

Repairing alliance ruptures in emotionally focused therapy:

A preliminary task analysis

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ABSTRACT

Prior research has shown the therapeutic alliance to be positively related to therapeutic outcome in couple therapy (Johnson & Talitman, 2007; Knoblock-Fedders, Pinsoff, & Mann, 2007). It is common for the therapeutic alliance to vary over the course of therapy. Alliance ruptures can be defined as “deteriorations in the relationship between therapist and patient” (Safran & Muran, 1996, p. 447). If managed successfully, these moments of alliance rupture can positively impact therapy (Safran & Muran, 1996; Sprenkle, Davis, & Lebow, 2009). As a result, researchers have begun to develop models of alliance rupture repair to help further our understanding of how this process is achieved in various therapeutic approaches (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder, Holgerse, & Nielsen, 2008; Safran & Muran, 1996). The purpose of this study was to conduct a preliminary, discovery-oriented task analysis (Greenberg, 2007) in order to develop a model of alliance rupture repair in Emotionally Focused Therapy (EFT), a couple therapy approach which encourages emotional reconnection and restructuring of couple interactions developed by Susan Johnson and Les Greenberg (Johnson, 2004). By conducting a thought experiment with four experienced certified EFT therapists, a rational model of alliance rupture repair in EFT was formulated. The rational model was then compared with the analysis of alliance rupture repair sequences during the process of one couple’s therapy with a certified EFT therapist to develop a rational-empirical model of alliance rupture repair in EFT. The final model and treatment implications are discussed.

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CHAPTER 1: INTRODUCTION

Statement of the Problem

The role of therapeutic alliance in therapy outcome has received a great deal of attention in psychotherapy literature (Barber, Connolly, Christoph, Gladis, & Siqueland, 2009; Escudero, Friedlander, & Abascal, 2008; Garfield, 2004; Martin, Garske, & Davis, 2000; Lambert & Barley, 2001; Sprenkle, Davis, & Lebow, 2009). Therapeutic alliance is defined as “the collaborative and affective bond between therapist and patient” (Martin, Garske, & Davis, 2000, p. 438). Additionally, alliance refers to agreement on goals and tasks of treatment (Bordin, 1979). Miller, Duncan, and Hubble (1997) identified the quality of the therapeutic relationship as the second largest contributing factor to the occurrence of change in treatment, in which the authors highlighted clients’ readiness for change, clients’ goals and also their views of the therapeutic relationship having been developed through empathy, respect, genuineness, and validation. For Miller et al. (1997), common factors, therapeutic alliance being one such factor, across therapeutic models are more important to change in therapy than the modality of treatment itself. In a review of therapeutic alliance and outcome research, Lambert and Barley (2001) also support that a strong therapy alliance is more highly correlated with positive therapeutic outcome than specific interventions.

Therapeutic alliance is connected to change across therapies (Sprenkle, Davis & Lebow, 2009). Building a strong alliance helps clients in the beginning of therapy to engage in the process and helps clients be more receptive to interventions throughout treatment (Sprenkle et al., 2009). Sprenkle et al. (2009) understand alliance to be a collaborative process, one in which the client and the therapist co-create. Alliance can be broken down into goals, tasks and bonds (Bordin, 1979). Goals refer to the amount of agreement that clients and therapist share about

treatment expectations and outcome (Sprenkle et al., 2009). Tasks refer to agreement between clients and therapist on how appropriate and helpful what is being done in therapy is to treatment. Finally, bonds refer to the affective bonds between the clients and therapist (Sprenkle et al., 2009).

In comparison to individual therapy, when there are multiple people being seen in couple therapy, there are unique aspects and challenges to the therapeutic alliance. Couple therapists not only have to build and maintain an alliance with one person, but balance the alliance between each partner of the couple. Regarding balancing the alliance, Friedlander, Escudero, and Heatherington (2006) report that discrepancies in partners' alliances with their therapist, or split alliances, must be attended to or can lead to poor treatment outcomes or therapy drop-out.

Further research continues to surface demonstrating the relationship between therapeutic alliance and outcome in various couple treatment modalities (Bourgeois, Sabourin, & Wright, 1990; Brown & O'Leary, 2000; Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof, & Mann, 2007; Raytek, McCrady, Epstein, & Hirsch, 1999). In one such study, Knobloch-Fedders et al. (2007) investigated couple psychotherapy and found that therapeutic alliance accounted for 5-22% of the variance in decreased marital distress.

Given the reported importance of the therapeutic alliance in therapy, it would seem essential to also understand what one should do as a marriage and family therapist to repair the therapeutic alliance if it should experience a rupture. A rupture is considered to be a decline in the therapeutic relationship (Safran & Muran, 1996). Several studies have looked specifically at this process of repairing alliance ruptures (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder, Holgersen, & Nielsen, 2008; Muran et al., 2009; Safran & Muran, 2000; Safran & Muran, 1996; Safran, Muran, Samstag, & Stevens, 2001). If ruptures in the therapeutic alliance

are appropriately managed, they can lead to positive therapeutic change; however, if not dealt with properly, these ruptures can lead to drop out or other negative outcomes in therapy (Safran & Muran, 1996).

Significance

While therapeutic alliance has been well researched and well documented to have an impact in therapy, the majority of research has been conducted with individuals who are in therapy (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). When working with couples and families, the alliance is said to take on an ever greater importance as the therapist is called on to balance the therapeutic alliance with multiple participants that are being seen conjointly (Friedlander et al., 2006). When researching therapeutic alliance in couple therapy, early therapeutic alliance accounted for as much as 22% of the variance in outcomes (Knobloch-Fedders et al., 2007). Given the importance of therapeutic alliance in couple therapy, it would seem important for marriage and family therapists to better understand the therapeutic alliance when working with couples.

In Emotionally Focused Therapy (EFT), developed by Susan M. Johnson and Leslie Greenberg in the 1980s, the focus of couple treatment is establishing connection between couples through encouraging new emotional and interactional experiences (Johnson, 2005). The EFT model places an emphasis on constructing a strong therapeutic alliance (Johnson, 2004; Sprenkle & Blow, 2004). EFT therapists address the following tasks in therapy: the creation and maintenance of a therapeutic alliance, the accessing and reformulating of emotion, and restructuring interaction (Johnson, 2004). Johnson (2004) highlights the importance of the therapeutic alliance in the first task, built through empathic attunement, acceptance, genuineness, monitoring of the alliance and engaging the relationship system.

Research by Johnson and Talitman (1997) supports the importance of the therapeutic alliance. They found that the quality of the therapeutic alliance accounted for 20% of the variance in outcome of EFT therapy. A strong alliance by the third session predicted higher marital satisfaction, higher levels of intimacy and greater therapeutic change. Therefore the therapeutic alliance seems to be especially important in EFT as it asks clients to “explore and reveal vulnerable emotions and to take emotional risks in session” (Denton, 2008, p. 117).

In the chapter entitled “A Strong Therapeutic Alliance”, Sprenkle et al. (2009) assert that therapeutic alliance is not constant throughout treatment and instead changes throughout therapy. It seems that changes in the level of therapeutic alliance in therapy are a normal and inevitable process in therapy. It is also suggested that “the sequence of ‘tear and repair’ can have a strong positive effect on the treatment” (Sprenkle et al., 2009, p. 95). These moments of rupture and repair seem to provide an opportunity for therapeutic growth for clients.

