedback	"I will say, 'I'm really glad that you made the mark the way you did, and I want you to know this is exactly what you need to do, and the next time you experience it, don't wait until I give you the form, you can tell me right then'" [Scott Miller, 295]
Responsiveness		"I want you to know I'm willing to hear it, big or small, doesn't matter. That's my job" [Scott Miller, 350]
Clarification/elaboration	Exploration of experience	"Broad questions, like 'tell me more about that', erm, reflection back of what they said, particularly the feelings about it, and trying to get concrete, trying to make it very concrete, the more concrete the better" [Mike Lambert, 11]
		"It's a way of triggering reflections and conversations" [David Green, 37]
		"We can have an interesting exploratory conversation" [David Green, 63]
	Enquiring about emotions	"One main thing is I think, the feelings, what did you feel, what did I feel, well no, that really wasn't what I felt, I felt this instead… so, the feelings in the rupture, would be central to me" [Rolf Holmqvist, 128]
	Linking to specifics	"The second thing I'm going to say is 'can you tell me what led to that lower piece, was there a moment during the visit… what was going on at the time? What words were used, what actions took place that led to that?" [Scott Miller, 286]
	Assessing area of difficulty	"If I get a differentiated score, if I'm a nine on goals and topics, but approach and method I'm a seven, then I'm gonna ask specifically about that… 'Can you say more?' I'm usually asking an open ended question at that point" [Scott Miller, 253]
		"I'm assuming that I probably need to explore the relationship with the client, and probably need to go back and ask them directly whether I have been working on things that they want to work on and talk about, that the means and methods I'm

		using make sense to them and fit with their values and preferences, and whether I'm living up to what they think my role is in the process" [Scott Miller, 60]
	Tolerating discomfort	"So I wouldn't be too eager to resolve the rupture, I mean that's really what makes a good therapist, the ability to stay in a tense situation as long as the patient can have some use of it" [Rolf Holmqvist, 165]
Non-defensive stance	Non-blaming approach	"This isn't about me blaming them for not speaking up, this is about me having done something and not noticing that it had that impact" [Scott Miller, 311]
		"As a therapist, rather than feeling 'oh god, I'm being criticised', I'm intrigued about what's going to come next" [David Green, 78]
	Validating client experience	"It's OK for them to have the feelings they have" [Mike Lambert, 36]
	Exploring therapist contributions	"I wouldn't want to be smoothing things over, erm, I would wanna help, sort of help them articulate what it is about what I did or said, or my body movements, or what the clues and triggers that they were picking up on were" [Mike Lambert, 20]
	Establishing and communicating partnership	"I suppose it would be something about is there anything we can do to respond to that, to improve those circumstances… I like the idea of a 'we' solution as it were" [David Green, 251]
Bond	Noticing and commenting on process	"I might say something like… I wonder if you're afraid I'll be judging you… I'd want to put myself into the equation… I'd hope they would go inside, and try to figure out, for example, what their fantasies were about me… I would hope she would be able to reflect and say, 'yeah, I really am afraid you'll not like me, if I tell the truth, or something, and I'd hope if we discussed it then they'd take a risk of doing what, you know, take a risk and test out whether I withdraw from them" [Mike Lambert, 433]
	Client elaboration	
	Client testing interpersonal hypotheses	

Task/goals	Validating client experience	"So within that, I think acknowledging that I may persist in my behaviour, but that I appreciate at times it may be frustrating, so that I'm aware that it's difficult sometimes to not get what you want" [Mike Lambert, 67]
	Re-visiting rationale	"I think, erm, if there was a goal discrepancy they might have to experiment with goals that are more in my mind more appropriate, or longer lasting, or more healthy, and see if, how that goes for them" [Mike Lambert, 202]
	Clarifying contradictions	"Maybe part of a step, or an early step is clarifying the goals so that you're sure of what they are, and erm, and maybe clarifying contradictions that people have, because they have goals that are not actually congruent" [Mike Lambert, 242]
		"So it's not just a discrepancy between the therapist's goals and her goals, but her goals and her goals, as well as the therapist's ideas about that way of coping, so it's possible you could start to elaborate, or help the client elaborate on the downside of containing feelings all the time, or being overly positive, there's a cost to that" [Mike Lambert, 225]
	Re-negotiating	"I mean, people should be the architects of their own therapy shouldn't they?... That line, the heroic client, that's where the engine of change lies… If they want to point the engine in a different direction, then it's best to respond" [David Green, 443]
Re-engagement		"Most of the time clients come back, and if the outcomes have moved up then rupture solved, and I'm not sure I have to go back" [Scott Miller, 389]
		"If she didn't choose to show up… If she didn't come because it was so frightening to her… I wasn't able to be supportive enough… so checking out engagement with the process" [Mike Lambert, 409]
Successfully failing	Planned ending	"Planned ending, that's honey to my ears, because we know that more effective

		therapists have more planned terminations, I consider this a successful failure. I didn't help this particular person, but I didn't get in their way" [Scott Miller, 386]
	Not hindering further therapy	"A grown up acknowledgement that this is not going very far right now, and maybe another time, maybe another therapist, but basically it doesn't leave people soured with their attitude towards a process" [David Green, 397]
	Exploring options	"I think a successful leakage or rupture, for me at least, could be that the client says 'you know, I don't think it's gonna work out between you and me', to me it could be successful… And then can I help you find somebody else?" [Scott Miller, 379]

Example of coding:



great deal, so if you give that to a few hundred patients you can calculate a mean for that item, and you can calculate a standard deviation on the negative side of that item, and you can use that as a cut for there's a problem with that, and erm, if a therapist simply has, depends on the absolute values on the scale then they're in a bit of trouble, because I don't think I, or other therapists would actually identify something wrong, cause the answers are always skewed up to the positive side, so you kind of a need a, you're operating more on relative to other clients I'm not getting a high rating on that

CL: Right

ML: I wouldn't see it necessarily er, as necessarily talking with that about the patient, I mean I can use that information from the patient's report on a scale to reflect on the bond, because I don't see that as a task or a goal item, I see that as a bond item, and I've have to reflect on whether I'm happy to see them

CL: Right

ML: And I've have to give some thought as to why not, and I might have to talk to a supervisor or a colleague about my less than positive feelings about my visits

CL: Yeah

ML: And, usually if I'm not especially happy to see somebody it's because they're difficult, and I feel inadequate, and when I feel inadequate then there's a little more dread about facing my limitations then, so I would try to own what my problem is by identifying within me what... but I don't think I necessarily need to discuss that with my patient, I can resolve it

Appendix O

Example of Rupture and Feedback Transcripts

Participant 3 – Session 2 – Rupture

55:00

C: I was going to go and do musicology in America, possibly

T: Mmm mmm

C: And maybe come back maybe not, see what happened

T: Mmm

C: Umm, and I, I wrote that off entirely

T: Mmm

C: I was prepared to give up academia entirely

T: Mmm

C: To be the stay at home wife while he had his

T: Wow

C: While he had his big flourishing career, which isn't really big and flourishing. Nevermind

T: Yeah, yeah yeah

C: That's that's a rant I can have with people in the pub

T: So you were, you know, you got to a point where you were willing to put to one side some really important things for you

C: Yeah

T: That were, were part of your identity, part of your

C: Yeah, they were

T: What you wanted, what you were excited by

C: Yeah

T: What, what was important for you

C: I

T: Mmm, so stay with your how you're feeling as well,

C: Yeah

T: This is you know, what are the feelings connected with that giving up, and that

C: Again there's that shame

T: Shame, uh huh

C: That I, I was always brought up to do what I wanted

T: Hmmm mmm

C: That would make me happy

T: Hmmm mmm

C: That would be validating in whatever sense

T: Mmmm

C: You know, my, I've grown up, my dad has refused, has refused, erm, promotions for the last ten fifteen years because he doesn't, he wants to be an engineer, he doesn't want to be a manager, he wants to be an engineer

T: Hmmm mmmm

C: My mum gave up work to have us, but is now doing a theology course

T: Mmmm

C: And er, she's on diocese and synod

T: Hmmm

C: And she helps out at church

T: Hmmm

C: So she's doing all these things

T: Hmmm

C: My grandfather retired at 50, and did volunteer sports stuff for the rest of his life

T: Hmm mmm

C: At the sort of level where he got a personally signed sympathy card from the Duke of Edinburgh

T: Wow

C: I know, erm

T: Right

C: They didn't know it was coming either

T: Yeah

C: Erm,

T: Yeah, so you're…

C: This is the sort of thing (talking over)

T: You, what you do is important

C: Yeah

T: You're not so materialistic you're more kind of

C: Hmm

T: As a family, this is you know you

C: Yeah

T: Wanna do what you you really value

C: Yeah

T: And what's precious to you…

C: And

T: And you were prepared…

C: Yeah

T: To give this up. Erm

C: And of course having a family was (talking over) is part of, well, no, there isn't an of course

T: Hmmm

C: But for me it's of course because that's how it works

T: Hmmm

C: But I do want my own family

T: Ummm mmm,

C: Because

T: Umm mmm

C: I just do. I

T: Hmm mmm

C: But I, I felt like I could put off a lot of what [redacted] made me feel at that time, and put it, and sort of, put my effort into children

T: Mmmmm

C: And I could ignore anything bad

T: Mmm

C: That had happened with [redacted] because we'd have the kids

T: Mm mmm

C: I don't think he would have connected with them at all

T: Mmm mmm

C: I'm quite scared of the concept that I might have actually ended up having

T: Right

C: Kids with him, because that would of….

T: So this is kind of scary. It's like a near miss then, you know

C: Very very near miss

T: Right

C: Erm

T: Right

C: You know, I wouldn't have been surprised if we'd got married and gone for a family fairly quickly

T: Hmm mmm

C: And, actually thinking about it now, that's the kind of, I would probably want to have kids

T: Hmm mmm

C: Relatively early in

T: Hmm mm hmm mm

C: My marriage anyway

T: So let's

C: What I've (interrupting)

T: The one thing that came up that sounded like it was a little bit difficult to feel

C: Hmmm

T: Was the hatred or the anger

C: Yeah

T: That somehow that transgressed or felt transgressive

C: Mmmm

T: How does that feel, you know, to feel that anger, or hatred, and to be transgressing in some way… how is that for you?

