chapter 6

A Relational Approach to Personality Disorder and Alliance Rupture

Sumru Tufekcioglu and J. Christopher Muran

It is agreed by clinicians from diverse orientations as the cognitive (Pretzer & Beck, 2005), interpersonal (Benjamin, 2005), attachment (Levy, 2005), and object relations (Clarkin, Yeomans, & Kernberg, 2006) perspectives that clients with personality disorders encounter difficulties with self or identity and interpersonal functioning. In fact, more often than not, it is an interpersonal problem in the social or work environment that brings clients with personality disorders into treatment. As such, interpersonal functioning is a major focus of treatment with this group of clients.

Although they are taken from different theoretical orientations, many different treatments have been proven to be effective in treating personality disorders, suggesting that it might be the common elements in these various approaches rather than the modalities of treatments that are responsible for change. One such common element contributing to successful treatment of personality disorders has been shown to be the interpersonal component in therapy (Clarkin, Levy, & Ellison, 2011). In fact, it can be posited that each successful treatment for personality disorder is "a carefully considered, well-structured and coherent interpersonal endeavour" (Bateman & Fonagy, 2000, p. 142). It follows, then, that an integrative approach to treating personality disorders would have to focus on the interpersonal component of therapy; that is, the therapeutic relationship.

In this chapter we examine, with a relational approach to personality and the psychotherapy process, the therapeutic relationship with clients with personality disorders. First, we present a relational view of the self. Next, we discuss how this "self in relation to the other" emerges in the therapeutic relationship and how the therapeutic relationship is used as a mechanism of change. We also present the challenges that are encountered in the therapeutic relationship, namely, ruptures, especially with individuals with personality disorders. We examine how ruptures are resolved in the therapeutic relationship, provide a view of ruptures as change events, and illustrate this notion with clinical examples. Finally, we discuss the training implications of this approach. Our perspective has been informed by our research on rupture resolution (Safran & Muran, 1996) and in turn has informed the development of a treatment model and training regimen with some empirical support (e.g., Muran, Safran, Samstag, & Winston, 2005; Safran et al., 2014).

A RELATIONAL THEORY OF PERSON AND PERSONALITY DISORDER

Muran and Safran have written about the person as a relational phenomenon (Muran, 2001; Safran, 1998; Safran & Muran 2000), describing the continuous interplay among the various processes and structures of the self. The processes refer to the various cognitive and interpersonal operations that establish and protect the representational structures of the self. This refers to the self in relation to others, as well as to itself. The structures refer to memory stores of multiple discrete experiences of the self in relation to significant others. These are relational schemas that are abstracted on the basis of interactions with attachment figures (and others of interpersonal significance) to increase the likelihood of maintaining a relationship with those figures. They contain specific procedural information regarding expectancies and strategies for negotiating the dialectically opposing needs for agency or self-definition and for relatedness or communion (see Safran & Muran, 2000, for elaboration). They are also considered emotional structures that include innate expressive-motor responses that develop from birth into subtle and idiosyncratic variations and that serve a communicative function in that they continually orient the person to the environment and the environment to the person.

We have also described the emergence of a corresponding experience, a particular state of mind or *self-state,* with the activation of a particular relational schema. Self-states are the experiential products of the various processes and structures of the self, the crystallization in subjective experience of an underlying relational schema. Different self-states can activate different relational schemas, resulting in a cycling through different states of mind. The transition points or boundaries among the various self-states that each person experiences vary in terms of seamlessness. They are naturally smoothed over, creating the illusory sense of continuity and singular identity, through

the process of dissociation. The more conspicuous and abrupt the transitions between self-states are, however, the more problematic the dissociative process is. It is useful to distinguish between dissociation as a healthy process of selectively focusing attention and dissociation as an unhealthy process resulting from traumatic overload and resulting in severing connections between relational schemas.

Finally, a central tenet of our relational perspective is the recognition that there is an ongoing reciprocal relationship between the self-states of one person and those of the other in a dyadic interaction. This refers to the ways in which self-states are interpersonally communicated and mutually regulated in a dyadic encounter. As individuals cycle through various self-states in an interpersonal encounter, they should both influence and be influenced by the various self-states of the other. In such encounters, one is always embedded in a *relational matrix* (Mitchell, 1988) that is shaped moment by moment by the various states and implicit desires of the two individuals.

As noted earlier, relational schemas shape the person's perceptions of the world, leading to cognitive processes and interpersonal behaviors that in turn shape the environment in a way that confirms the representational content of the schemas. To the extent that they are limited in the scope of internalized interpersonal experiences, they will restrict the range of interpersonal behaviors, which pull for similar responses from a range of different people, resulting in redundant patterns of interaction and limiting the possibility of new information in the form of new interpersonal experiences. For example, an individual who generally expects others to be essentially hostile and attacking might tend to act in a defensively hostile and aggressive manner, which would invariably provoke the response from others that is expected—a frequent pattern seen in individuals with personality disorders.

THE THERAPEUTIC ALLIANCE

We have found a conceptualization of the therapeutic alliance along the lines that Bordin (1979) suggested to be useful in our work (see, e.g., Safran & Muran, 2000). Bordin defined the alliance as comprising three interdependent factors of the agreement between client and therapist: on (1) the *tasks* and (2) the *goals* of treatment and (3) the *affective bond* between client and therapist. This definition highlights the interdependence of relational and technical factors: It suggests that the meaning of technical factors can be understood only in the relational context in which they are applied. It also highlights the importance of negotiation between client and therapist on the tasks and goals of therapy, which is consistent with an increasingly influential way of conceptualizing the psychotherapy process as one involving the negotiation between the client's desires or needs and those of the therapist (see Mitchell & Aron, 1999). As such, in our relational approach, the therapeutic relationship is the vehicle for change, and one major component of the therapeutic relationship

that leads to change is the inevitable failures in relatedness between the client and the therapist, that is, the ruptures.