Rationale

Knowing the importance that alliance has on treatment outcome, the unique challenges of alliance in couple therapy and the fact that alliance can fluctuate over the course of treatment, it is important that therapists providing couple therapy have a better understanding of how to address alliance ruptures. Furthermore, given the clinical emphasis of forming and maintaining an alliance in EFT and the emotional vulnerability that it asks of clients, as well as the research supporting the strong association of the alliance to successful outcome, it is particularly important to understand how to address alliance ruptures in EFT. More specifically, formulating a model by which EFT therapists might handle ruptures in the therapeutic alliance has the potential to improve supervision and training practices, as well as treatment effectiveness.

According to Greenberg (2007), task analysis is a method that allows researchers to discover and validate the process of resolution of many different types of problems presented in therapy. Through a series of studies that build upon knowledge of the subject matter being studied, task analysis utilizes concentrated observation of resolution of a problem in therapy, model building, defining steps within the model and validating the model constructed through subsequent rigorous research. There are two phases to the task analysis method: the discovery-oriented phase and the validation-oriented phase. The discovery-oriented phase is primarily concerned with model building and defining steps within the constructed models. This phase can be considered a preliminary phase. Afterwards, further research can be undertaken to test the models constructed in the discovery-oriented phase of task analysis known as the validation-oriented phase. This study will employ the discovery-oriented phase of task analysis. Therefore, the task analytic approach will contribute to the development a step-wise model of the process of alliance rupture repair which EFT therapists utilize to address such ruptures. Through continued research, this preliminary model may be modified or validated through further observation.

Theoretical Framework

This study will be guided by the principles and concepts of conflict theory. This theory has its roots in the thinking of Thomas Hobbes who was concerned with social order and believed that all human beings are concerned with self-assertion and self-preservation (Hobbes, 1651; White & Klein, 2002). Additionally, Simmel (1904) saw conflict as being a natural part of groups; as conflict is endemic to groups, it needs to be managed so as not to rise to damaging levels. So, for people that come together to attain a common goal, there will be conflict and disagreement. For example, in the context of couple therapy, the couple and therapist come

together to improve the couple's relationship and alleviate negative symptoms; however, there may be disagreements during the process.

In order to better understand conflict theory, it is helpful to have an understanding of the related concepts. First, Sprey (1979) defined conflict as a process which is understood as "a confrontation between individuals, or groups, over scarce resources, controversial means, incompatible goals, or combinations of these" (p. 134). Within the context of the present study, conflict may arise between the therapist and clients due to several possible scenarios, including incongruence between the therapist's goals for therapy and that of one or both partners in the couple.

Structure is another key concept within conflict theory. Structure can be indicative of the situation or of the group. In terms of the structure of a situation it can either be competitive for resources or cooperative where there is an exchange of ideas and collaboration between group members (Simmel, 1904). Alternatively, one should also consider the social structure of the group. Groups of two can only utilize negotiation as a means to manage conflict, whereas groups of three or more can form power coalitions to influence other members of a group (Simmel, 1904).

Another concept within conflict theory is that of resources which include power, authority, knowledge, skills, and techniques (White and Klein, 2002). Power is related to a group member's ability to exercise control in the group (Sprey, 1979). In the therapeutic setting, the therapist inevitably has more resources and power than the clients, even if they are taking a non-expert stance as do EFT therapists. The therapist has the training to help couples through distress within their relationship and may be viewed by the client's as the experts. Furthermore, the power differential makes the therapeutic relationship unbalanced. As a result, the therapist

might have some influence when conflict arises that helps to manage conflict within the therapeutic relationship.

Finally, conflict is managed in groups by negotiation when there is an individual or group goal which cannot be met without the help of others in the group. Negotiation is often reached when members move towards each other's goals. An advantageous outcome of negotiation is consensus in which each member of the group is in agreement (White & Klein, 2002). Generally, one of the therapist's goals in couple therapy is a positive outcome in treatment for the couple relationship. In order to achieve this goal, having the cooperation of each partner would be necessary.

Overall, conflict theory would be helpful in organizing and understanding the repair of alliance ruptures in EFT therapy. As previously stated, conflict is seen as an inevitable part of groups and it is helpful to investigate how conflict is managed. This is essentially the focus of the present study in that it is concerned with the ways in which an EFT therapist repairs alliance ruptures during the course of couple therapy.

Purpose of the Study

This study intends to better understand the tasks that EFT therapists utilize to repair ruptured therapeutic alliances with clients. As indicated previously, a strong therapeutic alliance has been shown to be related to positive therapeutic outcomes. Much of the research that has been undertaken in this area has been with individual clients, although advances have been made in observing and measuring alliance in couple and family work. Given the focus on difficult and vulnerable emotions in EFT, it seems key to develop and maintain a strong therapeutic alliance in order to create the atmosphere of safety needed to complete such interventions. In working with couples, therapists try to maintain a good therapeutic relationship with each partner.

Despite this effort and desire, alliance tends to decrease and increase at different points in the therapeutic process. Given this, it seems vital to understand how to repair and rebuild alliance during the EFT therapeutic process.

Research Question

This study intends to answer the following question:

- 1) How does an EFT therapist address ruptures in the therapeutic alliance during the course of therapy?

CHAPTER 2: LITERATURE REVIEW

In order to gain a better understanding of the significance of the therapeutic alliance in therapy, a more thorough investigation into the role of therapeutic alliance and therapy outcome will be highlighted. Literature related to alliance within individual therapy as well as couple therapy will be examined more closely. Additionally, literature regarding alliance ruptures and repairing alliance will be explored. Finally, a more detailed description of EFT and alliance in EFT will be included in the following chapter.

Therapeutic Alliance

There has been a substantial amount of research conducted on alliance and therapeutic outcome in individual therapy (Barber et al., 2009; Brown & O'Leary, 2000; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000); however, there is less extensive research on the therapeutic alliance and couple therapy (Bourgeois, Sabourin, & Wright, 1990; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Knobloch-Fedders, Pinsof, & Mann, 2007; Symonds & Horvath, 2004). The therapeutic alliance helps clients in both individual and couple therapy to become engaged in the therapeutic process and contributes to positive treatment outcome and change (Martin et al., 2000; Sprenkle et al., 2009). As a result of the important research conducted regarding therapeutic alliance and individual therapy, a brief introduction to this research will be highlighted here, including two meta-analyses of therapeutic alliance and treatment outcome. Then, research on alliance in couple therapy will follow.

Alliance and Therapeutic Outcomes in Individual Therapy

Horvath and Symonds (1991) conducted a meta-analysis of 29 published studies of alliance and therapeutic outcome. The clinical studies included in this meta-analysis involved individual therapy only and each study included five or more participants. Upon calculating the

effect size (.26) of alliance on therapy outcome, a reliable and moderate association was found between good alliance scores and positive therapy outcomes.

More recently, Martin et al. (2000) conducted a meta-analysis of 79 studies, 58 of which have been published, that relate alliance to outcome. The studies included in this meta-analysis had to include at least five subjects and was limited to studies that examined individual therapy. Martin et al. (2000) found the relationship of alliance and outcome to be moderate and consistent, i.e. that the “strength of the alliance is predictive of outcome” (p.446). In addition, the correlation between alliance and outcome was .22. While a moderate effect was found in this meta-analysis, it may be a conservative report as the researcher inputted zero in the dataset for the studies in which there was no effect size available or the effect size was listed as nonsignificant.

Additionally, Barber et al. (2009) examined alliance and outcome in the treatment of 86 clients that were experiencing generalized anxiety disorders, chronic depression, avoidant personality disorder or obsessive-compulsive disorder receiving between 16 and 52 sessions of supportive-expressive dynamic psychotherapy. The measure of alliance used in this study was the California Psychotherapy Alliance Scale (CALPAS) and was completed at sessions two, five and ten. Barber et al. (2009) found that the higher the CALPAS score at each session, the higher the decrease in depressive symptoms, as reported on the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) in the same session, post-treatment and the four month follow-up. This study demonstrated the importance of alliance to therapy outcome and reduction of symptoms.