C: It feels quite anti-Christian, that's part of my problem

T: OK, and you just mentioned that your mum is you know, quite serious about her…

C: Yep (interrupting),

T: Erm

C: I am trying (interrupting),

T: Beliefs

C: To be serious about my faith

T: Right

C: I am very pissed off with god at the moment

T: Ahah

C: For various reasons

T: Right

C: I did make it into church over the weekend

T: Uh huh

C: Because I erm, and people are

T: Hmm mmm

C: I managed to be relatively honest with people

T: Mmmm mmmm

C: For once, and say I'm not actually OK

T: Hmmmmmmm

C: I'm putting on a great front if I say so myself

T: Mmmmm

C: But I can't pretend I'm alright

T: Mmm mmm

C: And that it got, it got, erm, the basic sort of, not quite understanding, but pitying face that old ladies at church are very very good at

T: Oh right, yeah

C: But everybody just sort of like yeah, ok, that's a thing, look after yourself, we'll be there

T: Hmmmm

C: And, er, telling people about where I was, and what I've, what was going on, and I didn't tell them too much, because

T: Hmmm

C: You know there are moments, and church coffee is not one of them

T: Hmmmmmm

C: But you know I told them a bit and I, I told, it was very strange telling them about something I might possibly need from them

T: Hmm mmm

C: Erm, and I don't, I don't, I don't want to need things from people

T: Hmmm mmm

C: Because I'm scared people will ask for repaying at some stage

T: Right, right

C: Erm,

T: Yeah

C: I still feel like….(sigh)….very very wronged

T: Mmmm (interested)… so what's that feel like emotionally, so wronged is what he did to you, he wronged you

C: Yeah

T: And, and, and, just connecting with what the emotion is inside… towards him,

C: Again, angry,

T: So how does anger feel right now… how does it feel right there in your body? (more intense) here, in this room, in your body?

Silence….

C: I don't know, I'm not used to feeling stuff in my body like that at all

T: Mmmm, mmmm, so that could be, this could be really helpful,

C: Mmm

T: Learning to notice the sensations in the body

C: Hmmm

T: So it will give you a bit more

C: I mean the heartburn is still there (interrupting)

T: Of a grounding

C: That's part of the problem (talking over)

T: OK

C: It's been pretty constant the entire time

T: Mmmm mmmm

C: It's sort of a bit more, it's a bit more down here now

T: Hmm mmm

C: I can see where people get the idea of fire in their belly about something

T: Oh, great (appreciative) wow

C: It's the wisdom of the body

T: Right, so you're feeling a bit of fire in the belly about, towards Jake right now

C: Yeah

T: Yeah, and how is that?

C: It's pretty unremarkable actually (dismissive)

T: It's… OK (surprised), you're living with it

C: It's OK

T: It's OK

C: It's

T: Great

C: It's a thing that I

T: Yeah

C: I dunno,

T: It's an

C: I feel

T: Energy

C: I feel that you want a, want a more complicated answer, but I think the point is

T: No… (protesting)

C: I think the point is (interrupting, louder tone, and more aggressive) you don't!

T: (Laughter) right,

C: Sort…

T: Just what is…

C: Exactly

T: You know, er so

C: I….

T: You feel the fire in your belly

C: Yeah

T: And that's OK, it's not too alarming, it's not worrying,

C: No

T: It's there… you know that you're angry with him

C: I am, yeah

T: And anger

C: And I'm (talking over)

T: Has a really important function

C: Mmm

T: In setting limits

C: Hmmm

T: And being clear about what you don't want, and what you don't need

C: Yeah, I'm very sad for him as well

T: Right

C: I feel like there must be

T: Mmmmm

C: Huge chunks of his personality that he must have just totally cut off

T: Hmmm mmm

C: To be that

T: Hmm mm

C: I didn't, I very very rarely felt any genuine compassion from him

T: Hmm mmm

C: Certainly when I was in meltdown he…

T: Mmmm

C: There's people not understanding

T: Mmm

C: And there's people dealing with misunderstanding badly. [redacted] doesn't understand,

T: Mmmm

C: He says he doesn't understand

T: Hmmmm

C: He goes in and tried to help, and if you tell him it's not helping he'll back off and ask what he can do

T: Hmm mmm, hmm mmm

C: And it's only having seen, it's only have seen

T: Mmmm

C: How somebody can do it right

T: Hmm mmm

C: That I realised how wrong it was done before

T: OK, so there's something… [redacted] sounds pretty remarkable, he sounds like er he's really, he's really open to

C: Mmm

T: Talking through it with you

C: He's immensely switched on

T: Right, erm

C: He's he's an extraordinary human being

T: Yeah, I've got a book in the back of mind that might be fun for the two of you to read together

C: Mmm mmm

T: About communicating in a couple

C: Hmm hmm

T: If you're both interested in that sort of thing, I can, I can let you know

C: Maybe

T: Erm…

C: What's it called?

T: It's called Hold Me Tight

C: Hmm mmm

T: By somebody called Sue Johnstone

C: Hmm mm

T: I'll write it down for you if you like

C: I can look it up, we'll see

Coding Form

Participant Number: 3 Session Number: 2 Coding From Number: 1

Precipitant (way in which therapist did something the patient did not need, or failed to provide what was needed)

Continued to pursue feelings, when the client was reluctant to engage with them

Rupture Markers: Expressions or indications of a patient's distress resulting from an emotional disconnection from the therapist

Narrative Manner or Tone	Time Point	Narrative Content	Time Point
Long silence/minimal response/refusal to respond		Intellectualisation	
Laughing at therapist/nervous laughter		Denial	1:01:32
Directs therapist		Vague/tangential/abstract narrative	
Dismisses therapist		Storytelling	
Interrupts and talks over therapist	56:52/57:06/58:45 1:01:06	Talking about other people	1:02:15 →
Mimics therapist		Content-affect mismatch	
Mocking tone/saracasm		Overly ingratiating comments	
Demanding tone		Yes-but	
Whining tone		Self-critical statements	
Flirtatious/coy		Self-justifying statements	
Heavy sighs	1:00:20	Helpless behaviour	
Quiet voice		Passive-aggressive behaviour (e.g. suicidal threats)	
Loud voice		Use of obscure vocabulary	
Changing topic		Criticises therapist	1:01:42
Talks directly to recording device		Questions relevance of intervention/tasks	
		Doubts about being in therapy	
		Complaints about parameters of therapy	
		Complains about lack of progress	

Participant 3 – Session 2 – Feedback

1:03:30

T: Yeah, (sigh), erm, I think it would be great to to have a conversation about how this conversation has been

C: Hmm mm

T: To kind of check in with how you're feeling and what it's been like to talk about these things, and how you've experienced me being with you and so on

C: Mmm

T: Is that OK?

C: Yeah,

T: And we'll kind of wind down

C: Sure

T: We've got maybe another 5 minutes

C: That's all good

T: So I'll. I'll do it in this formal way if you're OK with that

C: Yeah, all good

T: Erm, so this gives you a chance to kind of step back, and…be, use your honesty

(Silence whilst measure is completed)

T: OK, let's look here (quietly). OK, so it looks a little bit like you're

C: Hmmm

T: Kind of less sure about today's session than you were about last time

C: Hmmmm

T: Yeah?

C: Yeah

T: Particularly the goals and topics and approach and method, so

C: I think the goals

T: Yeah

C: And topics is the difficult one because I think

T: Hmmm mmmm

C: We're still trying to work out what those are

T: Hmmm mmmm

C: I think hmmm,

T: Yeah… what might have helped pull that back further across to the right, erm, what could I have done hat would have helped us, help you, focus more on what you wanted, or do it in a way that felt better for you?

C: Mmm, I don't know there's something you could have done, I think I could have

T: Ah hah

C: Reigned myself in on the stuff, I miss, this is the thing

T: Hmm mmm

C: I'm answering this from the point of view of

T: Hmm

C: What the relationship could have done

T: Hmm mmm

C: I feel like most of my answers

T: Hmmm

C: Have been more down to… more down to what I have or haven't done

T: Hmmm mmmm…so you have a kind of, this tendency to to as it were, put responsibility on you

C: Hmmm

T: Rather than thinking what could I have done that might have helped you more

C: Definitely

T: Yeah, so if you, it is possible to just kind of turn that round, and point it round towards me

C: (slight laughter), OK, erm

T: Because obviously we're both responsible for this

C: Hmm, well the feeling things in the body thing is quite strange

T: Hmmm mmm

C: I'm not sure it's an approach that necessarily

T: Hmm mmm

C: Chimes

T: Hmmm mmm

C: Perfectly with me

T: Right

C: I don't, I don't think, I don't think

T: Yeah

C: It's invalid

T: Yeah

C: But I think I've spent a lot of time this session

T: Mmmm

C: Trying to work out feeling

T: Hmmm mmm

C: In my body

T: Hmmm mmm

C: That I just can't find, erm, and OK fine, there is a process of…

T: So like

C: Me also finding them

T: Right

C: But I think I feel like we might be flogging a dead horse a little bit on that

T: Right

C: just for the moment, and particularly while at the moment

T: Yeah

C: I've had when I've had weeks like this I tend to go very flat and very numb

T: Hmmm mmm

C: Rather than stirring up the emotion in the same way

T: Hmmm mmm

C: So I actually go, I actually go further in than I do out

T: So in a way it feels like, erm, that the numbness is something protective

C: Yeah

T: And that if we're finding the spark

C: Hmmm

T: That might be a little dangerous

C: It might be

T: Or

C: But I think also

T: Right

C: The numbness is something that fluctuates

T: Yeah

C: And will decrease as I get

T: Right

C: Better

T: Right

C: And

T: Hmmm

C: So, I think

T: Hmm mmm

C: Being able to, being able to feel things is something that will come

T: Hmm mmm (encouraging)

C: It's just that it

T: Yeah

C: This week isn't a good week to be trying to concentrate too much on feeling

T: Right,

C: It is, I have replaced feeling with thinking

T: Ah ha

C: A huge amount

T: Ah ha, ah ha, so that's one thing

C: I feel like the step we're trying to make

T: Yeah

C: With me being able to feel things in my body

T: Hmm mmm

C: Is sort of actually, I need to engage with what I think

T: Hmm mmm

C: The feelings are to begin with

T: Ah hah, ah hah (understanding), yeah, yeah

C: I think

T: Yeah

C: There might be an intermediary step in there

T: Yeah

C: That

T: So you'd like to get to the feelings eventually

C: Yeah, I would

T: But it feels like a stepwise process

C: Yeah

T: And it's kind of useful to start with

C: Mmm

T: Thinking it through

C: Yeah

T: And then that would inch maybe a little more

C: Yeah, a friend of mine said a long time ago

T: Yeah

C: I said something about this thing in my head is bothering me, he said you spend way too much time in there, and he was

T: Right

C: And this was when I was 15 or 16,

T: Right

C: He was absolutely right

T: Right

C: And he is absolutely right

T: Yeah

C: And I wish I could get in contact with him again and tell him he's absolutely right

T: (laughter)

C: but I don't think he's even on facebook anymore

T: right, right, so you recognise

C: erm

T: that this a way that you have of, kind of, if you like, regulating your feelings

C: yeah

T: is to go, is to intellectualise things, and to think things through, go into your head and you really recognise that, and you see that, it has it's uses, but sometimes it's too much, and you'd like to be more able to, kind of, get below it into the feelings

C: Yeah

T: Yeah

C: And the fact that

T: Right

C: Having understood

T: Yeah

C: That I dealt with emotions very differently

T: Yeah

C: I had to find some way of dealing with, of dealing with them that wouldn't look too weird to everybody else

T: Hmm mmm, hmmm mmm

C: And if you think it through you can spout the same sentence as somebody who's felt it

T: Hmmmm

C: Through

T: Hmmm mmm

C: And people don't know the difference

T: Hmm mm

C: And you've hidden, and you have passed the test

T: Hmm mm

C: Which really annoys me cause it's like, when people say

T: You can talk it, but

C: It's like when people say they can't tell a trans person is not, when you, when the trans person's gender identity is not the same

T: Hmm mm

C: As what they were assigned at birth, it's like I couldn't tell. It's like I didn't know it was… they did… well, forgive them if they didn't know it was their job to pass your little test as to whether they

T: Hmm mmm

C: Whether they get to feel like that

T: Hmmm mmm

C: And I still feel like I'm trying to pass a test that doesn't actually exist or if it does, shouldn't.