RUPTURES IN THE THERAPEUTIC ALLIANCE

Clients and therapists are always embedded in a *relational matrix* (Mitchell, 1988) that is shaped, moment to moment, by their implicit needs and desires. Ruptures in the therapeutic alliance mark points at which there is a tension between the client's and the therapist's respective desires (see Safran & Muran, 2000). Ruptures indicate vicious cycles or enactments that can be unduly driven by one participant's dysfunctional *relational schemas* described earlier. Ruptures also invariably involve the unwitting participation of the other member of the dyad. Ruptures are inevitable events and are viewed not as obstacles to overcome but as opportunities for therapeutic change. They can be understood as windows into the relational worlds of both the client and the therapist and thus as opportunities for expanded awareness and new relational experiences. Alliance ruptures have received increasing attention over the past 25 years in the research literature, with growing evidence that they are common events (e.g., they are reported by patients in as much as 50% of sessions; they are observed by third-party raters in 70% of sessions); they predict premature termination and negative outcome, but when resolved they predict good outcomes (Eubanks-Carter, Muran, Safran, 2010; Safran, Muran & Eubanks-Carter, 2011, Samstag, Batchelder, Muran, Safran, & Winston, 1998).

In a self-report and observer-based study of ruptures, Sommerfeld, Orbach, Zim, and Mikulincer (2008) found that sessions in which both patient and observer saw a rupture were rated as having greater depth by the patient. As ruptures that are identified by both self-report and observer report are likely ones that are explicitly discussed in the session, this finding suggests that patients find therapy more helpful when therapists are sensitive to subtle indications of ruptures and encourage patients to explore them. Sommerfeld and colleagues (2008) also found a significant association between the occurrence of ruptures and the appearance of dysfunctional interpersonal schemas involving the therapist, identified by using the core conflictual relationship theme (CCRT) method (Luborsky & Crits-Christoph, 1998). This finding suggests that when ruptures occur, dysfunctional schemas are likely to be active; thus ruptures provide critical opportunities to identify, explore, and change patients' self-defeating patterns of thought and behavior.

Ruptures can be organized into two main subtypes: (1) *withdrawal ruptures* and (2) *confrontation ruptures* (Harper, 1989a, 1989b). In withdrawal ruptures, clients withdraw from the therapist (e.g., through long silences) or from their own experience (e.g., by denying their emotions or by being overly deferential to the therapist's wishes). In confrontation ruptures, clients move against the therapist, either by expressing anger or dissatisfaction

(e.g., complaining about the therapist or the treatment) or by trying to control the therapist (e.g., telling the therapist what to do). These markers can be understood as reflecting different ways of coping with the dialectical tension between the need for self-definition and the need for relatedness: Withdrawal ruptures mark the pursuit of relatedness at the expense of the need for self-definition; confrontation ruptures mark the expression of self-definition at the expense of relatedness.

RUPTURES AND PERSONALITY DISORDER

As noted earlier, relational schemas shape how a person views the world, leading to interpersonal behaviors that in turn lead to experiences with other people similar to the original relational schema, thus confirming and perpetuating a pattern of relating to others. To the extent one's relational schemas are limited in terms of interpersonal experiences, they will restrict the range of behaviors he or she is able to exhibit in relations with others. This will pull for similar responses from others, resulting in a repetition of a particular relational pattern, and will limit possibilities for new information and new experiences.

Clients with personality disorders, who invariably have a restricted range of interpersonal behaviors that lead to significant interpersonal problems, might have more difficulty developing a good alliance with the therapist in our interpersonally focused treatment. In particular, as Muran, Segal, Samstag, and Crawford (1994) found in their study of short-term cognitive therapy, clients with a tendency toward hostile, dominant interpersonal behaviors, which are characteristic of DSM Cluster B personality disorders (American Psychiatric Association, 1994), might have difficulty establishing a good alliance. Further, outcome research has shown that patients with personality disorders are especially challenging and resistant to treatment, resulting in more negative process, higher attrition rates, and greater treatment length (Benjamin & Karpiak, 2002; Clarkin & Levy, 2004; Westen & Morrison, 2001). This is particularly significant given that patients diagnosed with personality disorders in clinics and practices make up as many as 45% of the total of patients seen (Zimmerman, Chelminski, & Young, 2008).

In examining the therapeutic alliance and the inevitable ruptures therein with clients with personality disorders, a particular issue arises that requires further consideration and poses challenges to the therapists: that the characteristics that pertain to personality disorders in general seem to be multidimensional (Dimaggio et al., 2012). As noted earlier, patients with personality disorders are observed, regardless of the particular type of disorder, to present with constricted and inhibited personality traits such as (1) poor metacognition (Bateman & Fonagy, 2004, and Chapter 7, this volume; Dimaggio, Popolo, Carcione, & Salvatore, Chapter 8, this volume; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007); (2) dysfunctional constructions of

self-with-other relationships, such as seeing oneself as not lovable, unworthy, guilty, omnipotent, and betrayed and the other as rejecting, abusing, and so forth (Benjamin, 1996); and (3) emotion and impulse dysregulation (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) or overregulation. For example, a patient might have poor metacognition while also presenting with negative constructions of self with others. This multidimensional aspect of personality disorder makes it more complicated for therapeutic intervention and requires treatment of all of the elements involved, each with specific techniques. This calls for an integrated approach possibly combining therapeutic components from different models (Clarkin, Levy, Lenzenweger, & Kernberg, 2007 Dimaggio et al., 2012; Livesley, 2003). Furthermore, this multidimensional and complex picture of patients with personality disorder lends itself to a layer-by-layer unfolding of the therapy process, and it is observed that different aspects of the disorder might surface at different stages of therapy. This necessitates specific interventions at different stages of treatment based on the particular elements of the pathology that emerge at that point in therapy (Dimaggio et al., 2012). Moreover, patients with personality disorder are observed to have a negative view of themselves, and the more they become aware, in therapy, of the features they find unacceptable, the more they feel angry. This will aggravate any alliance ruptures, and any aspects of the patient that emerge need constant validation from the therapist (Dimaggio, Carcione, Salvatore, Semerari, & Nicolò, 2010).

A further complication in working with clients with personality disorders is that each type of personality disorder produces its own type of interpersonal challenge. In her consideration of the therapeutic alliance with respect to DSM personality disorders, Bender (2005) suggests that each type of personality disorder poses different challenges to forming a working alliance in psychotherapy and outlines specific challenges for each of the following types of personality disorders.