Alliance in Couple Therapy

In their book concerned with the therapeutic alliance in couple and family treatment and its practice, Friendlander et al. (2006) highlight the unique challenges of couple therapy as it

relates to alliance. First, Friedlander et al. (2006) recognize the difficult task of forming an alliance with each individual person as well as to the relationship, especially when each partner may have different motivation in coming to therapy. Another aspect of couple therapy that differs from individual therapy is that there is more of a lack of control as to what is revealed in session; whereas in individual therapy, the client chooses what to share and what not to share with the therapist. This point speaks to the challenge in creating safety for each partner in couple therapy, which calls for the therapist to gauge each partner's anxiety in taking risks in session so that no one partner feels overwhelmed or afraid to share in session. Overall, it is important that the therapist form an alliance with each partner in couple therapy. It is also important to maintain this alliance throughout treatment, with the understanding that alliance does not remain constant over time and can become strained.

In couple therapy, a split alliance may occur when one partner feels more strongly about the therapist than the other partner, which may be related to a disparity about goals and tasks of treatment (Friedlander et al., 2006). In a study of 19 families in therapy in the US, Muniz de la Pena, Friedlander and Escudero (2009) found that 14 had experienced split alliances (73.6%), which suggests that this occurs quite frequently in conjoint treatment. Friedlander et al. (2006) identify ways in which a therapist might address a ruptured or split alliance. One recommendation is for the therapist to meet individually with the client who does not feel as positively about the therapist. Doing this centers attention on this person and conveys a sense of empathy and understanding for this client by focusing on a shared sense of purpose, accepting responsibility for what has transpired, and utilizing humor when appropriate.

There have been several studies which investigated the effect of therapeutic alliance in various couple therapy modalities to treatment outcome and retention (Bourgeois et al., 1990;

Brown & O'Leary, 2000; Holtzworth-Munroe et al., 1989; Knobloch-Fedders et al., 2007; Raytek, McCrady, Epstein, & Hirsch, 1999; Symonds & Horvath, 2004). First, the therapeutic alliance has been shown to have a significant effect on completion of treatment. Raytek et al. (1999) studied 90 couples that received Alcohol Behavioral Marital Therapy (ABMT) which included cognitive-behavioral interventions to help manage an alcohol problem (dependence or abuse) of the male partners. Couples were identified as having completed treatment, partially completed treatment or dropped out. Alliance was found to be positively correlated to retention at a significant level such that couples who attended more sessions had therapists that had been better able to form a positive therapeutic alliance.

Knobloch-Fedders et al. (2007) explored the relationship between alliance and treatment progress (both individual and couple specific variables) in the beginning and middle phase of systemic psychotherapy with 35 couples. Compared to couples not included in this study due to early termination, couples who completed at least eight sessions reported significantly stronger alliance. Although alliance did not predict individual functioning it accounted for up to 22% of the variance in improved marital distress.

The therapeutic alliance and treatment outcome were studied within group couple therapy formats (Bourgeois et al., 1990; Brown & O'Leary, 2000). In Canada, Bourgeois et al. (1990) studied 63 couples which participated in group couple therapy, the Couples Survival Program, in which constructive fighting, good communication skills and expression of positive and negative emotions was facilitated. The group met for nine weeks for three hours each with two co-therapists. A measure of alliance was administered at the third session. For the female partner, therapeutic alliance accounted for 5% of the variance of the post-treatment DAS scores. The therapeutic alliance accounted for 7% of the variance in post-treatment DAS scores for males.

Another study investigated therapeutic alliance in a group couple therapy format for male perpetrated spouse abuse treatment (Brown & O’Leary, 2000). There were 70 couples which were included in the study, and they were randomized to receive either conjoint group couple therapy of up to eight couples or gender-specific group therapy of up to eight. It was found that a positive alliance significantly predicted a decrease in both psychological and physical aggression at post-treatment for the male partner.

Alliance Ruptures

As a clear understanding of the importance of therapeutic alliance has demonstrated, the study of alliance ruptures and their repair was the next logical wave of research to be conducted in the alliance field (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Safran & Muran, 2000; Safran & Muran, 1996; Safran, Muran, Samstag, & Stevens, 2001). Safran and Muran (1996) define ruptures in therapeutic alliance as “deteriorations in the relationship between therapist and patient” and that they are “interpersonal markers indicating critical points in therapy for exploration” (p. 447). Alliance ruptures can vary in their intensity, frequency of occurrence, and duration (Safran & Muran, 1996). There are several well known constructs that overlap with alliance ruptures, including what therapist’s might call resistance as well as transference and countertransference (Safran & Muran, 1996).

Muran et al. (2009) conducted a correlational study examining alliance ruptures and their resolution to therapeutic process and outcome. This study was comprised of 128 clients with a personality disorder randomized to three different treatment modalities: cognitive behavioral therapy, brief relational therapy, or short-term dynamic psychotherapy. It was found that lower rupture intensity and higher rupture resolution were significantly correlated with better scores of alliance and session quality. Moreover, less intense ruptures were significantly predictive of

positive outcomes on interpersonal functioning and higher rupture resolutions were indicative of higher treatment retention. Thus, unresolved ruptures in alliance were related to negative outcomes and higher dropout.

Not only can alliance ruptures lead to termination of treatment or negative outcome in therapy, but research also supports the idea that therapeutic relationships which experience a decrease in alliance followed by an increase may have the same, or even better, therapeutic outcomes than therapeutic relationships where the alliance was stable or increased over the course of treatment (Kivlighan & Shaughnessy, 2000; Patton, Kivlighan, & Multon, 1997). Kivlighan and Shaughnessy (2000) investigated 79 clients receiving psychotherapy from student therapists and found that the group of clients who experienced a strong therapeutic alliance at the outset of therapy, a drop in alliance and then a return to the original level of alliance reported significantly greater treatment outcome success than clients who experienced differing patterns of alliance development. This finding supports alliance ruptures as opportunities to facilitate greater change and improvement in therapy.

Repairing Alliance Ruptures

Safran et al. (2001) suggest general guidelines for good therapeutic practice when dealing with alliance ruptures in individual therapy. First, Safran et al. (2001) calls on therapists to simply be aware that it is far from uncommon for clients to experience negative feelings about therapy or the relationship with their therapist. As a result, therapists should try to be aware of ruptures when they do occur, as clients may be hesitant to share these negative feelings openly. As such, Safran et al. (2001) suggest that the therapist should take the initiative to explore possible ruptures with clients. Next, when clients are able to communicate negative feelings, the

therapist is encouraged to respond in a nondefensive manner. Finally, processing fears that often get in the way of openly expressing fears with the client may be beneficial.

Safran and Muran (2000) present different ways to approach alliance ruptures along different aspects of alliance in individual, couple and family therapy. First, Safran and Muran (2000) distinguish between direct and indirect ways of attending to alliance ruptures and suggest that when working systemically, indirect ways of addressing alliance ruptures might be the most useful. When working with couples and families, the therapist needs to maintain alliances with more than one person in therapy, and so may benefit from subtly shifting alliances without doing so in a direct manner. In addition to direct and indirect approaches, the therapist might approach alliance ruptures differently depending on the alliance component that is related to the rupture, i.e. bond, task or goals.

The following direct interventions are specified by Safran and Muran (2000): outlining the rationale for treatment intervention and exploring interpersonal themes that may be contributing to the rupture (task and goal oriented), and making clear misunderstandings in the interaction and again exploring interpersonal themes that contribute to the rupture (bond oriented). Likewise, the following interventions are categorized as indirect ways of addressing alliance ruptures: changing the task or goal so that it is more relevant to the client and reframing the purpose/meaning of the task or goal (task and goal oriented), and reframing the problem in positive terms and acting in such a way that allows for new and positive interpersonal experience for the client (bond oriented) (Safran & Muran, 2000).