T: OK, so when I'm asking about feelings it feels a bit like a test or something, or a hoop that you've got to jump through or something like that

C: Perhaps

T: Is that, erm, yeah, certainly not how I

C: No

T: Wished it to be

C: No I didn't think so

T: But thanks, thank you for letting me know that it felt like that, because if that happens again maybe we can open up the conversation and say oh that's happening again…

C: Yeah

T: And then I…if you can let me know I can say oh right ok

C: Yeah

T: Let's do something else

C: Well you've got fewer sidesteps to make if you catch it soon right?

T: Right, exactly

C: Erm

T: Exactly. So it felt a little bit like erm, being under pressure to do something that you weren't sure it was there anyway or…

C: I just don't think I have the building blocks in my brain

T: Hmmm hmmm

C: To actually put emotions together

T: Hmmmm

C: Quite as, quite on the level I need to.

T: Hmm mmm

C: And I'm trying to do it with thoughts, and it's sort of

T: Yeah

C: It's sort of working

T: Yeah

C: But it's not… I think that, I think that's probably going to be one of the biggest things I get out this is

T: Hmmmm

C: That actually being able to engage with my feelings as much as I need to

T: Ok, ok, yeah

C: Yeah

T: So if I can give you just a little encouragement,

C: Sure

T: It seemed to me like you were doing fine and and that you know, if you feel numb then that's just as valid

C: Yeah

T: As anything else

C: Yeah

T: But er, which you did feel at one point, but

C: Hmm

T: You also noticed some really, some sparks of real emotion

C: Yeah

T: And energy, and that, that fitted in with what you were talking about that somehow as you process

C: Hmm

T: You know the really traumatic stuff that's happened with [redacted], your emotional response is kind of

C: Hmmm

T: Going through different phases

C: Yeah

T: And that you're beginning to find the energy in you that's about setting limits, that's about saying no, about being pissed off about mistreatment

C: Hmmm

T: And that that is a kind of energy that can be, you know have a real use…

C: I think I need to acknowledge more

T: Right

C: Of the traumatic

T: Right

C: That happened with [redacted]

T: So would it be helpful for us to make more space to go, to work through that

C: I think so, yeah

T: Experience and, yeah, yeah

C: I, because at the moment a lot of what happens in meltdown is related to [redacted]

T: OK

C: It's

T: OK

C: It's

T: Yeah

C: It's me quoting those things that he's said to me

T: Right, right

C: That are supposedly true, but

T: Right

C: You're not really, they aren't, they aren't true

T: Right, right. So maybe with the, as you tune in more to your anger,

C: Yeah

T: Instead of that all pointing back on you

C: Hmmm

T: And kind of you as it were scratching yourself with it

C: Hmmm

T: It can begin to point a bit more out towards him

C: Yeah

T: And you can feel that actually

C: Hmm

T: You're angry with him

C: Hmm

T: Because of the hurtful things that he did

C: I have to let it out at some stage

T: Right,

C: Erm, I think…

T: That's something we can definitely play with here if you want to

C: I asked my mum about her erm, abuser

T: Hmm mm

C: A little bit. I haven't asked her a great deal

T: Hmm mmm

C: I know they were known to her, I know they weren't related to her

T: Hmmm mmm

C: And that it happened before she was 18

T: Hmmm

C: That's all she's told me

T: Hmm mmm

C: And I said do you still hate them, and she goes nope,

T: Hmm

C: I don't

T: Hmmm

C: It does sort of help that they're dead and it's a bit late, but like even, I think

T: Hmmm mmm mmm mmm

C: Before they died

T: Hmm mm

C: She didn't

T: So she managed to get through it

C: Yes

T: And process it somehow yeah

C: But I tried to do that process too soon, and actually you

T: Ok

C: Cannot get past hate

T: Yeah

C: If you don't even let yourself get to it

T: So there's something about pressure, and that maybe you need to allow and be allowed by other people like me to work through it, that it takes a bit of time and that it's

C: Yeah

T: That it doesn't necessarily all happen very quickly

C: But being angry with [redacted]

T: Right

C: Acknowledges that he did a bad thing to me that I didn't deserve

T: Right

C: And if

T: Right

C: I didn't deserve it, what does that do to what I'm worth

T: Right

C: And if it does something

T: Right

C: To what I'm worth

T: Right

C: Then suddenly we have a problem again, er, because what I am worth is not

T: Hmmm mmm

C: It's not a given value for me

T: Mmm mmmm

C: Erm, so yeah, that's erm

T: Hmmm

C: Sort of I think where we are

T: Hmmm mmm hmmm mmm hmmm mmm. Well thank you so much, you've given me a lot of really helpful sort of feedback and pointers, and understanding to feel like what it's been like in this conversation.

Coding Form

Rupture Repair During Feedback:

Statement of Understanding	Time Point	Affective Shift	Time Point
Being able to feel things is something that will come, it's just that this week isn't a good week to be trying to concentrate too much on feeling	1:07:30	Much more in touch with feelings, less tense, more of a content-affect match	e.g.: 1:10:10 1:12:35 1:13:24
Well you've got fewer sidesteps to make if you catch it soon, right	1:10:22		
I think that's probably going to be one of the biggest things I get out of this, is actually being able to engage with my feelings as much as I need to	1:10:49		
Actually you cannot get past hate if you don't even let yourself get to it	1:13:10		

Appendix P

Empirical Model Coding Scheme and Supporting Quotes

Category	Sub-Category	Selected Quotes
Creating a culture of feedback	Explain rationale	"What I'll ask you to do is fill one in every time you come in, and we can have a conversation about whether there's something that you're finding difficult about my way working, or the kind of, something about maybe not feeling understood with me or anything" [Participant 1, session 1, line 8] "Maybe it makes it a little easier to talk about anything if it's getting in the way of progress" [Participant 1, session 1, line 12]
	Explain ease of feedback	"I'll ask you to do a very, very short questionnaire" [Participant 3, session 1, line 4]
	Frame as opportunity for reflection	"That gives you a chance to take a bit of a step back, break eye contact with me as it were, just think about how it was for me, this session, and erm, then we can have a bit of a conversation about it" [Participant 5, session 1, line 4]
	Encourage honesty	"And then really hopefully be absolutely as honest as you can about that experience" [Participant 3, session 1, line 12] "Please be honest, don't spare me" [Participant 1, session 1, line 71]
	Plays role in shaping therapy	"This is really critical to the success of therapy, so if there's something that you don't feel happy about… or comfortable about, then it's really great for me to know right from the word go, as soon as possible" [Participant 1, session 1, line

		67]
Attentiveness to feedback	Noticing small changes	"Yep, erm, a little bit less for the goals and topics, was there anything in that, that was er, that you were kind of picking up, up, that sort of…" [Participant 1, session 5, line 10]
	Noticing differentiations	"Particularly the goals and topics, and the approach and method" [Participant 3, session 2, line 24]
	Triangulation	"Kind of less sure about today's session than you were about last time" [Participant 3, session 2, line 20]
Emphasising importance of feedback	Conveying openness	"So if you, is it possible to just kind of turn that around, and point it toward me?" [Participant 3, session 2, line 51]
		"That's something we can definitely play with here if you want to" [Participant 3, session 2, line 291]
	Responding positively to feedback	"Ah, that's so helpful" [Participant 3, session 8, line 98]
		"It's great that you've been able to say that" [Participant 3, session 8, line 156]
		"Well, thank you for letting me know that something didn't feel quite right anyway" [Participant 3, session 8, line 179]
		"But thanks, thank you for letting me know that it felt like that" [Participant 3, session 2, line 205]
		"Well thank you so much, you've given me a lot of really helpful sort of feedback and pointers, and understanding to feel what it's been like in this conversation" [Participant 3, session 2, line 344]
		"And I'm fine with being disagreed with if I've got it wrong… absolutely fine with

	Encouraging more feedback	that, in fact I would hope that you…" [Participant 3, session 8, line 73] "And you might say no no no, left a bit, as it were" [Participant 3, session 8, line 86] "Yeah, yeah, but if you disagree with something I say then it's really important that you let me know" [Participant 3, session 8, line 116] "So if I kind of paraphrase something in a way that doesn't feel right, just, you know, please let me know" [Participant 3, session 8, line 193] "Because if that happens again, maybe we can open up the conversation and say oh, that's happening again… And then I, if you can let me know I can say 'oh right, ok'" [Participant 2, session 3, line 205]
Clarification/elaboration	Checking understanding of feedback	"Does it feel like I've really understood that, or maybe I need more feedback from you next time" [Participant 3, session 8, line 159] "And it was to do with the sort of paraphrasing, not quite getting it right" [Participant 3, session 8, line 182] "So you'd like to get to the feelings eventually… But it feels like a stepwise process… And it's kind of useful to start with… Thinking it through" [Participant 3, session 2, line 128] "Exactly. So it felt a little bit like erm, being under pressure to do something that you weren't sure it was there, anyway?" [Participant 3, session 2, line 215]
	Further exploration of experience	"So I suppose did we talk about what you felt like, in retrospect, was the right thing, or whether there was something else that might have been…" [Participant 3, session 8, line 50] "What might have helped pull that back further across to the right, erm, what could I have done that would have helped us, help you, focus more on what you wanted, or

		do it in a way that felt better for you?" [Participant 3, session 2, line 32] "So in a way it feels like, erm, that the numbness is something protective… And that if we're finding the spark… that might be a little dangerous?" [Participant 3, session 2, line 86]
Therapist Contribution	Clarifying intentions	"OK, so I was seeing us like we're in a workshop together, and kind of like working towards what might be emerging and what might be important" [Particiapnt 3, session 8, line 80] "That's certainly not how I… Wished it to be" [Participant 3, session 2, line 201]
	Acknowledging therapist role	"Ok, so sometimes, yeah, I'm aware of that, sometimes I'm, er, adding maybe a little bit because I'm thinking is this the right direction we're moving in… Sometimes you say yes, sometimes you say no" [Participant 3, session 8, line 66] "So not that I'm thinking I'm definitely right when I'm saying it's something, but I'm saying it seems like this, is that…" [Participant 3, session 8, line 83] "Because I don't have some kind of papal, er, authority to speak the truth" [Participant 3, session 8, line 119] "Ok, so when I'm asking about feelings it feels a bit like a test, or a, or a hoop that you've got to jump through or something like that?" [Participant 3, session 2, line 198]
	Communicating partnership	"Because obviously we're both responsible for this" [Participant 3, session 2, line 54]
Client Role	Offering specific feedback	"I think I'm finding the paraphrasing a bit hard… Because I am very keen to, I'm always at great pains to work out what I'm saying, whether I'm being understood or misunderstood, and when somebody paraphrases it back even slightly differently to