Cluster A: Eccentric

Cluster A personality disorders—the so-called odd/eccentric cluster—involve a profound impairment in interpersonal relationships, often with paranoid characteristics. In negotiating the therapeutic alliance, this group of clients pose challenges to their therapists that are characteristic of this type of personality, such as suspiciousness of the therapist's intentions, profound interpersonal discomfort with the therapist, emotional aloofness, and hypersensitivity to perceived criticism.

Schizotypal

Although it is often assumed that clients with schizotypal personality disorder have no desire to become involved in relationships, it is demonstrated by Bender and colleagues (2003) that clients with schizotypal personality

disorder had the highest involvement with therapy outside the session. These clients reported wishing to be friends with and missing their therapists, while also having aggressive and negative feelings. For many such clients, it is a matter of being extremely uncomfortable around people rather than not having a desire for connection. The discomfort that schizotypal clients often experience may not be readily apparent, so being attentive to clues about what is not being said may be required for alliance building.

Schizoid

This is a relatively rare disorder, so we mostly refer here to people with schizoid traits appearing in the context of other (e.g., avoidant) personality disorders. Schizoid traits are mostly associated with keeping people at a safe emotional distance. Clients with schizoid features may also present with affective coldness, dullness, lack of conflict, and emotional detachment. However, underlying this detachment, many of these clients feel an intense neediness for others and have some capacity of interpersonal responsiveness with a few selected people (Aktar, 1992). Thus many clients with schizoid traits can form an alliance in therapy, although this would require, from the therapist, special attention tailored specifically to these clients' characteristics.

Paranoid

Individuals with paranoia obviously pose challenges for alliance building, as they are usually vigilantly looking out for signs to get suspicious and find offense in the most benign of circumstances (Bender, 2005). However, it has also been suggested that behind their defensive paranoid presentation, these individuals have an extremely fragile self-concept and that thus it may be possible to build alliance with them in time with a sensitive affirmative approach and tactful handing of the ruptures (Benjamin, 1993).

Cluster B: Dramatic

Cluster B personality disorders—the "dramatic" cluster—is associated with pushing the limits and poses challenges to the therapeutic alliance, such as extremely demanding behavior, unstable emotional states, proneness to acting out, and need for constant approval (Bender, 2005).

Borderline

Clients with borderline personality frequently exhibit emotional instability, self-destructive acting out, and anger and aggression, and they tend to perceive their therapist in ways that alternate between idealization and devaluation. Thus it can expected that the therapy process with these clients will be rocky and challenging and will require special attention to the repairing of

the many ruptures that will inevitably occur. For example, Horwitz and colleagues (1996), studying the therapeutic alliance in the treatment of borderline personality disorder, observed that "the repair of moment-to-moment disruptions in the alliance often was the key factor in maintaining the viability of the psychotherapy" (p. 173). This finding underscores the importance not only of alliance building but also of moment-to-moment attention from the therapist to the ruptures in the therapeutic relationship with these clients.

Narcissistic

Narcissistic personality is associated with intense grandiosity and a need to maintain self-esteem through omnipotent fantasies and defeating others. As such, these clients pose significant challenges to therapists in alliance building. These clients will likely "know best" and not allow the therapist to express an alternative view to theirs for a long time in treatment. Although this interpersonal dynamic might be very difficult to tolerate for therapists, it might be possible to establish alliance with this group of clients by a consistent respect for their vulnerability and their need not to trust, as this may in time allow for a lessening of their defensive needs (Bender, 2005; Meissner, 1996).

Histrionic

Histrionic personality is associated with a need to be the center of attention, little tolerance for frustration, and demands for immediate gratification. As such, building alliance with individuals with histrionic personality requires the therapist to have the necessary skills to manage escalating demands, dramatic acting out, and the related ruptures that will inevitably emerge in the relationship with such clients.

Cluster C: Anxious

Clients with Cluster C personality disorders are observed to be emotionally inhibited and averse to interpersonal conflict. Although building alliance with these clients is seemingly easier than it is with clients with Cluster A and B disorders, it may involve the following certain specific challenges.

Dependent

Clients with dependent personality have been noted to be passive and submissive and fearful of offending others. In therapy, they are easily engaged but will often withhold information and refrain from being assertive from fear of offending the therapist in some way. Thus more withdrawal types of ruptures will likely occur in therapy. Moreover, the therapist may become more frustrated as time passes by and the client is not taking full responsibility for actions aimed at breaking patterns. The therapist can then become critical or judgmental (Dimaggio et al., 2007).

Avoidant

Avoidant individuals are extremely sensitive to criticism and fearful of saying something foolish or humiliating. This sensitivity poses challenges in building alliance with avoidant clients and keeping them in therapy. The therapists need to be mindful of how their comments will be experienced by the clients and will need to be able to attend to the moment-by-moment withdrawal ruptures that will not be readily apparent.

Obsessive–Compulsive

Obsessive–compulsive personality is associated with rigidity and maintaining control over internal experience and the external environment. In the context of therapy, these clients tend to be controlling and stubborn, but they also try to be "good patients," which likely enables the building of a constructive alliance (Bender, 2005). Their restricted expression of positive affects may evoke in the therapist feelings of boredom, distance, and mild irritation at the moralistic attitudes these patients sometimes endorse (Dimaggio et al., 2010).

Therapeutic Alliance and Personality Disorder

Considering the aforementioned characteristic ways of interpersonal relating that clients with Cluster A and B disorders most likely demonstrate in therapy, it can be posited that in working with such clients, a therapeutic alliance will be harder to establish and a higher frequency of alliance ruptures (especially confrontation ruptures) will likely be observed. Cluster C personality disorders, on the other hand, are characterized by being "anxious/fearful," emotionally inhibited, and averse to interpersonal conflict. These clients tend to be prone to shame and humiliation, perfectionistic toward themselves and others, conscientious, friendly, and compliant. They tend to internalize blame and take responsibility for their issues and will readily engage with the therapist to sort out their problems. This characteristic way of relating is very different from that of clients with Cluster A and B disorders, which in fact often facilitates alliance building (Bender, 2005). Considering the characteristic ways of relating that clients with Cluster C disorders typically demonstrate, a more positive therapy process and a higher frequency of withdrawal ruptures will likely be observed. In fact, a recent study examining the therapy process with 145 patients who received two different time-limited treatments compared patients with pretreatment diagnoses of Cluster C personality disorders with patients who did not receive personality disorder diagnoses found that patients with Cluster C personality disorders reported a significantly more positive therapy experience in a number of alliance measures. Further, the study found that there were no significant differences between the two groups of patients in terms of dropout rates (Tufekcioglu, Muran, & Safran, Winston, 2013).