Safran and Muran (1996) conducted a task analysis in which they observed 15 individual integrative psychotherapy sessions in which resolution of alliance ruptures had occurred. The psychotherapy session protocol included elements of interpersonal, experiential, and cognitive

approaches. The researchers included both client and therapist processes in their model of alliance rupture repair. As the focus of the present study is on therapist response to alliance ruptures, the examination of Safran and Muran (1996) will include only the therapist response. It was found in the preliminary model that the therapist brought the client's attention to the experience of the event. If the client expressed his/her negative feelings, then the therapist empathized with the client or accepted responsibility. If the client was hesitant to express his/her emotions, then the therapist probed for fears that obstructed the client from exploring his/her emotional experiences related to the rupture (Safran & Muran, 1996). The first task of bringing the client's attention to the present experience might include the therapist saying the following: "I have a sense of you withdrawing from me," or "How are you feeling about what's going on between us right now?" (Safran & Muran, 1996, p. 448). Safran and Muran (1996) found that this would either lead to exploration of feelings followed by the therapist expressing empathy or validation or exploring beliefs or fears that block the exploration of feelings.

After testing the above model with cases of both repair and non-repair, Safran and Muran (1996) modified the model of therapist response to the following steps: the therapist should bring the client's attention to the experience of the event, facilitate assertion of client's negative feelings related to the rupture event, probe blocks (i.e. fears and beliefs) to expressing negative feelings, and validate the client's experience. The last three tasks differ from the first model and will be explained here. In order to facilitate self-assertion, Safran and Muran (1996) observed that therapists inquired about the rupture experience, reflected on what the therapist observed, accepted responsibility, and focused on the therapeutic relationship. Next, the therapist probed for blocks, which is similar to probing for fears and beliefs that are interfering with processing

the experience and bringing awareness to the block. Finally, the therapist validated the client's experience of the rupture.

Aspland et al. (2008) also conducted a task analysis of alliance ruptures and resolution in successful cases of cognitive-behavior therapy. In constructing a rational model of rupture-repair, Aspland et al. (2008) supplied four CBT experts with a definition of a rupture as "an emotional disconnection creating a negative shift in the quality of the therapeutic alliance" (p. 701) and then asked the therapists to draw on their clinical expertise to think of how they might proceed upon becoming aware that such an event had occurred in therapy. For the empirical analysis, Aspland et al. (2008) analyzed rupture and repair sessions of two depressed individual clients to compare to the rational model.

The rational model reported by Aspland et al. (2008) included the following: the therapist acknowledged the rupture event with the client and sought the client's feedback, jointly explored the event and validated the client's experience, explored links/similarities to out of session scenarios, and the therapist and client agreed on a course of action (e.g. the need to revise goals). In comparing the rational and empirical model, Aspland et al. (2008) found differences between what experts said they would do to what occurred in session (e.g. that there was no explicit acknowledgement of rupture of event which prevented exploration of the rupture event). It seemed to take therapists several ruptures to recognize that such an event had occurred. There also seemed to be a lack of evidence in the empirical model for an agreement to monitor future ruptures in therapy (Aspland et al., 2008).

Binder et al. (2008) qualitatively examined the way in which therapists handled alliance ruptures in working with adolescents from outpatient psychiatric clinics in Norway. Through the use of semi-structured interviews with nine psychotherapists, Binder et al. (2008) were able to

identify five unique strategies used by these therapists to re-establish contact with the adolescent clients: therapists explored causes for the rupture from the client's point of view, dealt with ambivalence, established markers for fluctuation in motivation and distress, understood self-protection in adolescent's ambivalence towards therapy and explored the rupture from the therapist's point of view.

Emotionally Focused Therapy

EFT was developed in the 1980s by Susan Johnson, along with Leslie Greenberg and emphasizes emotions and the expanding and reprocessing of these emotions as an agent of change. Johnson (2004) outlines the stages and tasks involved in the EFT model. The first stage is focused on the de-escalation of negative cycles of interaction and involves an emphasis on creating an alliance, identifying the negative interaction cycle that the couple finds themselves in, accessing emotions involved in this cycle, and reframing the problem in relation to the cycle and attachment (Johnson, 2004). Stage two is concerned with changing interactional positions of the couple by helping each partner to get in touch with emotions and attachment needs and incorporating these emotions into the relationship cycle, helping each client to accept his/her partner's experience and new responses in the cycle, and bringing about emotional engagement by expressing attachment related needs and wants to one another (Johnson, 2004). Finally, the third stage is about consolidation and integration which encourages new ways of dealing with problems and strengthening new cycles (Johnson, 2004).

Johnson (2004) describes interventions utilized by therapists in the different stages of EFT. The interventions will be briefly covered at this time in a stage-wise progression; however, many of these interventions can be used at various stages of EFT. First, Johnson (2004) reviews interventions utilized in stage one, de-escalation of the negative cycle, including reflection,

validation, evocative responding, tracking and reflecting interactions, reframing, heightening, and empathic conjecture. First, reflection is a technique in which the therapist “attends to, focuses on, and reflects present poignant emotion” (p. 78). The result of using this technique correctly (i.e. not just paraphrasing the client but conveying empathy for the client’s experience), leads to the client feeling understood and heard. Second, validation is used by the EFT therapist in order to let each partner know that they have the right to their own emotions and experiences. Next, EFT therapists use evocative responding, which encourages further exploration of aspects of a partner’s experience, by tentatively offering further experiences of the client. For example, an EFT therapist might say, “When you said that, I noticed some sadness there, , as if you are afraid that you may not be what your partner wants”. EFT therapists are also called upon to track patterns of interactions and reflect them back to the couple so that the couple begins to see their cycle. Next, reframing is used to place each partner’s behavior in relation to the cycle and their partner. Johnson (2004) also describes heightening as an EFT technique. Heightening is when the therapist will highlight interactions that seem to play an important role in the negative cycle couples get caught in or new positive interactions that are emerging. Heightening can be done by the therapist repeating a phrase, changing his/her tone of voice, using body language, or utilizing metaphors that reflect experience or discourage changes in topic. The final EFT technique used in stage one is empathic conjecture in which the therapist infers the client’s experience from nonverbal cues in order to help the client give life to his/her current experience.

In the restructuring of interactions, stage two of EFT, the following techniques are utilized often by EFT therapists: evocative responding; the heightening of emotions, the problematic cycle, and the couples newly surfacing interactions; empathic conjecture; tracking and reflecting the cycle; reframing; and enactments. EFT therapists utilize enactments of key

interactions in order to highlight them. The EFT therapist will ask the partners to speak with one another about key interactions and emotions as they occur (e.g. You said that you feel hurt. Can you tell your partner about this pain?). It is in this stage of EFT that the partner who is withdrawn becomes reengaged and the blaming partner softens, which allows both partners to become more available to one another and better able to communicate their needs to one another.

In stage three of EFT, consolidation and integration, the EFT therapist would use the reflection and validation of new patterns, evocative responding, reframing, and summarizing the restructuring events that have taken place between the partners. These interventions are aimed at strengthening the new interactions and patterns that the couple is now engaging in with one another. The EFT therapist is called upon now to highlight and track the newly developing cycle of the couple (Johnson, 2004).