	Reflecting on experience	me, how I think about it… I start wondering if I've said the right thing to express what I'm feeling" [Participant 3, session 8, line 56] "I'm not very good at telling people they're wrong, because I assume it's me" [Participant 3, session 8, line 91] "I think that having my stuff repeated back to me always undermines my confidence about whether I've been clear in saying it in the first place" [Participant 3, session 8, line 185] "I don't know whether it's necessary or not" [Participant 1, session 5, line 25] "I think the goals… And the topics is the difficult one… Because I think we're still trying to work out what they are" [Participant 3, session 2, line 25] "Hmm, well the feeling things in the body thing is quite strange… I'm not sure it's an approach that necessarily… Chimes… Perfectly with me" [Participant 3, session 2, line 55] "I think I've spent a lot of time this session… Trying to work out feeling… In my body… That I just can't find" [Participant 3, session 2, line 67] "And I still feel like I'm trying to pass a test that doesn't actually exist, or if it does, shouldn't" [Participant 3, session 2, line 196] "My problem is I tend to get belligerent with people rather than openly disagreeing with them, which is genuinely counterproductive at this stage" [Participant 3, session 8, line 76] "I have come here for someone else's opinion… and I've got to… mediate with myself between whether I genuinely think that opinion is wrong…and whether I think it's wrong because it's hard to hear" [Participant 3, session 8, line 101]

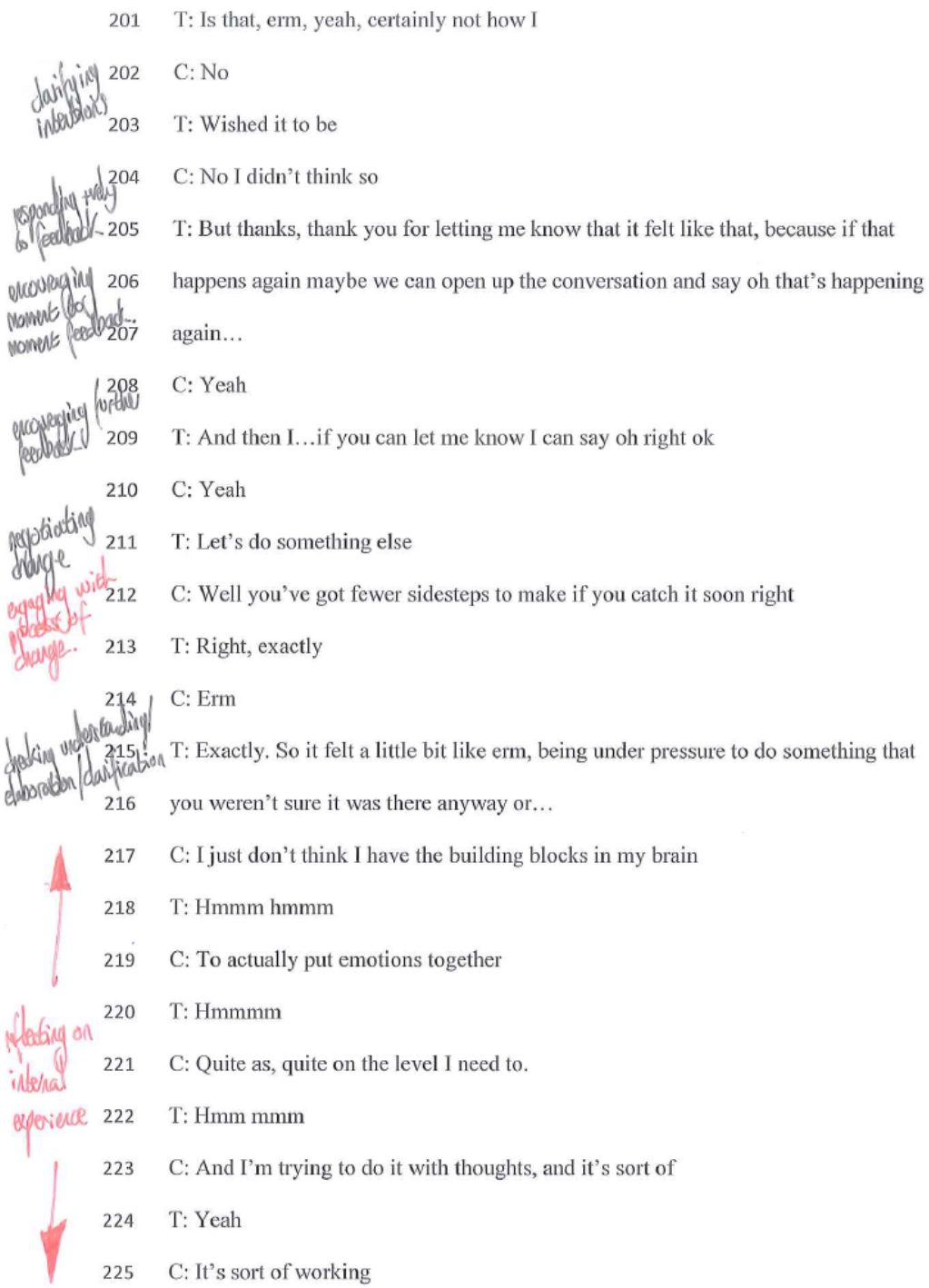
		"Erm… No, I guess, you know, I er, the thing with the goals is whether I'm blaming myself for this you know… I can't seem to break through that barrier, I can't seem to… Feel, I guess" [Participant 1, session 5, line 12] "I don't know there's something you could have done, I think I could have… Reigned myself in on the stuff, I miss, this is the thing… I'm answering this from the point of view of… What the relationship could have done… I feel like most of my answers… Have been more down to, more down to what I have or haven't done" [Participant 3, session 2, line 35] "Being able to, being able to feel things is something that will come… It's just that it… This week isn't a good week to be trying to concentrate too much on feeling… It is, I have replaced feeling with things… A huge amount… I feel like the step we're trying to make… With me being able to feel things in my body… Is sort of actually, I need to engage with that I think" [Participant 3, session 2, line 105] "I just don't think I have the building blocks in my brain… To actually put emotions together… Quite as, quite on the level I need to… And I'm trying to do it with the thoughts, and it's sort of… It's sort of working" [Participant 3, session 2, line 217]
Making links	Locating feedback in session	"Yeah, yeah, yeah. And you know, we kind of focused on your feelings, particularly anger today, and how was that for you? Cause I'm kind of thinking, you know, you noticed the connection with your headache getting bigger… As we went more and more into it, and it kind of felt like stickier and stickier, because sort of, er… Like very hard for you to accept… Having really angry feelings, or thoughts… Or fantasies" [Participant 1, session 5, line 38] "But, er, which you did feel at one point… But you also noticed some really, some sparks of real emotion… And energy, and that, that fitted in with what you were talking about that somehow as you process… You know, the really traumatic stuff that's happened" [Participant 3, session 2, line 240]

	Themes of therapy	"Right, right, so there's something about how easy it is to be over-accommodating… And you're noticing that outside here, and also in here" [Participant 3, session 8, line 153]
		"It's what you do with them next, you know, er, so, I'm kind of suggesting that from my experience that people who are quite permissive about the experience of it are often people who can be very in control of, of, of… The actual acting out of it in a way, it can kind of make it less likely that you will punch the wall, or punch somebody else if you can… Just kind of accept and reflect" [Participant 1, session 5, line 67]
	Broader patterns in life	"So there's something about how difficult it is when you have two feelings like that inside, you know that… you love him, but also you're furious with him at the same time" [Participant 3, session 8, line 144]
		"Hmmmm mmmmm, so you have a kind of, this tendency to to as it were, put responsibility on you?" [Participant 2, session 3, line 46]
		"So you recognise… That this is a way that you have of kind of, if you like, regulating your feelings… is to go, is to intellectualise things, and to think things through, go into your head… And you really recognise that, and you see that, it has its uses, but sometimes it's too much, and you'd like to be more able to get below into the feelings" [Participant 3, session 2, line 153]
Re-negotiation	Revisiting rationale	"It sounds like there's a part, a big part of you, that wants to feel more" [Participant 1, session 5, line 20]
		"And you feel ready to experiment with it… And then decide, you know… Having done that, whether it's right for you or not" [Participant 1, session 5, line 32]
		"So maybe with the, as you tine in more to your anger… Instead of that all pointing

	Exploring potential changes	back on you… And kind of you as it were scratching yourself with it… It can begin to point a bit more out towards him… And you can feel that actually… You're angry with him… Because of the hurtful things that he did" [Participant 3, session 2, line 275] "Right, so actually, maybe what could emerge from this, which would be really good, could be if you like kind of a corrective experience where you get to say what you feel and it gets more comfortable doing that" [Participant 3, session 8, line 121] "So what would you like more of from me, what… It feels like er, would help you more to…" [Participant 3, session 8, line 170] "So it might be an interesting experiment to maybe ask around a bit, and sort of try and get a sense of whether people have had really violent or aggressive fantasies, and you know, peaceful people, people who don't get into fights, you know" [Participant 1, session 5, line 53] "T: So you'd like to get to the feelings eventually? C: Yeah, I would" [Participant 3, session 2, line 128] "And then I, if you can let me know I can say 'oh right, ok'… Let's do something else" [Participant 2, session 3, line 209] "So would it be helpful for us to make more space to go, to work through that?" [Participant 3, session 2, line 261] "So there's something about pressure, and that maybe you need to allow and be allowed by people like me, to work through it, that it takes a bit of time" [Participant 3, session 2, line 319] Client quotes: "I think I need a little bit more control over the process" [Participant 3, session 8,

		line 72] “Actually I probably need to sit myself in the middle, and look both ways, and then decide, rather than starting at one end, and moving towards the other” [Participant 3, session 8, line 114] “I get the impression that that’s huh, um, what I need to do…In order to sort of break through things, because I haven’t really felt it” [Participant 1, session 5, line 21] “T: Just maybe something to C: Yeah, no T: To play with a little bit in your mind and see if anything comes up C: Will do T: And perhaps talk to other people about it and see what they think C: Ok, yeah” [Participant 1, session 5, line 80] “Well you’ve got fewer sidesteps to make if you catch it soon right?” [Participant 3, session 2, line 212] “I think that, I think that’s probably going to be one of the biggest things I get out of this… Actually being able to engage with my feelings as much as I need to” [Participant 3, session 2, line 227] “T: So would it be helpful for us to make more space to go, to work through that? C: I think so” [Participant 3, session 2, line 261]