The dynamics that emerge in the relationship with these clients can be specific to each disorder (Bender, 2005). It should be noted, however, that

these challenges become more complicated when one faces patients comorbid with multiple personality disorders or diagnosed with personality disorder—not otherwise specified according to DSM, in which features of personality disorders from different clusters are in evidence. In addition, considering the multidimensional nature of personality disorder, including poor metacognition (Bateman & Fonagy, 2004; Dimaggio et al., 2007), dysfunctional constructions of self-with-other relationships (Benjamin, 1996), and emotion and impulse dysregulation or overregulation, it follows that in successfully building and maintaining alliance with clients with personality disorders, an approach that is tailor-made not only to each type of disorder but also to each particular patient and to the particular stage in therapy is needed. This brings to the forefront the importance of the therapist's being attentive to the moment-by-moment shifts and ruptures in the relationship, which is the central tenet of our approach to resolving ruptures. We discuss this approach and illustrate it with clinical examples in the following sections.

RUPTURE RESOLUTION AS CHANGE EVENT

Psychotherapy change is essentially understood as involving the two parallel processes of (1) increasing immediate awareness of self and other and (2) providing a new interpersonal experience. Increasing immediate awareness begins with attending more closely to the details of experience at a molecular level. The client starts to develop a sense of the choices he or she is making on a moment-by-moment basis. With greater awareness of how he or she constructs his or her experience, the client develops an increased sense of responsibility and agency. This change process does not simply suggest a correction of a distorted interpersonal schema; instead, increasing the client's immediate awareness of the processes that mediate a dysfunctional interpersonal pattern leads to an elaboration and clarification of the client's self—in other words, expanded awareness of who one is in a particular interpersonal transaction. The clarification of the client's self invariably involves greater clarification of the therapist's self as well. Following our relational understanding of the role of increased immediate awareness in the change process, we have identified a specific mechanism of change: *decentering*, which consists of inviting the client to observe his or her contribution to a rupture or enactment in the relational matrix of the therapeutic relationship. We find the notion of mindfulness to be particularly useful in this regard. A primary task for therapists is to direct clients' attention to various aspects of their inner and outer worlds as they are occurring. This attention promotes the type of awareness discussed earlier that deautomates habitual patterns and helps clients experience themselves as agents in the process of constructing reality rather than as passive victims of circumstances. We also believe that the principle of metacommunication captures the spirit of this type of collaborative exploration and the essence of what we mean by *decentering*. Metacommunication involves an attempt

to disembed from the interpersonal claim that is being enacted by taking the current interaction as the focus of communication. It is an attempt to bring awareness to bear on the relational matrix as it unfolds. It is also important to recognize that the psychotherapeutic process is not only discovery oriented but also constructive (Mitchell, 1993). Operating in parallel with the process of increasing immediate awareness, the constructive process of psychotherapy helps to bring about change by providing the client with a new interpersonal experience. In this regard, we have identified another specific mechanism of change: the *disconfirmation* of the client's maladaptive relational schema through the new interpersonal experience in the therapeutic interaction.

As noted earlier, our relational approach conceptualizes change as occurring through the process of decentering, or increasing awareness, and the process of disconfirmation, whereby the client has a new interpersonal experience with the therapist that challenges the client's existing interpersonal schemas. The method for achieving these changes is to draw the client's attention to aspects of his or her experience that he or she is avoiding or disowning while maintaining a validating and empathic stance that provides a corrective emotional experience for the client. In particular, the therapist pays close attention to ruptures in the alliance, highlighting them when they occur and encouraging the client to explore them. The therapist draws on his or her own experience of the relationship and his or her sense of being connected to or disconnected from the client as a guide for identifying therapeutic impasses. When the therapist feels disconnected, this is a sign that the client may be withdrawing from the interaction or may not be in contact with his or her own inner experience.

One particular area that requires further consideration when working with personality disorders is that the process of decentering needs to be managed carefully based on the client's ability, at any particular point in therapy, to tolerate awareness of aspects of him- or herself that may be viewed as negative by the client. As clients with personality disorders often have a negative view of themselves, becoming aware of the characteristics that they find unacceptable often makes them angry. This leads to alliance ruptures; therefore, exquisite attunement and constant validation from the therapist are required as the process unfolds (Dimaggio et al., 2010, 2012).

RUPTURE RESOLUTION INTERVENTIONS

A number of interventions can be applied to problems related to the tasks and goals of therapy and the affective bond between client and therapist. In this section, we present a taxonomy of rupture resolution interventions. The strategies in the taxonomy are organized according to whether they address the rupture in a direct manner or whether they take an indirect approach to resolving the rupture. We begin with interventions that operate at a more surface level and then proceed to interventions, including metacommunication, that focus in more depth at the level of underlying meaning.

Surface-Level Strategies: Disagreements on Tasks and Goals

Indirect Resolution Strategy: Change or Reframe Tasks and Goals

The therapist may respond to the client's dissatisfaction with therapy tasks and goals by changing or reframing them, or the therapist may reframe the meaning of therapy tasks or goals by describing them in a way that is more appealing to the client. It is important that this intervention not be delivered in a manipulative way. The therapist must believe that the reframing is another valid way of understanding the task or goal rather than a "white lie."

Direct Resolution Strategy: Clarify Rationale and Tasks

The therapist also can outline or reiterate a rationale for treatment, or he or she can illustrate a therapy task.

Surface-Level Strategies: Problems Associated with the Affective Bond

Indirect Resolution Strategy: Ally with the Resistance

With indirect resolution strategies the therapist does not challenge the client's defensive behaviors but rather validates the ways in which they are adaptive and understandable. Allying with, rather than challenging, the resistance can help clients access aspects of their experience that they have been avoiding.