EFT and Alliance

In introducing the task of creating and maintaining a therapeutic alliance, Johnson (2004) describes the alliance as “the therapist’s being able to be with each partner as that partner encounters his/her emotional responses and enacts his/her position in the relationship” (p. 58). Alliance building is central to the first few sessions of EFT, as Johnson (2004) explains, interventions that help to build a strong alliance in these sessions include “reflection and validation of each partner’s experience of, and position in, the relationship, and the nonjudgmental description of how interactions are organized are powerful interventions in and of themselves” (p. 60). More specifically, Johnson (2004) outlines empathic attunement with each partner, acceptance, genuineness, continuous active monitoring, and joining the relationship system in the building of alliance. Johnson (2004) describes the alliance as allowing the couple to safely participate in the therapy process.

Denton (2008) describes the process of forming and maintaining an alliance in the beginning of EFT treatment and, while the focus of the present study is not on conducting an initial session in EFT, some of the concepts are applicable. Denton (2008) emphasizes the placed importance in EFT in building a strong alliance and recognizes the vulnerability in which couples must find themselves in expressing emotions when an attachment injury has occurred, including how risky it might feel like for partners to open up in session. In order to do this work, partners not only have to place trust in one another but also place trust in the EFT therapist. Denton (2008) points to the importance of alliance by describing the therapist as a safe person for the couple to engage with which will allow them to have emotionally vulnerable experiences in session. Denton (2008) explains how the stance of the therapist as a collaborative partner, as opposed to an expert, and being nonjudgmental are ways in which EFT therapists help to join with clients. Denton (2008) also suggests that the use of brief social conversation can put clients at ease in the beginning of therapy.

Johnson and Talitman (1997) conducted a study to examine client variables that predict success in EFT. In this study, 34 couples were seen for 12 sessions of EFT. One of the variables being assessed in this study was that of alliance, and to measure this variable the Couples Therapy Alliance Scale (Pinsof & Catherall, 1986) was completed by each partner privately after the third therapy session. This instrument measures bond, task and goals of alliance. It was found that alliance was significantly correlated with outcome of treatment and accounted for 22% of the variance in posttreatment satisfaction and 29% at 3 month follow-up. Additionally, alliance was found to be significantly correlated to an increase in marital satisfaction at both termination and follow-up and was related to increased intimacy at termination. Of the three

subscales of alliance measured in this study, the task dimension accounted for the most variance in satisfaction.

To conclude, alliance has been shown to be an important factor in individual and couple therapy, with convincing evidence in Johnson and Talitman's (1997) study of EFT. It is also known that alliance is likely to fluctuate throughout treatment and that times in which there has been a rupture in alliance can provide an opportunity for exploration and growth in therapy. Given this, our attention will now turn to the present study of repair of alliance ruptures in EFT.

CHAPTER 3: METHODS

Design of the Study

The current study is a task analysis that explored the alliance rupture repair process in EFT. By following the steps prescribed by Greenberg (2007) for the discovery-oriented phase of task analysis, rational and empirical models were constructed, which were synthesized to develop a rational-empirical model of alliance rupture repair in EFT. For the rational analysis, qualitative data were analyzed which included responses to a thought experiment (see the following section for a definition and description of the thought experiment) from four certified EFT therapists who provided procedures that they follow in regards to alliance rupture repair in EFT. For the empirical analysis, video recordings of EFT therapy sessions of an EFT case were analyzed. The videotaped therapy sessions were collected in a prior study by Dr. A. Wittenborn at Virginia Tech exploring the effectiveness of EFT with distressed couples in which one or both partners were experiencing mild to moderate levels of depression.

Study Participants

The participants recruited by the researcher included five certified EFT therapists, who were recruited using purposive sampling methods by means of an electronic mailing list which is comprised of therapists who have completed a five day externship in EFT authorized by the Ottawa Couple and Family Institute. The only criterion for inclusion of therapist participants was that they be certified by the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). Informed consent of the therapist participants was obtained electronically from the first five certified EFT therapists to respond. A therapist background questionnaire and directions for a thought experiment about how an EFT therapist would repair alliance ruptures were then e-mailed to the therapist participants as a part of the rational analysis of the task

analysis method. A thought experiment can be thought of as a mental exercise in which participants are asked to use their imagination to provide clear solutions to a problem.

Of the five EFT therapists who participated in the study, only four therapist responses were included in the analysis of the data. One therapist's response was removed from data analysis because it did not respond to the question on which therapists were asked to reflect. Of the four certified EFT therapists, three were female and one was male, all were Caucasian and between the ages of 29 and 66. The highest level of education held by the participants include two therapist participants with a Master's in MFT and two with a PhD in MFT or another mental health related field. Together, the therapists reported a mean of 18.75 years of experience in the mental health field, an average of 7.75 years of experience in EFT, and maintaining a caseload in which approximately 65% were treated using EFT.

In addition to these participants involved in the rational analysis, an additional EFT therapist and two client participants, who were part of a larger clinical trial, were included in the empirical analysis of the task analysis method. Specifically, videotapes of all therapy sessions that the clients and therapist completed during the prior study were analyzed during the empirical analysis portion of the task analysis in the current study. The client participants included a couple that had completed 15 sessions of EFT treatment with a certified EFT therapist in Dr. Wittenborn's study on the effectiveness of EFT with a depressed partner in the Washington, DC metro area. The therapist participant who worked with this couple is a certified EFT therapist, supervisor and trainer who follows the EFT model with all of her cases. The therapist participant is Caucasian and holds a Master's degree in marriage and family therapy. This EFT therapist involved in the empirical analysis did not contribute to the thought experiment for the rational analysis. .

In order to provide further context regarding the client participants, the inclusion criteria of the prior study in which the data comes from will be reviewed next. The criteria for inclusion in Dr. Wittenborn's study included that the couples had been married or cohabitated for at least one year, that they were not currently receiving any other treatment (individual, couple, or group treatment), were not experiencing problems related to substance abuse and intimate partner violence, and that they had not begun taking medication for a mental health problem, such as an antidepressant medication, in the past two months. In addition to these criteria, at least one partner must have scored between 20 and 30 on the Beck Depression Inventory- Second Edition (BDI-II; Beck, Steer, & Brown, 1996) and the partners must be considered distressed as indicated by the Dyadic Adjustment Scale (DAS) (Spanier, 1976). In addition, each partner in the couple must not be experiencing active suicidal thoughts and each partner should have reported a commitment towards improving his/her relationship.

Selective sampling methods were utilized to identify the client participants. The couple was chosen from the larger clinical trial for this study because they had completed 15 sessions of treatment with a certified EFT therapist, experienced positive outcome from treatment and had experienced episodes of alliance rupture during treatment by therapist report and validated by a decrease in reported alliance on the System for Observing Family Therapy Alliances, self-report version (SOFTA-s; Friedlander & Escudero, 2002) by one or both client participants for the rupture session as compared to the previous session's measure score. This couple is a heterosexual married couple and both partners are military. At screening, the husband's BDI-II score was 22, indicating a moderate level of depressive symptoms, and 84 on the DAS. The wife scored 12 on the BDI-II, which indicates minimal depressive symptoms, and 72 on the DAS. After the couple's final session of EFT, the husband's BDI score was 7 (minimal depressive

symptoms) and 105 on the DAS. The wife scored 9 on the BDI-II (minimal depressive symptoms) and 110 on the DAS. As evidenced by these scores, both the husband and wife demonstrated a clinically significant improvement in relationship adjustment and the depressed partner reported a clinically significant decrease in depressive symptoms from moderately depressed to not qualifying as depressed on the BDI-II.