Example of Coding



201 T: Is that, erm, yeah, certainly not how I

202 C: No

203 T: Wished it to be

204 C: No I didn't think so

205 T: But thanks, thank you for letting me know that it felt like that, because if that

206 happens again maybe we can open up the conversation and say oh that's happening

207 again…

208 C: Yeah

209 T: And then I…if you can let me know I can say oh right ok

210 C: Yeah

211 T: Let's do something else

212 C: Well you've got fewer sidesteps to make if you catch it soon right

213 T: Right, exactly

214 C: Erm

215 T: Exactly. So it felt a little bit like erm, being under pressure to do something that

216 you weren't sure it was there anyway or…

217 C: I just don't think I have the building blocks in my brain

218 T: Hmmm hmmm

219 C: To actually put emotions together

220 T: Hmmmm

221 C: Quite as, quite on the level I need to.

222 T: Hmm mmm

223 C: And I'm trying to do it with thoughts, and it's sort of

224 T: Yeah

225 C: It's sort of working

Appendix Q

Example of Feedback from Experts

From: Scott D. Miller, Ph.D. [scottdmiller@talkingcure.com]
Sent: 15 May 2015 15:30
To: Christopher Laraway
Subject: RE: Feedback/Ruptures Dissertation

Fantastic. Linear and comprehensive.

May I use it?!

Yours truly,

Scott D. Miller, Ph.D.
Director, International Center for Clinical Excellence

www.scottdmiller.com
o. 773.404.5130 c. 773.454.8511

Appendix R

Excerpts from Bracketing Interview

Extract 1

Ok Chris, what attracted you to this area?

It was probably a combination of my work before training, where I'd say there were quite a few ruptures, working with people with pd, they're traditionally quite difficult to engage, and retain in therapy, erm, but also the kind of, the growing erm, trend within the NHS to have to monitor outcomes, and monitor session-by-session stuff, which I initially thought was a bit rubbish, and not that therapeutic, and would actually, was a paper exercise really that was more for commissioners and more for services to show people what they were actually doing, erm, without it being in the best interest of the client, or clinically useful in any way, or anything like that, and, so I think I was interested to see whether they could be used clinically, and could be made clinically relevant, erm, so I definitely come into the project with that kind of bias, and preconception, that these measures perhaps aren't fit for purpose, and don't really add anything clinically.

Had you had any experience of the actual measure that you're using? Had you ever used that before?

Not before training, erm, but there was a lot of, when I was working in the therapeutic community we had whole sessions where people would sit down and fill out questionnaires, and had them at time points, and it always felt like an interruption, or not something that people took seriously, both clients and clinicians, or really saw the point of, and they were done and filed away, and not really followed up or used, it didn't seem to me.

So, what is you're, do you have any clinical experience of ruptures?

Erm, I think as I was saying before, I think I experienced quite a few ruptures in the personality disorder service I worked in, but I don't think prior to this I really knew what the definition of a rupture was, but I would certainly say that I had the experience of difficult relationships, or difficulties within relationships with clients I was working with therapeutically, and they were kind of all considered to be, kind of part of the therapy, and because it was a relational interpersonal therapy, based on social milieu principles, that it was, they were important points for people to work through, that they could then take a lot from. So I don't think I've ever had the idea of a rupture as a negative thing, probably until I started doing more individual work with clients as a trainee, and then I remember one of my clients in my adult placement took a five week break in the middle of therapy, announced it the session before he left, and went to Australia, which was pointed out was as far away from me as he could have got, geographically, erm, and that didn't seem like something to work through with him that would benefit him, it felt more like a "screw you" kind of thing. But that might be because I was doing CBT with him, there felt less space to address it in a constructive way.

And I guess as well the time limited nature of our placements, it's, you know, there's always going to be a limited amounted of time you have to address it.

Absolutely

So that sounds like an example of a withdrawal rupture, are you more familiar with withdrawal ruptures rather than confrontation ruptures?

Erm, I think within my experience since starting training I've been a lot more familiar with withdrawal ruptures, I think that fits with the literature too, that they're much more common than confrontation ruptures, so people moving away from the therapist in a way, through changing the subject, avoiding emotions, storytelling, they're almost part of

everyday therapeutic work. By virtue of therapy not being easy, people will try and avoid difficult things. I'm certainly more aware of withdrawal ruptures. Prior to training, probably equally as familiar, no, probably more aware of confrontation ruptures due to the client group I was working with, people becoming aggressive, or directly questioning the style of therapy, or therapist qualifications, or being flirtatious.

Extract 2

What sort of experience do you have of using feedback on the therapeutic alliance? Is it informal, formal? What have you done?

I think it's been mainly informal, in terms of trying to set things up so a conversation could be had, saying it's really important you can tell me if somethings not working, or if I'm doing something that is making it difficult to work together, and usually one of the ways I've done that is by thinking back to peoples' previous experience of therapy, and what worked, what didn't work, what would be the things I could do to make things different? I've always tried to set something up informally, and it's usually formed part of reviews, for example in CBT. Part of the review would always be what's going well, what's working well, what's not going so well?

Would you make that a formal process? Would you cue the client in beforehand?

Yeah, I'd say so, but I've never in the most part used a measure to track the alliance, or even to rate the alliance at a set point. The only time I did was when I was working in CAMHS. I think it was because they were part of the standard CAMHS monitoring forms. I used the adapted version of the SRS for young people, and I'll be using the adult version in my dissertation. It was a useful experience, of giving opportunity to open up a discussion.

Especially given the power imbalance that often comes with young people. I suppose it often goes one of two ways. Often they are very clear in saying I didn't like that, but a lot of the time I don't know if there's that space, or confidence to say that, especially amongst people that present to services.

How was it for you, using it? Did you find it a comfortable experience, or was it a bit exposing, or anxiety provoking?

Yeah, I think it was anxiety provoking to start with, because you are essentially saying "how am I doing? How is the therapy that I'm doing with you going?" I think I noticed I became more sensitive to little changes, because they're often scored highly regardless of how things are going. In one of my cases with a young girl, it allowed her, one of the questions was about the things we did today, and one of the things that came out of it was that she really liked the drawing element more than the talking element, and this was really useful to clue me in to thinking about what you can do to help this person achieve change? I think if I hadn't have had that feedback, she might have dropped out, or not achieved as much as she did. I certainly don't think that she would have felt able to offer the feedback right off the bat.

Extract 3

Something, although we've spoken about your therapeutic ruptures, and that being something that you've developed through clinical experience, on the technical side of it, which rupture resolution models are you most familiar with?

There's a stage model by Safran and Muran for integrative therapy, of an interpersonal nature, that I'm familiar with, and there's a CBT model, and a model for family therapy, and couples therapy. They're all stage by stage, this is what happens essentially.

There are some common factors, like the therapist stepping away from what's going on, thinking about the part that they play, thinking about what might be different.

Is there one model that sits with you most comfortably?

Probably the Safran and Muran model, I'd say that's one that I have in my mind when I'm working therapeutically, when I can, and part of that is meta-communication, commenting on what's going on in the moment, a mindful awareness of what you're feeling, what the client might be doing, exploring avoidance, what need is being communicated to you at that time, and adjusting your approach accordingly. It almost always seems to involve taking a step back and observing what's going on between you. I think their theory is that lots of people who come to therapy have maladaptive interpersonal schema, and expect things to go a certain way when they come to therapy based on their previous experience, and their internal working models of relationships, and it's very easy to get drawn into that, to confirm those and to repeat experiences that people have had. But if you step back, you can actually give them a different experience, kind of in line with the corrective emotional experience stuff from the more psychodynamic perspectives, and actually really start to challenge some of their beliefs about how relationships will go, and that's a really crucial moment, in therapy, and research backs that up, that it's better to go through therapy with repaired ruptures than a rupture-less therapy.

How about in terms, of, we've spoken about the process of how it might be helpful, how do you think it might be helpful to specifically repair ruptures?

I guess, I guess in my mind it will be used in a number of different ways. I'm not sure how this would all fit together in terms of a stage model, but the things that I think will be important would be the use of the feedback to, first off identify a rupture, and to make the therapist and the client aware of it, and raise that for discussion. I think the alliance measure

that I'm using in particular will also identify whether the rupture is about a disagreement in the goals for therapy, how those are to be achieved, or a, erm, something happening to the emotional bond, a deterioration in that area perhaps. That will then hopefully allow the discussion, the meta-communication, about what's going on, informed by the measure. So I guess in my mind it would be used as a framework and a guide that would inform the discussion, rather than previous models that have been reliant on the therapist internally recognising something, and then broaching the subject themselves. I think this will allow a more objective measure, and bring therapists' attention to things that they weren't aware of, and might have been avoiding, for a number of reasons. I think the measure would give people something to come back to, and also hopefully give an outcome actually, of, well, how can we tell that this rupture has been repaired? That's how I would envisage the two things coming together. I don't think there's going to be a radical departure from the existing models of rupture repair, but not of them at the moment track the alliance in a formal way session-by-session, and none of them conceptualise how that might be incorporated.

Appendix S

The Reflexive Journal

Introduction

The aim of this document is to describe the role that reflexivity played in this research project and how it impacted the study at each stage. It also offers the opportunity to reflect on the process of reflexivity. The appendix begins with consideration of the importance of reflexivity in qualitative research. Following this, reflections at each stage are described, including how they informed the progression of the research. Finally the appendix ends with considerations about the reflective process.

The role of reflexivity in qualitative research

Within the field of qualitative research, the researcher is a central figure that influences the collection, selection, and interpretation of data (Finlay, 2002). The process of reflexivity allows space to consider the position, the perspective, and the presence of the researcher. It is also an integral part of ensuring the trustworthiness and credibility of qualitative research. Reflexive analysis in research involves "continual evaluation of subjective responses, intersubjective dynamics, and the research process itself" (Finlay, 2002, p.532). The following sections attempt to provide this.