Direct Resolution Strategy: Clarify Misunderstandings

In an open, nondefensive manner, the therapist directly addresses misunderstandings that have led to tension or strain in the relationship with the client.

Depth-Level Strategies

Indirect Resolution Strategy: Provide a New Relational Experience

With this indirect strategy, the therapist addresses problems in the bond by behaving in a way that disconfirms the client's maladaptive relational schema. It is important to note that the surface strategies described earlier can also serve to provide a new relational experience and thus disconfirm a patient's schema.

Direct Resolution Strategy: Explore Core Relational Themes

Exploring strains in the bond can lead to exploration of the client's characteristic ways of experiencing and engaging in interpersonal relationships. It is important to note, however, that premature attempts to explore relational

themes via transference interpretations can elicit client defensiveness and obstruct further exploration.

Although we outline different types of rupture resolution interventions as surface versus depth and direct versus indirect, it should be noted that the ways ruptures unfold in a therapy session and their resolution is a complex process in that surface interventions can simultaneously lead to depth interventions. For example, an intervention aiming at clarifying goals and tasks can also lead to a new relational experience. In other words, by attending to a surface-level rupture, the therapist also brings change at the depth level. Likewise, indirect interventions can lead to direct interventions. For example, allying with the resistance can lead to exploring core relational themes. In fact, in the course of a session, the therapist often employs surface and depth, as well as indirect and direct strategies, and sometimes surface and indirect interventions can have the function of preparing the patient for depth and direct interventions. In the following clinical illustrations, we demonstrate the outlined rupture resolution strategies and show how complex this process can be with patients with personality disorder.

Case Example 1

Jim is a 42-year-old patient who has borderline personality characteristics and a history of multiple suicide attempts, most recently a few weeks before he started therapy after being discharged from the hospital. At the beginning of his first psychotherapy session, when the clinician asked him if this was his first therapy experience, he said, "Yes, and I'm skeptical about it."

THERAPIST: In what ways are you feeling skeptical about it?

JIM: I don't think it can be helpful. How can talking be helpful with anything! I'm on medications and they help, otherwise I feel depressed and try to kill myself. So, how is talking going to help?

THERAPIST: Good question. And it's natural to feel this way when you don't have previous experience with therapy. I would have felt the same way, too. I would think how can talking be helpful!

JIM: Yeah!

THERAPIST: OK, so then let me try to explain to you how it can help. And I'm glad you're bringing this up. It's important to talk about it at the beginning. So, the thinking is that medications help you with the symptoms of depression, which is important. And what we do in therapy is to get to know you better in terms of your current experiences that seem to trigger negative feelings. We also talk about your past experiences and explore together how they might have impacted you. A better, more detailed understanding of how you think and feel, great self-awareness, can help you deal with life's challenges

more effectively, and maybe not engage so automatically in habits that defeat you and leave you depressed.

In the preceding example, the clinician, by attending to Jim's skepticism about therapy in a nondefensive manner, validating his concern, and clarifying the rationale for therapy (a direct and surface-level strategy) helped resolve this rupture and made it possible for Jim to feel more comfortable. A few sessions later, he told the therapist that, coming to his first session, he was expecting to find a therapist who would pressure him to change his behavior and be critical of him but that he was happy to see that, instead, he found an understanding and flexible approach and that he enjoyed talking with the therapist. Thus the therapist's intervention in this session, while starting with a direct surface-level resolution strategy by clarifying rationale for therapy, also provided a new relational experience for Jim (an indirect depth-level strategy) that challenged an underlying schema.

Resolution of Withdrawal Ruptures

As noted earlier, in withdrawal ruptures the client withdraws from the therapist (withdrawal from other) or from his or her own experience (withdrawal from self). A withdrawal rupture can be very subtle; for example, the client may seem to be complying with the therapist with respect to a therapy task but behaves in an overly deferential way that suggests that the client is not in contact with his or her true feelings about the task. This kind of appeasement is indicative of a pseudo-alliance rather than a truly genuine and collaborative interaction. When clients withdraw, they are prioritizing their need for relatedness at the expense of their need for agency. The process of resolving withdrawal ruptures involves exploring the interpersonal fears, expectations, and internalized criticisms that are hindering the client from directly expressing his or her feelings, especially negative ones. The goal is to help clients assert their true feelings and underlying wishes. For example, Jim sometimes would go silent in sessions. In one instance, the therapist invited him and was able to get him to talk about what he was experiencing. She found that Jim was afraid to ask her if they could extend the length of the session or schedule another that week for fear that she would reject the request. This revelation set the stage for an exploration of Jim's feelings of isolation and his wish to be connected to another: in this case, the therapist. It also resulted in the clarification of what he could realistically expect in his relationship with the therapist.

Resolution of Confrontation Ruptures

In a confrontation rupture, the client moves against the therapist. Confrontation ruptures can be very difficult for therapists to endure because they may arouse feelings of anger, impotence, and even despair. The client may express anger or dissatisfaction by complaining about the therapist's competence or

about different aspects of the therapy. In a confrontation, the client favors the need for agency over the need for relatedness. The resolution process for confrontation ruptures involves exploring the fears and self-criticisms that are interfering with the client's expression of underlying needs and helping the client to express more vulnerable feelings. Sometimes confrontations are mixed with withdrawal, and in such instances the resolution process begins much like the withdrawal resolution process, whereby the therapist's task is to get the client to stand by his or her anger. For example, later in treatment, Jim angrily confronted his therapist: He said that he had been noticing, in many of his sessions, that the therapist vividly remembered the details of their previous sessions and of what Jim had told her, which made him feel very happy at the time. However, after his last session, while walking home, it suddenly occurred to him that the therapist was most likely taking notes after sessions to look at before the following session to remember the details of what Jim had said. He complained: "You tricked me! How stupid of me! How could I think that you really cared and that I was more than just a patient on paper!" An exploration of Jim's feelings led to an expression of more vulnerable feelings, including his wish to be special in the eyes of the therapist. This added further dimension to his understanding of his underlying need for connection.