Procedures

The study procedures were first reviewed and approved by the Virginia Tech Institutional Review Board. After approval, purposive sampling methods were utilized to recruit certified EFT therapists to gain their understanding of alliance rupture repair in EFT for the rational analysis. With the permission of Dr. Susan Johnson, the researcher sent a recruitment e-mail to her electronic mailing list asking for the participation of certified EFT therapists. The first five certified EFT therapists to respond were sent informed consent forms (Appendix A) via e-mail and informed consent was returned to the researcher via e-mail with electronic signatures. The research forms, which included a therapist background questionnaire (Appendix B) and directions for a thought experiment about how a certified EFT therapist repairs alliance ruptures (Appendix C), were then e-mailed to the therapist participants. The therapists then returned their completed research forms to the researcher via e-mail.

As the client participant data used in this study was previously collected by Dr. Wittenborn at Virginia Tech, the protocol for screening, intake and treatment had already been pre-determined. Potential participants were screened via telephone to determine whether or not they qualified for inclusion in the study. If the couple was eligible for treatment, an appointment was scheduled to obtain informed consent and conduct further assessments before the couple was randomized to either EFT treatment or treatment as usual. The informed consent signed by the

couple gave Dr. Wittenborn and her research team the ability to use the data obtained throughout treatment for research purposes, while maintaining confidentiality and privacy. Couples must agree to have their therapy sessions videotaped, knowing that they could be used for research purposes.

After this intake appointment, the couple taking part in the current study was then randomized to EFT treatment with a certified EFT therapist. The couple completed 15, 50 minute EFT sessions. These sessions were conducted weekly as schedules allowed. The second session was comprised of individual sessions for both partners. After each of the 15 sessions, both partners completed a post-session questionnaire which included the BDI-II, DAS, and the SOFTA-s. After each therapy session, the EFT therapist also completed the SOFTA-s to assess the therapist's understanding of the therapeutic alliance. The SOFTA-s is a self-report measure designed to assess therapeutic alliance in couple and family therapy.

Instruments

Therapist measures. The five recruited certified EFT therapists completed a basic demographic questionnaire and a thought experiment as a part of the rational analysis of the task analysis method. The therapist background questionnaire included basic information such as therapist age, gender, race, marital status, religious affiliation, highest level of education completed, and the field in which the highest degrees are held. The therapist background questionnaire also included questions about their therapeutic practice, such as how many years of experience they have in the mental health field and in practicing EFT, type of mental health licenses they hold, how many cases they see per week, and more specifically how many EFT cases they see per week.

The instructions for a thought experiment were also provided to the certified EFT therapists. The thought experiment instructions included a brief introduction of the researcher and the objective of the study. As an introduction to alliance ruptures, the following definition was provided in the document: “deteriorations in the relationship between therapist and patient” (Safran & Muran, 1996, p. 447). The thought experiment instructions asked the certified EFT therapists to draw upon their own clinical knowledge, EFT training, and past experiences with clients to compose a description of the steps they would take to repair an alliance rupture in therapy.

Client screening measures. The couple included in the empirical analysis were screened for inclusion in the study by the use of the BDI-II and the DAS. The BDI-II is a 21 item self-report instrument measuring the severity of depression in adults. Each item on the BDI-II is rated on a 4-point scale (0-3), with 63 being the maximum score (0-13 is minimal, 14-19 is mild, 20-28 is moderate and 29-63 is severe depressive symptomatology). Examples of items and the responses include “Sadness” with the response set of 0=I do not feel sad, 1=I feel sad much of the time, 2=I am sad all the time, 3=I am so sad or unhappy that I can’t stand it, as well as “Loss of Interest in Sex” with 0=I have not noticed any recent change in my interest in sex, 1=I am less interested in sex than I used to be, 2=I am much less interested in sex now, 3=I have lost interest in sex completely. The internal consistency reliability of the BDI-II is $\alpha=.92$ (Beck, Steer, & Brown, 1996). The BDI-II also demonstrates good construct validity with significant correlations to other measures of depression, content validity as the items were based on criteria for depressive disorders, and factorial validity when comparing the items on the BDI-II.

The DAS is a 32-item instrument aimed at assessing the quality of marriage and similar dyads. The DAS contains four subscales: dyadic satisfaction (e.g. “How often do you or your mate leave the house after a fight?”), dyadic cohesion (e.g. “Do you and your mate engage in outside interests together?”), dyadic consensus (e.g. “How often do you agree upon ‘Leisure time interests and activities’”), and affectional expression (e.g. “How often do you agree upon ‘Sex relations’”). Most of the items have a five or six-point scale. Scores range from 0 to 151 with higher scores indicating better quality of relationship adjustment. Spanier (1976) demonstrates high reliability ($\alpha=.96$). Spanier (1976) also reports good content validity, criterion validity, and construct validity of the DAS. The criterion validity was established by administering the measure to divorced and married couples and responses on each item was significantly different between the two groups. Construct validity was demonstrated by a correlation of .86 between the DAS and another measure of dyadic adjustment (Spanier, 1976).

Client weekly measures. In addition to the BDI-II and DAS, the SOFTA-s was collected after each of the 15 therapy sessions. The SOFTA-s was developed as a self-report measure for both clients and therapists to assess the quality of therapeutic alliance, which includes subscales related to Engagement in the Therapeutic Process, Emotional Connection to the Therapist, Safety Within the Therapeutic System and a Shared Sense of Purpose Within the Family. Before the development of the SOFTA, all measures of alliance followed Bordin’s (1979) conceptualization of alliance, i.e. dimensions of goals, tasks, and bonds. The subscales of Engagement in the Therapeutic Process and Emotional Connection to the Therapist on the SOFTA-s are a reflection of Bordin’s (1979) goals, tasks, and bonds (Muniz de la Pena et al., 2009). On the other hand, the subscales of Safety Within the Therapeutic System and Shared Sense of Purpose Within the Family reflects distinctive characteristics of conjoint treatment (Muniz de la Pena et al., 2009).

The SOFTA-s has 16 positive and negative items which clients and therapists can rate on a 5-point Likert scale (1=not at all, 5=very much) (Friedlander, Escudero, & Heatherington, 2006), with a total score ranging from 16 to 80. Higher scores indicate a stronger therapeutic alliance. According to Friedlander et al. (2006) safety within the therapeutic relationship is important to establishing a good therapeutic relationship at the beginning of treatment. Items related to Safety Within the Therapeutic System on the client SOFTA-s include “I feel comfortable and relaxed in the therapy sessions” and “There are some topics I am afraid to discuss in therapy” (Friedlander, Escudero, & Heatherington, 2006, p. 298). Second, a Shared Sense of Purpose Within the Family helps to keep the family system central to treatment and includes questions such as “All of us who come for therapy sessions value the time and effort we all put in” and “Some members of the family don’t agree with others about the goals of the therapy” (Friedlander, Escudero, & Heatherington, 2006, p. 298). Third, Emotional Connection to the Therapist can help to create, as well as maintain, a good therapeutic relationship and include questions on the SOFTA-s such as “The therapist understands me” and “The therapist lacks the knowledge and skills to help me” (Friedlander, Escudero, & Heatherington, 2006, p. 298). Finally, the subscale related to Engagement in the Therapeutic Process involves the clients taking a collaborative stance in their therapy and includes items such as “The therapist and I work together as a team” and “It is hard for me to discuss with the therapist what we should work on in therapy” (Friedlander, Escudero, & Heatherington, 2006, p. 298).

Friedlander, Escudero, and Heatherington (2006) report the internal consistency reliability of the SOFTA-s client version to be $\alpha = .87$. Concurrent validity is supported by significant associations between scales on the SOFTA-s and the SOFTA-o (the observational measure of the SOFTA) and significant associations between client and therapist-rated SOFTA-s

scores (Friedlander, Escudero, Haar, & Higham, 2005). Friedlander et al. (2006) also support predictive validity of the SOFTA-s as a result of positive associations between this measure and Stiles and Snow's (1984) Session Evaluation Questionnaire and the Penn Helping Alliance Questionnaire (Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983).