The researcher

I have tried to remain aware of my own position, in relation to this research. For this reason, I will provide a brief background of my perspectives and values which will have inevitably have impacted upon my relationship with the data, and the project as a whole.

I am a male Trainee Clinical Psychologist. I am one of only two males in the year group of fifteen, and at the start of the project was one of only eight males on a course of fifty people. Throughout my clinical placements I have been supervised entirely by female clinical psychologists. This has echoed patterns from my personal life – I was raised almost entirely by my mother, have two sisters, and have limited contact with my father. I have no doubt that this played some part in choosing a male supervisor for this project, as I felt it was important on a number of levels to find a male role model from within the profession.

My interest in the topic of ruptures and feedback has its roots in my experience prior to clinical training. The most formative experience of my career to date, perhaps even including my three years training as a clinical psychologist, was a two year period when I was working in a therapeutic community (TC). This was part of an NHS based Complex Needs Service for individuals who would meet the criteria for a diagnosis of personality disorder. I had worked with individuals with personality disorder in a number of different settings prior to moving to this specialist service – on an acute psychiatric ward, and as part of a Crisis Resolution and Home Treatment Team.

I had many negative experiences working with this client group, experiences that left me feeling unskilled, and no doubt felt unhelpful for the individual involved. They regularly felt able to tell me so! This was where I first came across the experience of a 'rupture' in the therapeutic alliance, although was not aware at this point that it could be conceptualised as such. When I got the opportunity to work in a therapeutic community, I was attracted to the values inherent in this approach (democracy, permissiveness, reality confrontation and cohesion), and also the opportunity to learn how to work with a group of people I had always been challenged by.

In this setting, I began to see how crucial the therapeutic alliance was, and constantly marvelled at the strength of relationships between therapist members and client members of the TC. I was amazed by how these relationships could help contain such powerful emotions, and allow challenging things to be said in a thoughtful and therapeutic way. Perhaps most importantly, I gained first-hand experience of actually working through ruptures with clients. Whereas previously, this was often the end of engagement, the TC model helped provide a setting where 'ruptures' could be acknowledged, observed, and worked through. I saw how powerful this process this was, particularly as the people I was working with had often not experienced this reparative process. It offered them a new way of relating to other people, and offered me repeated insights into how important relationships were in therapy. My interest in process research had been piqued.

These experiences stayed with me throughout training, and when the time came to discuss potential dissertation ideas, I was clear from the outset that I wanted to research ruptures in the therapeutic alliance.

My relationship with session-by-session feedback was more complex. Throughout my experience both prior to, and during training, I was regularly told "and these are the measures we need you to complete every session". I was extremely concerned about the impact me turning up at each therapy session, clipboard in hand, would have on the therapeutic alliance I had come to value so much. I was terrified that they would suggest I was interested in scores, not an individual's story, their responses on a scale of one to ten, rather than their lived experience. I also rallied against the idea of being told to collect data that was important to faceless commissioners, but meaningless to the client.

At this point I should also acknowledge that there was certainly a fear of being 'found out'. The measures to be completed at the end of each session would provide solid,

incontrovertible evidence that I was in fact not helping my clients, and should not have become a clinical psychologist. Talking to colleagues, and supervisors, I have come to realise that this is not an uncommon internal monologue, indeed the experience of 'imposter syndrome' was highlighted to us all on the first day of training!

'Imposter syndrome' aside, I remained unsure about the utility of session-by-session outcomes. I was encouraged to explore the evidence further by a supervisor, and was surprised to find that they there was a body of high quality research that showed, if used properly, session-by-session outcome monitoring could in fact improve outcome. Less was known about monitoring the therapeutic alliance session-by-session, but it seemed an important component of feedback monitoring systems. Through discussion with my dissertation supervisor, I began to see an opportunity. I saw the chance to develop a model of how exactly session-by-session feedback could be used, to improve the experience of client, rather than it being a paper exercise.

Reflexivity as part of the project

Reflexivity was incorporated throughout this research in a number of ways. As is common throughout qualitative research, a reflexive journal was kept from the start of the research. Below are reflections from each stage of the project, illustrated with quotes from the journal itself.

Initial stages

I had decided to use a task-analytic approach as the methodology for this research. This was the methodology used by all other research that had developed models for the resolution of ruptures. Despite the prevalence of this methodology in this area, there were was a lack of simple example describing the methodology. All explanations were dense with

jargon, and it became clear that a large proportion of the early stages was going to be spent familiarising myself with the model. I was also wary of how I was going to communicate the intricacies of the methodology to the research team at university, who weren't as familiar with the model.

> *"today we had further teaching on qualitative methodology. The lecturer asked us to go around the room and briefly explain our project, and identify the methodology we were planning on using. When I described mine, the lecturer said that she hadn't heard of the methodology, and this was the third time this had happened during teaching. Another moment of panic! I wonder whether using this unique methodology might impact on how accessible my research is to a wider audience"*

I discussed this with my dissertation supervisor, who suggested that he worked with a clinical psychologist who was familiar with the task analytic approach, and suggested that she joined the research as a co-supervisor. This helped provide containment, and reassured me that it was a legitimate approach to use. I also discussed my concerns with my research supervisor at the university. She suggested that there were clear links between the methodology and the more prevalent methodology of grounded theory, and offered this a way of conceptualising the data analysis in a way that would make the research accessible to a wider audience.

As the initial stages continued, and the research began to take shape, I immersed myself in the reading surrounding the therapeutic alliance, and feedback. I found this process enjoyable, but was at the same time daunted by the task ahead. The idea of developing a model from scratch, bringing together two emerging fields of research was an intimidating prospect:

"I am feeling a mixture of excitement and anxiety having begun to read around the subjects, and speaking about them with my supervisor. Today he very kindly suggested that following this research I will be one of the experts on the topic in the country. This idea seems like a long way off at the moment, especially at these early stages. I wonder whether I will be able to contribute something different to the field, and I realise I am already putting pressure on myself to create something new, something ground breaking."

Looking back these concerns were interesting. One of the strengths of the task analytic methodology, and one of the reasons it was well suited to this research is the fact that it combines theoretical knowledge and speculation with what is observed in practice. Whilst this provided some reassurance, I was aware, even at this early point, than the analysis would be conducted through the lens of my personality, my values and my beliefs.

Expert interviews

I was both excited and extremely anxious about conducting the expert interviews. My research supervisor had regularly informed me of how collegiate the psychotherapy research world was, and very kindly put me in contact with several people who were considered 'experts' in the field. Two people in particular, Dr Jeremy Safran, and Dr Michael Lambert, were widely considered to be the international experts in the fields of rupture resolution and session-by-session respectively. I was astounded that they agreed to take part in the project, and felt very privileged to be able to interview them regarding the project. At the same time, I felt under immense pressure to make the most of our interviews:

"I have just interviewed Michael (now Mike to me!) Lambert. It felt at times like a truly surreal experience, here was I, a trainee, interviewing the person who makes up a significant chunk of my reference list! I wonder what he will make of how I have

interpreted his work so far, or what themes I create based on our interview. I am not sure I will get another chance to interview him, I just hope I asked all the right questions. I hope I'm able to really capture the themes of what he was saying, without imposing my own beliefs and pre-conceived ideas on his thoughts. It feels like a huge responsibility."

Emboldened by the interest in the project, I decided to approach Dr Scott Miller to see if he would be willing to take part in the project. He was one of the developers of the SRS, the feedback measure used by the clinicians in the study, and also developed one of the most widely used feedback systems. To my surprise, he e-mailed back and was extremely enthusiastic about the project. I interviewed him, and he offered a very different perspective to my own about the use of session-by-session feedback:

"My interview with Scott was fascinating!!! He absolutely lives and breathes feedback. One interesting thing that he said that chimed with me was that he was often wracked with doubt going into therapy sessions. This reminded me that no matter how experienced or "famous" we were, we all suffer from the same insecurities. But, instead of thinking that feedback would expose him, he thought that feedback would give him the key, let him know what was going well, and what needed to be changed! This now seems like an obvious way of looking at things, but it was inspiring to hear if from someone who I associate with 'supershrinks'"

Empirical data

Listening to the audio-tapes of the sessions was perhaps the most difficult, but also the most useful part of the project. I felt privileged to be able to listen to an experienced clinician, who I had grown to respect and value, conduct therapy. This was a rare opportunity to gain an insight into his therapeutic style, and how he addressed the many challenges

inherent in conducting therapy. I felt even more privileged to be able to listen to aspects of the five participants' therapy. I was shocked that they were willing to let someone they had never met listen to their struggles, and their personal experiences.

At times, this process felt voyeuristic, which left me feeling very uncomfortable. I felt as though I were in some way intruding on the most personal of moments, eavesdropping on the things that they had often never told anyone before.

> *"I have listened to the first few sessions of participant one that were identified for analysis. This has been a difficult experience, as I felt as though I didn't have the right to be doing this, and it felt wrong. I had to consistently remind myself that I was doing this in order to help therapists provide better therapy in the future. I wonder whether I will be able to listen to the tapes wholly impartially, without this feeling lingering, or feeling drawn into the person's life. It would be unusual to be listen to the tapes without feeling some empathy, and I hope this process doesn't knock this out of me"*

It was also very strange coding ruptures in my supervisor's therapy. Even though I was fully aware that ruptures occurred in almost every therapy, it still felt as though I was passing judgement on his competence. I also wondered what his reaction would be once he saw my coding forms, and what I had coded:

> *"I wonder if James will agree with what I have coded? Anne-Marie has agreed with them so far, but I hope James doesn't feel like I am criticising him."*

I began to realise how subjective the process of coding for ruptures could be. The list of rupture markers was extensive, and in theory almost all client behaviours (e.g. long silences, storytelling, interrupting, quiet voice, self-critical statements) could be coded as

significant. I grew aware of how intricate the rupture coding process was, and the importance of situating it within the context of therapy. The process made me reflect on my own work with clients, and what subtle communications I might be missing. I began to see the personal benefit that this project would have for me, both in terms of my approach being informed by the skilful way that my supervisor practiced, and also in a growing awareness of the process of therapy.

Model development – rational model

I thoroughly enjoyed listening back to the interviews I conducted with the experts. I felt as though it was like additional teaching. Initially the prospect of incorporating the views of five experts felt unmanageable. They all seemed to have unique ways of approaching the task of resolving a rupture in the therapeutic alliance using session-by-session feedback. However, as I endeavoured to immerse myself in the data, themes began to emerge. This was a heartening part of the research process. I began to relish the challenge of producing a framework that would capture the main themes that ran through the interviews. I also noticed elements of the model beginning to creep into my therapeutic approach, trying to approach my clients' feedback non-defensively, and paying much more attention to my own experience during sessions.