Resolution via Metacommunication

Metacommunication is the critical technical principle for exploring core relational themes and resolution of ruptures. First introduced to the psychotherapeutic situation by Kiesler (1996), the principle of metacommunication is an approach that fits the relational formulations presented earlier especially well. In very simple terms, *metacommunication* means communicating about the communication. It is predicated on the idea that we are in constant communication—that all behavior in an interpersonal situation has message value and thus involves communication. Metacommunication describes an attempt to increase awareness of each person's role in an interaction by stepping out of the interaction and communicating directly about what is taking place between the client and therapist (Safran & Muran, 2000). Efforts at metacommunication attempt to minimize the degree of inference and are grounded as much as possible in the therapist's immediate experience of some aspect of the therapeutic relationship—either the therapist's own feelings or an immediate perception of some aspect of the client's actions.

Ruptures not only are the result of a collaborative effort but also can only be understood or resolved by a collaboration of both patient and therapist (Safran & Muran, 2000). Therapists are not seen as being in a privileged position of knowing; rather, their understanding of themselves and their clients is always partial, evolving, and embedded in the complex, interactive, patient–therapist matrix (Hoffman, 1998; Mitchell, 1993; Stern, 1997). Metacommunication is the effort to look back at a recently unfolded relational process from a different vantage point; however, "because we are always caught in the

grip of the field, the upshot for clinical purposes is that we face the endless task of trying to see the field and climb out of it—and into another one, for there is nowhere else to go" (Stern, 1997, p. 158). The following list includes some basic principles that we have found useful in our efforts to metacommunicate with clients. (For more detailed descriptions of these and other principles, see Safran & Muran, 2000.)

- *Invite a collaborative inquiry and establish a climate of shared dilemma.* Clients often feel alone during a rupture. Frame the impasse as a shared dilemma that you and the client will explore collaboratively; acknowledge that "we are stuck together." Communicate observations in a tentative, exploratory manner that signals your openness to client input. In this way, instead of being yet one more in an endless succession of figures who do not understand the client's struggle, you can become an ally who joins him or her.
- *Keep the focus on the immediate, and privilege awareness over change.* The focus should be on the here and now of the therapeutic relationship rather than on events in prior sessions or even earlier in the same session. In addition, keep the focus on the concrete and specific rather than abstract, intellectualized speculation. A specific, immediate focus helps clients become more mindful of their own experience. The goal is not to change the client's experience but to increase the client's awareness of his or her experience because awareness is the necessary precursor to lasting change.
- *Emphasize your own subjectivity and be open to exploring your own contribution.* All metacommunications should emphasize the subjectivity of the therapist's perception. This helps establish a collaborative, egalitarian environment in which the client feels free to decide how to make use of the therapist's observation. In addition, therapists should be open to exploring their contributions to the interaction with the client in a nondefensive manner. This process can help clients become more aware of feelings that they have but are unable to clearly articulate, in part because they fear the therapist's response. Accepting responsibility for one's contributions can validate clients' experience of the interaction and help them to trust their own judgment. Increasing clients' confidence in their judgment helps to decrease their need for defensiveness, which facilitates their exploration and acknowledgment of their own contribution to the interaction.

Metacommunication is a valuable principle for exploring core relational themes. The process of metacommunication can begin with questions or observations that focus the client's attention on different aspects of the client–therapist interaction. The therapist might start by focusing the client's attention on his or her own experience with a direct question, such as "What are you feeling right now?" or with an observation about the client's self-state, such as "You seem anxious to me right now. Am I reading you right?" To direct attention to the interpersonal field, the therapist might ask "What's

going on here between us?" or offer an observation about the interaction, such as "It seems like we're in some kind of dance. Does that fit with your sense?" A third potential avenue for metacommunication is to focus on the therapist's experience by asking a question that encourages the client to be curious about the therapist's self-state: "Do you have any thoughts about what might be going on for me right now?" Alternatively, the therapist could make a self-disclosure about his or her internal experience, such as "I'm aware of feeling defensive right now." It is important to bear in mind that these three foci represent parallel dimensions.

Although the preceding outlined principles can be applied fairly successfully with most clients, it can be much more challenging in the presence of personality disorders. Attempts at metacommunication can be responded to with resistance, and escalation of the rupture can be observed in the session. As noted earlier, clients with personality disorders have a restricted range of interpersonal behaviors and, more often than not, can feel threatened by the therapist's attempts at metacommunication. What follows is a clinical illustration of a rupture resolution that involves both withdrawal and confrontation and the use of metacommunication.

Case Example 2

Jean is a 44-year-old patient who had a childhood sexual abuse history and borderline personality characteristics. Jean had abusive and critical parents who put the blame on her for their own failures at parenthood. For example, when Jean's mother was unavailable and neglectful when Jean needed her help, her mother would tell Jean that her own incompetence made her need her mother and that Jean should be able to take care of herself. In the following exchange, the therapist tries to employ metacommunication to collaboratively explore a rupture in the session:

THERAPIST: Jean, I'm getting a sense that something is different today. It seems like you don't want to talk. Am I reading you right?

JEAN: Yes, I don't feel like talking today.

THERAPIST: OK, do you have any thoughts about why that might be?

JEAN: I don't know. Maybe it's because you don't want to talk today.

THERAPIST: What do you mean?

JEAN: Just what I said. You don't seem engaged with me today, and so I don't feel like talking with you, either.

Here, the client moves against the therapist in a confrontation rupture. In what follows, the therapist tries to explore the fears that are interfering with the client's expression of underlying needs and to help the client express more vulnerable feelings:

THERAPIST: What made you think that I wasn't engaged with you today?

JEAN: See, this is what I don't like. You always do this! It's always my fault when I think something about you. It's never that I'm right that you don't want to talk today; it's always "in my head," and not the reality!

THERAPIST: Oh, OK. I didn't know you felt that way.

JEAN: Yes, you're like my mother. She always made it about me. When I complained about something that she did, she always said it was in my head.

THERAPIST: OK, I understand. Sorry for making you feel that way. Let me think. Do I not feel like talking with you today? Well, I agree I'm not feeling fully present today. I do have a lot on my mind. . . .