Analysis

The procedure for the discovery-oriented phase of conducting a task analysis (Aspland et al., 2008; Greenberg, 2007) was utilized to identify the tasks undertaken by the EFT therapists to address ruptures in the therapeutic alliance. The use of the task analysis procedure aided in identifying and describing the process of repairing alliance ruptures and emphasizes studying process within context (Rice and Greenberg, 1984).

In the discovery-oriented phase, the goal is to construct a model of the change process, as well as a way to measure parts of the process. The first step is to specify the task being studied, which in this study is the resolution of alliance ruptures. The problem state of an alliance rupture was identified by therapist report and verified by a decreased score on the SOFTA-s on either partners' SOFTA-s score. With this definition, one can now proceed to the analysis of how an EFT therapist repairs ruptures.

Rational analysis. A rational analysis of how EFT therapists repair ruptures was formulated. This was accomplished through a thought experiment with four certified EFT therapists, in which they were asked to think about how they might address a rupture in therapeutic alliance. Based upon their responses, a map of alliance rupture repair was assembled by the researcher and a second coder. Two coders were used in order to ensure credibility and trustworthiness in the data analysis process. The coders separately read the therapists' responses to the thought experiment using content analysis methods, which is concerned with the study of

human communications and results in summary of the content being analyzed (Krippendorff, 2004). Afterwards, these two coders came together to share the results of their analysis and discussed all discrepancies, until consensus was reached by both coders. This initial model was then e-mailed back to the EFT therapists for validation. Based on therapist feedback, a consensus was reached on a rational model of alliance rupture repair in EFT.

Empirical analysis. In order to complete the empirical analysis, the following steps were taken. First, the couple's EFT therapist identified sessions in which the therapeutic alliance had experienced a rupture, verified by a decrease in the SOFTA-s score by one or both of the partners for that session in comparison to the previous week's SOFTA-s score. This process identified sessions that were analyzed further for alliance rupture repair behaviors through the method of task analysis.

From review of the videotaped sessions identified by the therapist as sessions of interest (session 5 and 15), rupture markers were identified by the researcher and a second coder. Non-rupture sessions were also reviewed by the coders to provide a baseline of session characteristics, which aided in the identification of rupture markers. Once the rupture marker was identified, the researcher and second coder then analyzed the session from this point to identify repair markers. In this step of the task analysis, the researcher and second coder were called upon to "look intensively at the in-session performances to discover the essential components of change" (Greenberg, 2007, p. 19). According to Greenberg (2007), there are two main purposes for the empirical analysis: to identify components of resolution and to develop ways to measure these observed components. Upon further review of the repair markers, in depth descriptions of these repair markers were obtained based upon the characteristics and structure of the repair process.

These observations led to the development of an empirical model of alliance rupture repair in EFT.

Synthesis of a rational-empirical model. The results of the rational and empirical analysis procedures were then compared with one another, which resulted in the construction of the rational-empirical model. The empirical model was used to validate, expand upon or alter the rational model (Greenberg, 2007). As it is outside of the scope of this study to compare resolved and unresolved ruptures, this study will not enter into the verification stage outlined by Greenberg (2007) for conducting a task analysis; however, the discovery-oriented model can now serve as a preliminary model for repairing alliance ruptures in EFT.

CHAPTER 4: RESULTS

Repairing alliance ruptures in emotionally focused therapy:

A preliminary task analysis

The therapeutic alliance between therapist and client is essential to positive therapeutic outcome across all therapies, including Emotionally Focused Therapy (EFT) (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Johnson & Talitman, 1997; Martin, Garske, & Davis, 2000; Sprenkle, Davis & Lebow, 2009). Alliance ruptures refer to a decline in the therapeutic relationship between therapist and client and often occur during the course of therapy (Safran & Muran, 1996). These moments of alliance rupture can lead to negative outcome in therapy, but if handled properly, can act as a catalyst for therapeutic change (Safran & Muran, 1996). Given the documented importance of therapeutic alliance in EFT and the repair of alliance ruptures, it would seem of great consequence for EFT therapists to better understand the process of alliance rupture repair (Johnson & Talitman, 1997; Safran & Muran, 1996).

Therapeutic Alliance

The role of therapeutic alliance in therapy outcome has received a great deal of attention in psychotherapy literature (Barber, Connolly, Christoph, Gladis, & Siqueland, 2009; Escudero, Friedlander, & Abascal, 2008; Garfield, 2004; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000; Sprenkle, Davis, & Lebow, 2009). Therapeutic alliance is defined as “the collaborative and affective bond between therapist and patient” (Martin, Garske, & Davis, 2000, p. 438). Additionally, alliance refers to agreement on goals and tasks of treatment (Bordin, 1979). Miller, Duncan, and Hubble (1997) identified the quality of the therapeutic relationship as the second largest contributing factor to the occurrence of change in treatment. Lambert and Barley (2001) also speak to the importance of the therapeutic alliance by stating that it is more important to therapeutic outcome than specific interventions utilized by therapists.

Couple therapy presents unique aspects and challenges to the therapeutic alliance; couple therapists not only have to build and maintain an alliance with one person, but balance the alliance between each partner, and the couple system (Friedlander, Escudero, & Heatherington, 2006). In order to form and maintain an alliance with the couple, it is important that the therapist develop a safe atmosphere in which the couple can interact with one another and the therapist freely. It is the task of the therapist to maintain alliances with both partners despite the possibility of differing client motives for seeking treatment, needs, and clinical problems. In couple therapy, the alliance between the therapist and any one partner is observed by the other partner and is likely to affect the other partner in turn.

Further research continues to surface demonstrating the relationship between therapeutic alliance and outcome in various couple treatment modalities, including the role of the therapeutic alliance in Emotionally Focused Therapy (EFT) (Bourgeois, Sabourin, & Wright, 1990; Brown & O'Leary, 2000; Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof, & Mann, 2007; Raytek, McCrady, Epstein, & Hirsch, 1999). In EFT, developed by Susan M. Johnson and Leslie Greenberg in the 1980s, the focus of couple treatment is establishing connection between couples through encouraging new emotional and interactional experiences (Johnson, 2005). EFT places an emphasis on constructing a strong therapeutic alliance (Johnson, 2004; Sprenkle & Blow, 2004). Johnson (2004) describes the alliance as "the therapist's being able to be with each partner as that partner encounters his/her emotional responses and enacts his/her position in the relationship" (p. 58). Johnson and Talitman (1997) support the importance of the therapeutic alliance. They found that the quality of the therapeutic alliance accounted for 20% of the variance in outcome of EFT therapy at post-treatment and 29% at 3 month follow-up. Additionally, therapeutic alliance was found to be significantly correlated to an increase in

marital satisfaction at both termination and follow-up and was related to increased intimacy at termination (Johnson & Talitman, 1997). Therefore, a strong therapeutic alliance is important to positive treatment outcome in EFT.

Alliance Ruptures and Repairs

Safran and Muran (1996) define ruptures in therapeutic alliance as “deteriorations in the relationship between therapist and patient” (p. 447). Sprenkle, Davis, and Lebow (2009) assert that therapeutic alliance is not constant and instead changes throughout therapy. It seems that changes in the level of therapeutic alliance in therapy are a normal and inevitable process in therapy. It has also been suggested that “the sequence of ‘tear and repair’ can have a strong positive effect on the treatment” (Sprenkle et al., 2009, p. 95).