> *"I found myself in one of my sessions today consciously trying to really listen to the feedback my client was giving me, and not to take it as a personal criticism, instead thinking of it as 'the key' to future therapy. I think I will have to be careful to make sure that the model I am in the process of developing over the next few weeks does not draw on my own experience of therapy, but stays true to the thoughts of the experts. This is something I need to remember to pay attention to, and watch out for."*

Model development – empirical model

I was initially disappointed that more sessions weren't identified as containing ruptures, as it meant that the model was built on a smaller number of sessions than I had originally hoped for. However, I was surprised by both how rich the data was from the feedback contained within the session, and how similar the successful administrations of feedback were. I was aware during this process of a desire for it to be similar to the rational model I had developed, as this would in some way vindicate the work I had put in so far. I had to remind myself on many occasions that one of the reasons the task analytic methodology was so sound, was that it combined both theoretical perspectives with what was observed in practice. I didn't want one to contaminate the other, and wanted to stay true to what was observed in actual clinical practice. The combination of the two models would come later.

> *"The model I'm developing seems simpler than the rational model. I think this is a good thing, but I worry about capturing the intricacies of the therapeutic encounter I'm listening to. I wonder if video-taping sessions would have been appropriate? It feels intrusive, but at the same time would have given me even richer data. Perhaps this is something to think about at a later point. I have deliberately hidden the rational model I have developed, as I worry I'll fall into the trap of trying to fit things into those boxes. I suppose it's good I'm aware of that, but it's really hard not to do!"*

The synthesis of the models

The synthesis of the models was a surprisingly challenging part of the research. Prior to embarking on this process, I imagined it would be a relatively simple task. However, I found myself strangely attached to both models. I had spent many hours developing each, and felt after a great deal of hard work late into many a night, I had created models that were true

to the data they had emerged from. The rational model seemed to capture the views of the experts, and all had agreed that it was true representation of the conversations we had. Jeremy Safran was particularly complimentary, which I was extremely proud of. Scott Miller even asked if he could use it in his teaching on feedback informed therapy.

The empirical model felt solidly grounded in actual therapy sessions. I felt honoured to have been able to listen to actual therapy sessions, and strangely felt as though my model represented some of the struggles, bravery, and honesty that both the therapist and the participants had contributed. It was definitely as much their model as mine. At first I was very reluctant to combine the two, unwilling to lose parts of either.

> *"I can't believe how averse I am to combining the two models. At times I feel I will end up with a bastardised version of both models, which won't do justice to either. I know this is my own personal struggle. I wonder if this represents my anxiety about my own voice coming through. The combination of both models feels like I will be putting my stamp on the project, adding my voice to that of the experts and the therapist-client contributors. This feels like a significant point in the project."*

Final stages

Re-reading the reflexive journal, and selecting extracts for this appendix, has made me reflect on the many contradictions inherent in this research. At almost every stage of the research I felt both excited, and daunted. Excited at the prospect of creating something new, of making a genuine contribution to a field I am passionate about. Daunted about the weight of expectation (both my own, and that of my supervisors) that came with this. On reflection, I have enjoyed the research process significantly more than I thought I would. Research was not something that I was initially very passionate about. However, throughout training, and specifically throughout this project, I have come to realise its importance. I think what I will

take most out of this experience is how supportive other researchers (be they fellow trainees, or established psychotherapy researchers) have been. Their passion has helped drive me, and sparked an interest in research that I hope will continue beyond training.

References

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative research*, *2*, 209-230. Retrieved from http://qrj.sagepub.com/

Appendix T

Research Sub-Committee Approval

Oxford Health NHS
NHS Foundation Trust

The Oxford Institute of Clinical Psychology Training

UNIVERSITY OF OXFORD

Oxford Doctoral Course in Clinical Psychology
An NHS Course validated by the University of Oxford

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2nd October, 2014

Christopher Laraway
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Isis Education Centre

Dear Chris,

Thank you for your very comprehensive reply to the letter from the Research Sub Committee. You now have full approval for your research dissertation.

We wish you all the best with your work.

Yours sincerely,

Angela Fox.

Dr Myra Cooper
Chair, Research Sub-Committee

c.c. James Macdonald
Anne-Marie Daly
Carmen Chan

Appendix U

Central University Research Ethics Committee Approval

MEDICAL SCIENCES INTER DIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, University of Oxford

University Offices, Wellington Square, Oxford, OX1 2JD
Tel: +44(0)1865 616577 Fax: +44(0)1865 280467
ethics@medsci.ox.ac.uk http://www.medsci.ox.ac.uk

CONFIDENTIAL

Ref: MSD-IDREC-C1-2014-214

Mr Christopher Laraway
Oxford Institute of Clinical Psychology Training
Isis Education Centre
Warneford Hospital
Oxford

17th December 2014

Dear Christopher

CUREC checklist

I am writing to acknowledge receipt of your CUREC-1 form for your project: **Resolving Ruptures in the Therapeutic Alliance Identified using Session by Session Feedback: A Preliminary Task Analysis**

On the basis of the information you have provided this has now been approved by the Medical Sciences IDREC **subject to:**

a) **receipt of the hard copy of your application signed by your head of department (Please note that should this not appear or the head of department is unwilling to sign then this approval would not be valid);**

b) **it is your responsibility to comply with the requirements for administering any tests or questionnaires and if in doubt to contact the publisher of those tests or questionnaires.**

The reference number for this project is **MSD-IDREC-C1-2014-214** and is valid for a period of **12 months** from the CUREC 1 approval date, **15th December 2014**. Please may I remind you that your project may be reviewed at some stage during an annual audit of projects.

Amendments

Should you at some stage alter some of the techniques or procedures then you should first undertake a checklist (CUREC-1) to see whether these changes alter the ethics of the research. If these remain the same then the committee will require notification of the changes to lodge with the project. If they do not remain the same then you may need to complete a CUREC-2 form and undergo further scrutiny by the committee.

Please do not hesitate to contact me if you have any queries about this.

Yours sincerely

Gill Halstead
Research Ethics Co-ordinator, Medical Sciences

Appendix V

Existing Models of Rupture Resolution

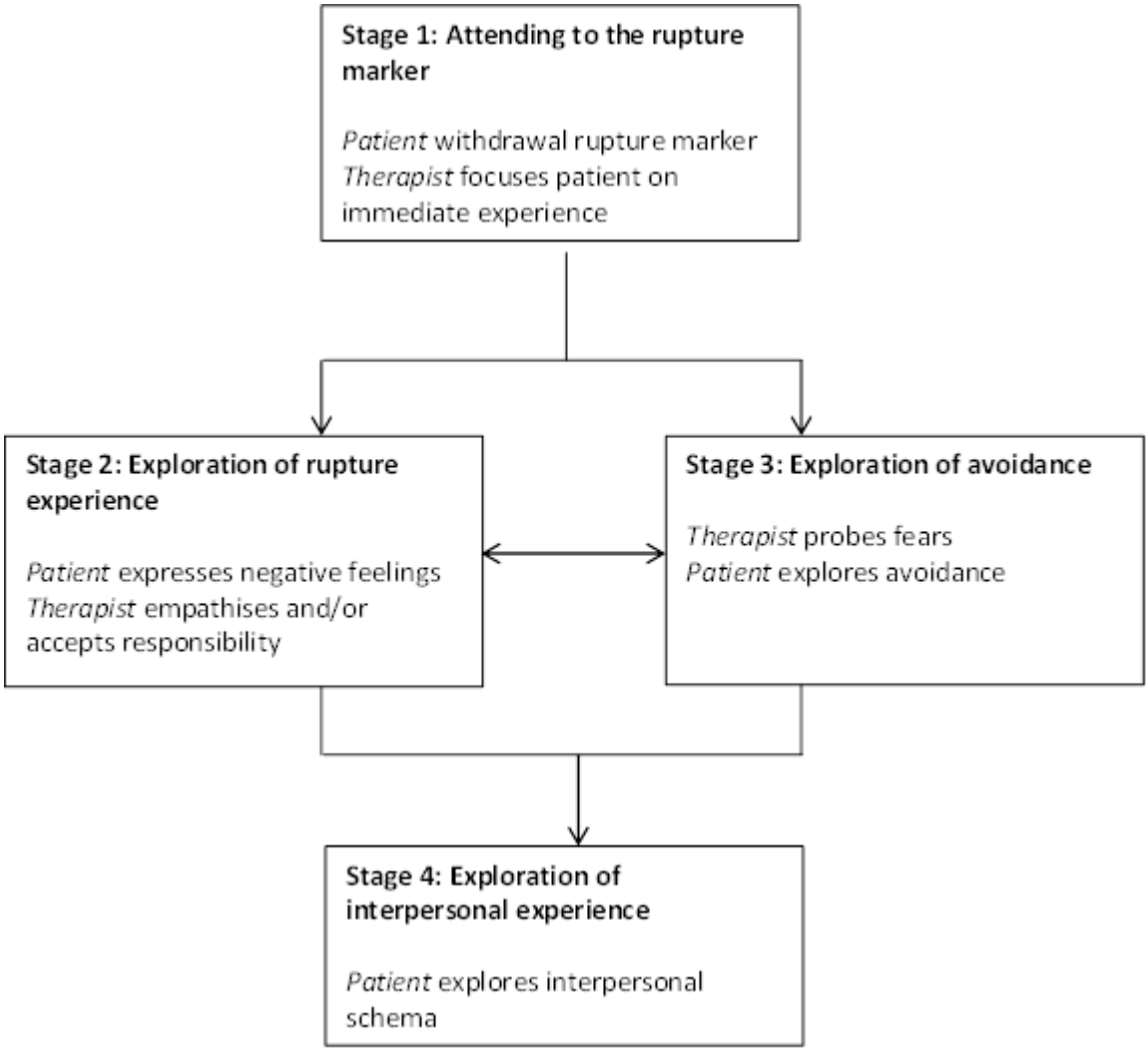

Figure 1 – Stage Process Model of Rupture Resolution in Integrative Therapy (Safran & Muran, 2001)