As demonstrated in the preceding conversation, the therapist's attempts at metacommunication were leading to an escalation of the rupture with Jean. It did not seem possible to invite her to a collaborative inquiry until the therapist openly explored her own contribution and validated Jean's point of view. This opened the way to a conversation in which Jean was able to expand her awareness of her expectations, based on a core relational theme of neglect and blame, which ultimately led to an examination of how Jean meets her needs in negotiations with those of another. This is a case that involves withdrawal mixed with confrontation, as the client initially was withdrawing from the therapist by not talking much. As much as it was important for the client to assert herself with the therapist, it was also important for her to recognize her expectation that the therapist will be like her mother. This is a good example of how ruptures can come in both types in a single case and how the resolution process can help a client negotiate the dialectic between the need for agency and the need for relatedness. Learning to negotiate this dialectic more adaptively is essential to rupture resolution, especially with clients with personality disorders. This example also involves exploration of core relational themes (a direct depth-level strategy), demonstrating the complexity of the rupture resolution process and the need for the therapist to be attuned to the moment-by-moment shifts in the alliance over the course of a session in order to be able to make effective rupture resolution interventions.

IMPLICATIONS FOR TRAINING

Elsewhere, we have provided a detailed description of our training regimen (Muran, Safran, & Eubanks-Carter, 2010). Here we provide a brief overview. Recently, with another grant from the National Institute of Mental Health (MH071768: Principal Investigator, J. Christopher Muran), we have been examining the additive impact of this training to a cognitive-behavioral therapy for personality disorders and have found some preliminary support for its

benefit to the interpersonal process between patient and therapist (Safran et al., 2014).

Basic Therapist Skills

Research has consistently demonstrated that therapists' individual differences strongly predict alliance quality and treatment success (Baldwin, Wampold, & Imel, 2007; Luborsky et al., 1986). Some therapists are consistently more helpful than others and are better able to facilitate the development of the therapeutic alliance, thus underlining the importance of an alliance-focused approach to the training of therapists. Based on our relational approach to psychotherapy, the training of psychotherapists concentrates on the development of therapists' abilities to recognize ruptures and to resolve them. With regard to rupture recognition, our training targets three specific skills—*self-awareness*, *affect regulation*, and *interpersonal sensitivity*—which we see as interdependent and as critical to establishing an optimal observational stance. By self-awareness, we refer to developing therapists' immediate awareness and bare attention to their internal experience. Our aim here is to increase therapists' attunement to their emotions so that they may use them as a compass to understand their interactions with their patients. By affect regulation, we refer to developing therapists' abilities to manage negative emotions and tolerate distress, their own as well as their patients.' In other words, we try to facilitate their abilities to resist the natural reaction to anxiety—to turn one's attention away or to avoid dealing with it in some way, which means not attending to or exploring a rupture. By interpersonal sensitivity, we refer to increasing therapists' empathy to their patient's experience and their awareness of the interpersonal process they engage in with their patients. In this regard, we try to balance therapists' attention to what they or their patients say with an increased sensitivity to how statements are communicated, the impact of expressions, and the nature of their interactions with patients. The training also attempts to teach the various rupture resolution strategies from direct to indirect and from surface to depth, but with special attention to the technical principle of metacommunication, which, as discussed earlier, we have found useful for exploring core relational themes.

Fundamental Training Principles

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

- *Recognizing the relational context*. The relational context is of utmost importance in training as in therapy. It is impossible for the supervisor to convey information to the trainee that has meaning independent of the relational context in which it is conveyed. Supervision thus needs to be tailored to the specific needs and development of the trainee. Supervisors need to recognize

and support trainees' needs to maintain their self-esteem and must calibrate the extent to which they need support versus new information or confrontation in a given moment. It is also critical for supervisors to monitor the quality of the supervisory alliance in an ongoing fashion that parallels the ongoing monitoring of the quality of the alliance in therapy. When strains or tensions emerge, the exploration of the supervisory relationship should assume priority over other concerns.

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

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

Training Strategies and Tools

Our training program makes use of various strategies to develop therapist abilities and essential skills to recognize and resolve ruptures. The main training strategies we use include:

• *Manualization.* In this regard, we use our book *Negotiating the Therapeutic Alliance: A Relational Guide* (Safran & Muran, 2000) as a training

manual. It provides background and justification for our relational approach to practice and training. Probably the most important benefit of this book is that it presents various clinical principles and models, including our own empirically derived rupture resolution model, which can serve to help therapists organize their experience, regulate their affect, and manage their anxiety in the face of a very difficult treatment process (see Aron, 1999, for more on this point).

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

- *Videotape analysis.* We also conduct intensive analysis of videotaped psychotherapy sessions. This provides a view of a treatment process unfiltered by the trainees' reconstructions and an opportunity to step outside their participation and to view their interactions as a third-party observer. It facilitates an orientation to interpersonal process. There are a variety of useful ways to use videotape, including as a prompt for accessing and defining a trainee's internal experience and to provide the trainee with subjective feedback about the impact of the patient on others, which can be validating when it corresponds but also illustrative of the uniqueness of interactions when it differs.

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

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

CONCLUDING COMMENTS

One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is a robust predictor of outcome across a range of different treatments and that, conversely, weakened alliances are correlated with unilateral termination by the patient (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011; Tryon & Kane, 1995). Patients with personality disorders that are associated with serious impairment in interpersonal relationships pose significant challenges to therapists, especially in building and maintaining the therapeutic alliance. Furthermore, as noted earlier, each type of personality disorder produces different challenges to forming a working alliance in psychotherapy, suggesting the necessity of a customized approach to working with personality disorders.

One such tailored approach to enhancing the therapeutic relationship involves the negotiation of the ruptures that inevitably take place in every therapy relationship. In the last two decades, a "second generation" of alliance research has emerged, attempting to clarify the factors leading to the development of the alliance, as well as those processes involved in repairing ruptures in the alliance when they occur (Safran, Muran, Samstag, & Stevens, 2002). Ruptures and their resolutions take on added importance when working with patients with personality disorders, as this group of patients is associated with difficulties in interpersonal relationships. Thus a therapist's attunement to subtle indications of alliance ruptures and ability to resolve ruptures becomes one of the most critical factors in the therapy process with personality disorders. In our relational approach to personality disorder and alliance ruptures, training of psychotherapists focuses on developing therapists' abilities in effective rupture resolution. We believe that training therapists in more effective negotiation of the therapeutic alliance, in a more attuned and responsive approach to their patients' characteristic ways of interpersonal relating, and in the specific challenges they experience in the therapeutic alliance represents the next frontier.

REFERENCES

Aktar, S. (1992). *Broken structures: Severe personality disorders and their treatment*. Northvale, NJ: Jason Aronson.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

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

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance–outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842–852.

Bateman, A., & Fonagy. P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. Oxford, UK: Oxford University Press.

Bateman, A. W., & Fonagy, P. (2000). Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry, 177*, 138–143.

Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice, 11*, 73–87.

Bender, D. S., Farber, B. A., Sanislow, C. A., Dyck, I. R., Geller, J. D., & Skodol, A. E. (2003). Representations of therapists by patients with personality disorders. *American Journal of Psychotherapy, 57*, 219–236.

Benjamin, L. S. (1993). *Interpersonal diagnosis and treatment of personality disorders*. New York: Guilford Press.

Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed.). New York: Guilford Press.

Benjamin, L. S. (2005). Interpersonal theory of personality disorders: The structural analysis of social behavior and interpersonal reconstructive therapy. In M. F. Lenzenweger & J. F. Clarkin (Eds.), *Major theories of personality disorder* (2nd ed., pp. 157–230) New York: Guilford Press.

Benjamin, L. S., & Karpiak, C. P. (2002). Personality disorders. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 423–438). New York: Oxford University Press.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252–260.

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

Clarkin, J. F., Levy, K. N., & Ellison, W. D. (2011). Personality disorders. In L. M. Horowitz & S. Strack (Eds.), *Handbook of interpersonal psychology: Theory, research, assessment, and therapeutic interventions* (pp. 383–403) Hoboken, NJ: Wiley.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164*(6), 922–928.

Clarkin, J. F., Yeomans, F., & Kernberg, O. F. (2006). *Psychotherapy of borderline personality: Focusing on object relations*. Washington, DC: American Psychiatric Publishing.

Dimaggio, G., Carcione, A., Salvatore, G., Semerari, A., & Nicolò, G. (2010). A rational model for maximizing the effect of regulating therapy relationship in personality disorders. *Psychology and Psychotherapy: Theory, Research, and Practice, 83*, 363–384.

Dimaggio, G., Salvatore, G., Fiore, D., Carcione, A., Nicolo, G., & Semerari, A. (2012). General principles for treating personality disorder with a prominent inhibitedness trait: Towards an operationalizing integrated technique. *Journal of Personality Disorders, 26*(1), 63–83.

Dimaggio, G., Semerari, A., Carcione, A., Nicolò, & Procacci, M. (2007). *Psychotherapy of personality disorders: Metacognition, states of mind and interpersonal cycles*. London: Routledge.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). Alliance ruptures and resolution. In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 74–94). New York: Guilford Press.

Harper, H. (1989a). *Coding guide: I. Identification of confrontation challenges in exploratory therapy*. Unpublished manuscript, University of Sheffield, Sheffield, UK.

Harper, H. (1989b). *Coding guide: II. Identification of withdrawal challenges in exploratory therapy*. Unpublished manuscript, University of Sheffield, Sheffield, UK.

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

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16.

Horwitz, I., Gabbard, G. O., Allen, J. G., Frieswyk, S. H., Colson, D. B., & Newsom, G. E. (Eds.). (1996). *Borderline personality disorder. Tailoring the psychotherapy to the patient*. Washington, DC: American Psychiatric Press.

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

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17*(4), 959–986.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*(12), 1060–1064.

Livesley, W. J. (2003). Personality disorder: Evidence of changing perspectives? [Review of the book *Personality Disorders Over Time: Precursors, Course, and Outcome* by J. Paris]. *Journal of Nervous and Mental Disease, 191*(12), 767–770.

Luborsky, L., Crits-Christoph, P., McLellan, A. T., Woody, G., Piper, W., Liberman, B., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry, 56*(4), 501–512.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method* (2nd ed.). Washington, DC: American Psychological Association.

Meissner, W. W. (1996). *The therapeutic alliance*. New Haven, CT: Yale University Press.

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

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

Mitchell, S. A., & Aron, L. (1999). *Relational psychoanalysis: The emergence of a tradition*. Hillsdale, NJ: Analytic Press.

Muran, J. C. (2001). Meditations on "both/and." In J. C. Muran (Ed.), *Self-relations in psychotherapy process* (pp. 347–372). Washington, DC: American Psychological Association.

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

Muran, J. C., Safran, J. D., & Eubanks-Carter, C. (2010). Developing therapist abilities to negotiate alliance ruptures. In C.J. Muran & J.P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 320–340). New York: Guilford Press.

Pretzer, J. L., & Beck, A. T. (2005). A cognitive theory of personality disorders. In M. F. Lenzenweger & J. F. Clarkin (Eds.), *Major theories of personality disorder* (2nd ed., pp. 43–113) New York: Guilford Press.

Safran, J. D. (1998). *Widening the scope of cognitive therapy*. Northvale, NJ: Aronson.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*(3), 447–458.

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

Safran, J. D., Muran, J. C., Demaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research, 24,* 269–285.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*(1), 80–87.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 235–254). New York: Oxford University Press.

Samstag, L. W., Batchelder, S., Muran, J. C., Safran, J. D., & Winston, A. (1998). Predicting treatment failure from in-session interpersonal variables. *Journal of Psychotherapy Practice and Research, 5,* 126–143.

Sommerfeld, E., Orbach, I., Zim, S., & Mikulincer, M. (2008). An in-session exploration of ruptures in working alliance and their associations with clients' core conflictual relationship themes, alliance-related discourse, and clients' postsession evaluations. *Psychotherapy Research, 18*(4), 377–388.

Stern, D. B. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis.* Mahwah, NJ: Analytic Press.

Tufekcioglu, S., Muran, J. C., Safran, J. D., Winston, A. (2013). Personality disorder and early psychotherapy process in two time-limited therapies. *Psychotherapy Research, 23,* 646–657.

Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research, 5,* 189–198.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 69*(6), 875–899.

Zimmerman, M., Chelminski, I., & Young, D. (2008). The frequency of personality disorders in psychiatric patients. *Psychiatric Clinics of North America, 31*(3), 405–420.