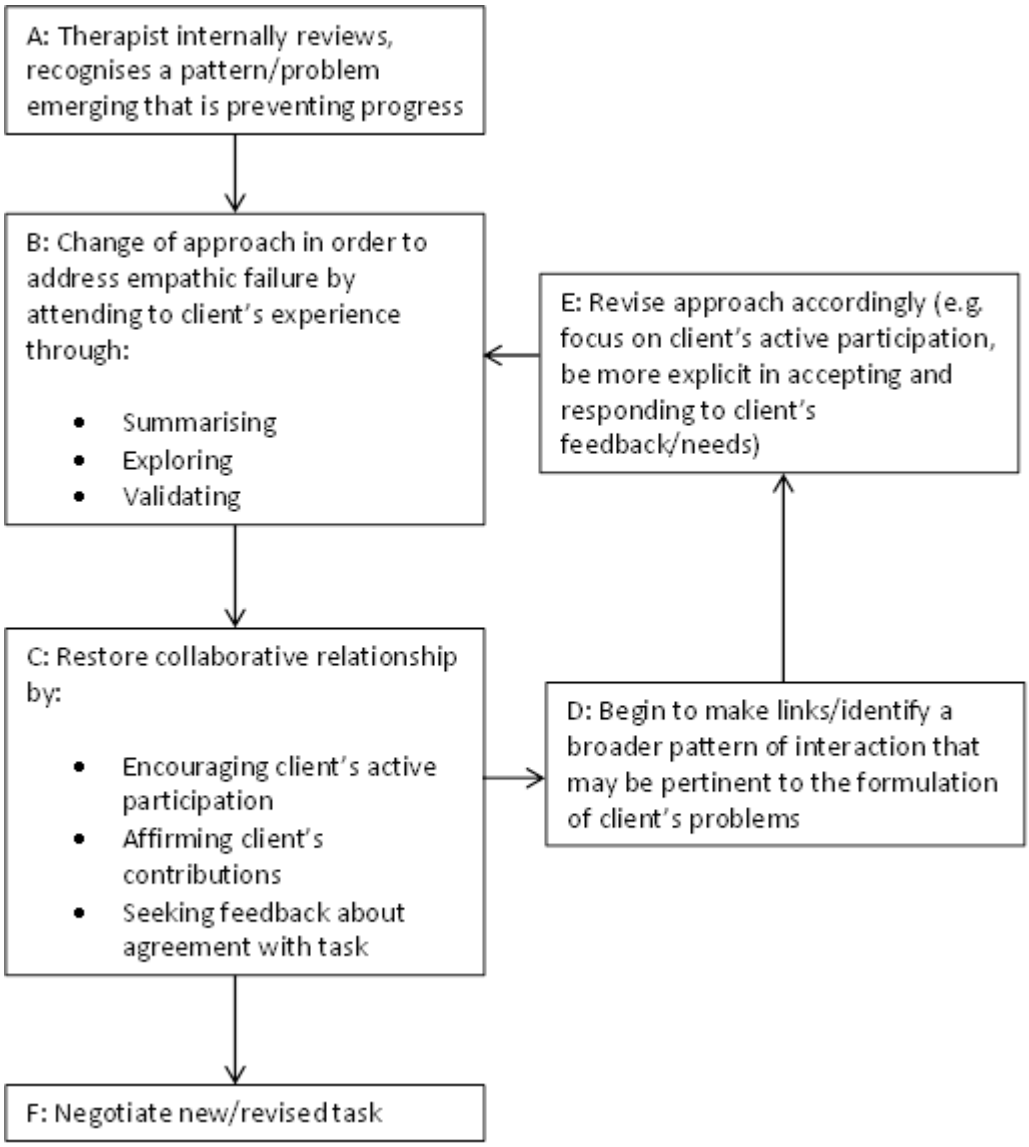

Figure 2 – Revised Model of Rupture Repair in CBT (Aspland et al., 2008)

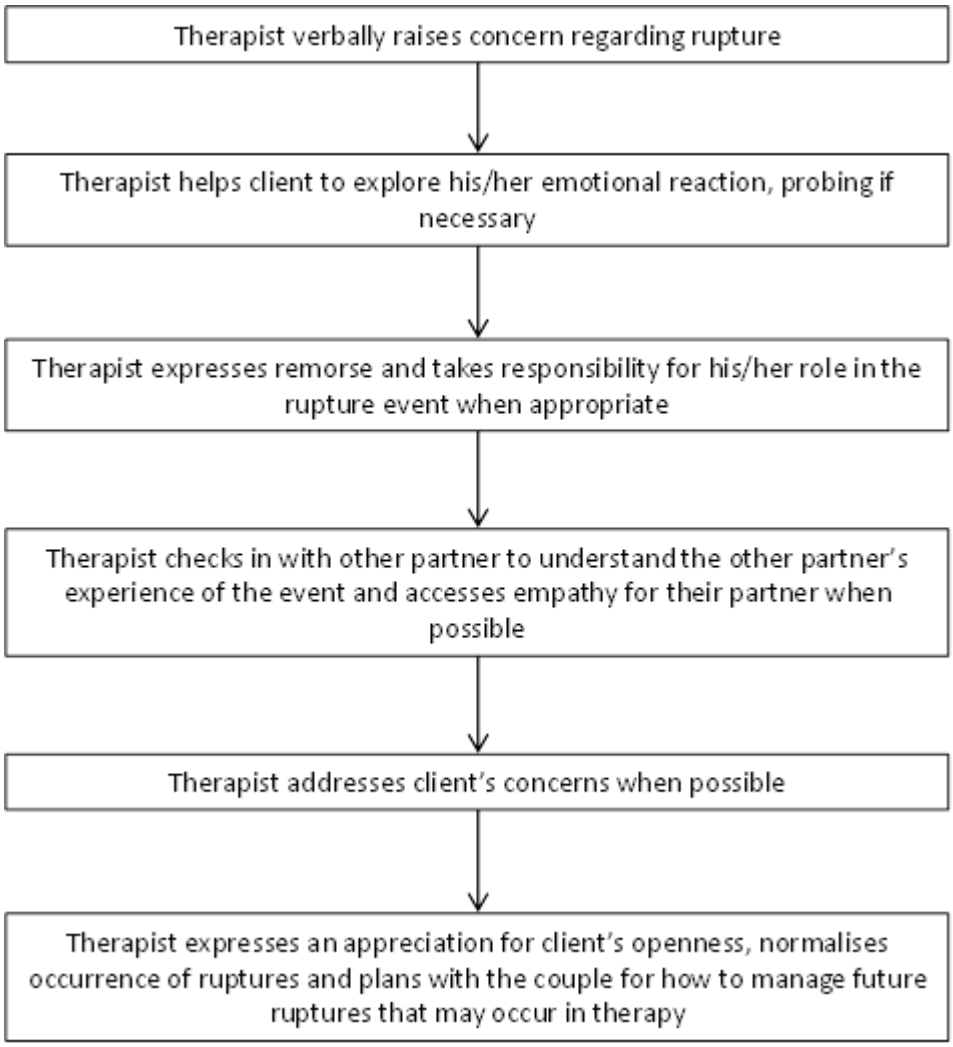

Figure 3 – Rupture Repair Model in Emotionally Focused Couple Therapy (Swank & Wittenborn, 2013)

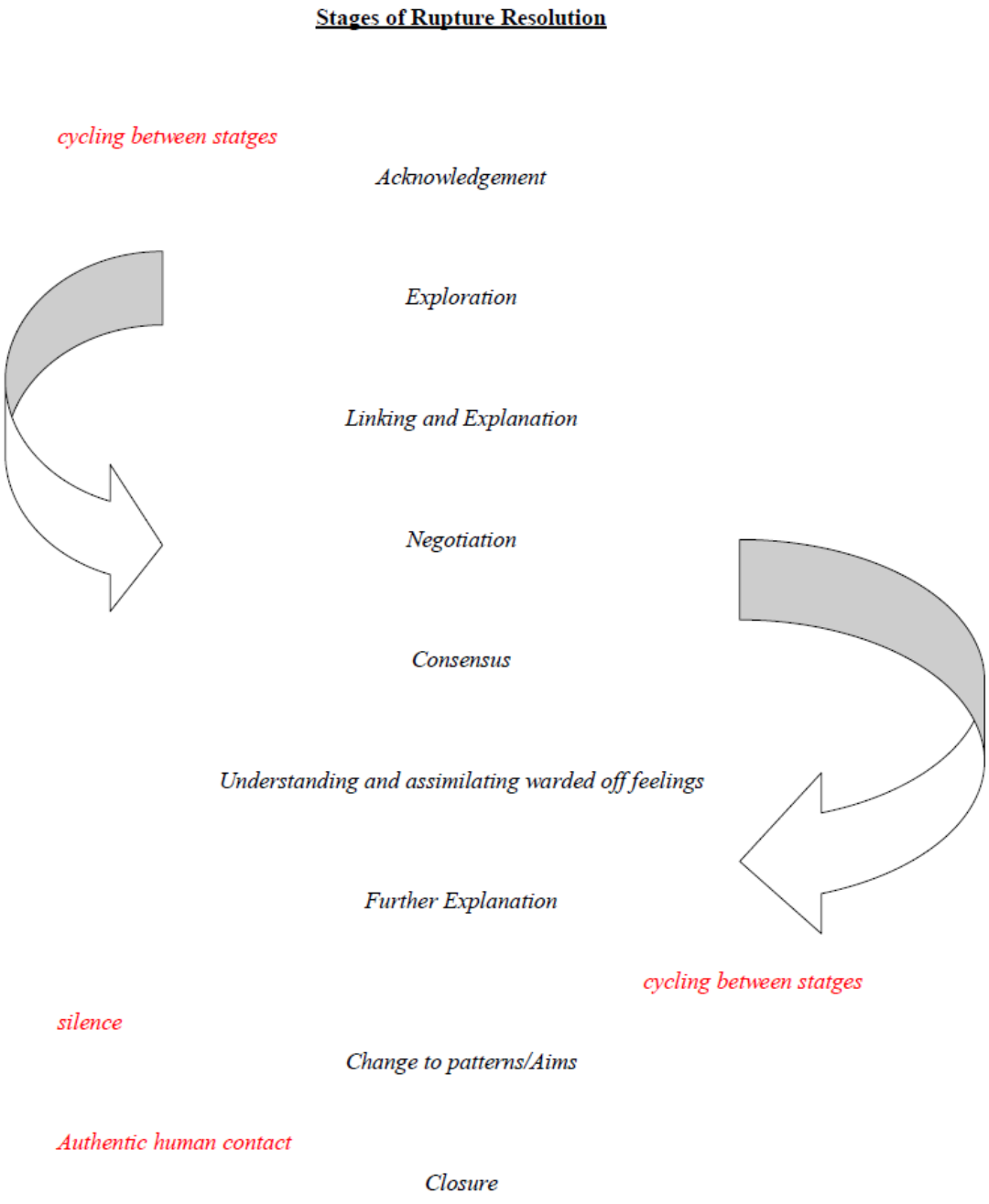

Figure 4. Refined Performance Model (Bennett et al., 2006) of Rupture Repair in CAT