Several studies have looked specifically at the process of repairing alliance ruptures (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder, Holgersen, & Nielsen, 2008; Muran et al., 2009; Safran & Muran, 2000; Safran & Muran, 1996; Safran, Muran, Samstag, & Stevens, 2001). If ruptures in the therapeutic alliance are appropriately managed it can lead to positive therapeutic change; however, if not dealt with properly, ruptures can lead to drop out or other negative outcomes in therapy (Safran & Muran, 1996). Thus, the way in which therapists approach these impasses is critically important.

Safran and Muran (1996) conducted a task analysis of 15 integrative psychotherapy sessions in which resolution of alliance ruptures had occurred. The psychotherapy session protocol included elements of interpersonal, experiential, and cognitive approaches (Safran & Muran, 1996). The preliminary model indicated that the therapist brings the client’s attention to the experience of the event. If the client is able to express his/her negative feelings, then the therapist empathizes with the client or accepts responsibility. If the client is hesitant to express

his/her emotions, then the therapist probes for fears that obstruct the client from exploring his/her emotional experiences related to the rupture (Safran & Muran, 1996). After testing the above model with cases of both repair and non-repair, Safran and Muran (1996) modified the model of therapist response to the following steps: the therapist would bring the client's attention to the experience of the event, facilitate assertion of client's negative feelings related to the rupture event, probe blocks (i.e. fears and beliefs) to expressing negative feelings, and validate the client's experience.

In another study, Aspland et al. (2008) conducted a task analysis of alliance ruptures and resolution in successful cases of cognitive-behavior therapy. The rational model reported by Aspland et al. (2008) included the following: the therapist acknowledging the rupture event with the client and seeking the client's feedback, joint exploration of the event and validation of client's experience, exploring links/similarities to out of session scenarios, and the therapist and client agreeing on a course of action (e.g. the need to revise goals). In comparing the rational and empirical model, Aspland et al. (2008) found differences between what experts said they would do to what occurred in session (e.g. that there was no explicit acknowledgement of rupture of event which prevented exploration of the rupture event). In practice, it took therapists several ruptures to recognize that such an event had occurred. Additionally, in practice, therapists did not seem to plan with clients for future ruptures in therapy (Aspland et al., 2008).

The Present Study

This study aims to identify the tasks that EFT therapists utilize to repair ruptured therapeutic alliances with clients during the course of treatment. The study employed the task analysis method (Greenberg, 2007). Task analysis is a method that allows researchers to discover and validate the process of resolution of many different types of problems presented in

therapy and employs concentrated observation of resolution of a problem in therapy, model building, defining steps within the model and validating the model constructed through subsequent rigorous research. There are two phases to the task analysis method: the discovery-oriented phase and the validation-oriented phase. The discovery-oriented phase is primarily concerned with model building and defining steps within the constructed models. Consequently, further research can be undertaken to test the preliminary models constructed in the discovery-oriented phase of task analysis in the validation-oriented phase. This study will employ the discovery-oriented phase of task analysis. Therefore, the task analytic approach will contribute to the development a step-wise model of the time-limited process of alliance rupture repair that EFT therapists utilize to address such ruptures. Through continued research, this preliminary model may be modified or validated through further research.

The discovery-oriented stage of task analysis involves both a rational and empirical analysis, and finally a synthesis of the two which results in a rational-empirical model. In the first stage of the current discovery-oriented task analysis, two coders analyzed the qualitative responses of four certified EFT therapists' who took part in a thought experiment by providing recommendations for repairing alliance ruptures in EFT, which resulted in the development of a rational model of alliance rupture repair. A thought experiment can be thought of as a mental exercise in which participants are asked to use their imagination to provide clear solutions to a problem based on their expertise. The next part of task analysis is the empirical analysis. In this stage, the two coders analyzed video recordings of EFT therapy sessions of an EFT case, which resulted in the construction of an empirical model. Finally, these two models were compared in a final analysis and an integrated, rational-empirical model emerged.

Methods

Procedures

The study procedures were approved by the Virginia Tech Institutional Review Board prior to recruitment of therapist participants for the rational analysis. These participants included five certified EFT therapists, who were recruited using purposive sampling methods by means of an electronic mailing list. The electronic mailing list is maintained by the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) and is comprised of therapists who have completed a five day externship in EFT authorized by the Ottawa Couple and Family Institute. The only criterion for inclusion of therapist participants was that they be certified by ICEEFT. The certification process requires therapists to complete extensive training requirements in order to demonstrate competence in the model, including a videotaped and written case presentation (International Centre for Excellence in Emotionally Focused Therapy, 2007). Informed consent of the therapist participants was obtained electronically from the first five certified EFT therapists to respond to the recruitment e-mail. A therapist background questionnaire and directions for a thought experiment about how an EFT therapist would repair alliance ruptures were then e-mailed to the therapist participants, completed by the certified EFT therapists, and returned to the researcher electronically. Of the five EFT therapists who participated in the study, only four therapist responses were included in the analysis of the data. One therapist's response was removed from data analysis because it did not respond to the question on which therapists were asked to reflect.

In addition to these participants involved in the rational analysis, an additional EFT therapist and two client participants, who were part of a larger clinical trial conducted by the second author, were included in the empirical analysis. This EFT therapist involved in the

empirical analysis did not contribute to the development of the thought experiment for the rational analysis. As the client participant data used in this study were previously collected by the second author, the protocol for screening, intake and treatment was pre-determined. The larger study sought to examine the effectiveness of EFT in treating couples who were in distress and included at least one depressed partner. Client participants were recruited from the Washington, DC metro area.. The couple chosen to be a part of the current study had completed 15, 50 minute EFT sessions with a certified EFT therapist. The couple was chosen through the use of selective sampling methods because they had completed EFT treatment, experienced positive outcome from treatment [based on the Beck Depression Inventory- Second Edition (BDI-II; Beck, Steer, & Brown, 1996) and Dyadic Adjustment Scale (DAS; Spanier, 1976)], and had experienced episodes of alliance rupture during treatment by therapist report and validated by a decrease in reported alliance on the System for Observing Family Therapy Alliances, self-report version (SOFTA-s; Friedlander & Escudero, 2002) by one or both client participants for the rupture session as compared to the previous session's measure score. .

Study Participant Demographics

Of the four certified EFT therapists included in this study, three were female and one was male, all were Caucasian and between the ages of 29 and 66. The highest level of education held by the participants include two therapist participants with a Master's in MFT and two with a PhD in MFT or another mental health related field. Together, the therapists reported a mean of 18.75 years of experience in the mental health field, an average of 7.75 years of experience in EFT, and maintained a caseload in which approximately 65% were treated with EFT.

In addition to the therapist participants, the study included an additional EFT therapist and two client participants. The client participants included a couple who had participated in the second author's clinical trial which tested the effectiveness of EFT for distressed couples in

which one or both partners were depressed. The therapist participant working with this couple was a certified EFT therapist, supervisor and trainer who follows the EFT model in all of her cases. The therapist participant was Caucasian and holds a Master's degree in marriage and family therapy.

Measures

Therapist measures. The five recruited certified EFT therapists completed a basic demographic questionnaire and a thought experiment as a part of the rational analysis. The therapist background questionnaire included basic information such as therapist age, gender, race, marital status, religious affiliation, highest level of education completed, and the field in which the highest degrees are held. The therapist background questionnaire also included questions about their therapeutic practice, such as how many years of experience they have in the mental health field and in practicing EFT, type of mental health licenses they hold, how many cases they see per week, and more specifically how many EFT cases they see per week.

The instructions for a thought experiment were also provided to the certified EFT therapists. The thought experiment instructions included a brief introduction of the researcher and the objective of the study. As an introduction to alliance ruptures, the following definition was provided in the document: “deteriorations in the relationship between therapist and patient” (Safran & Muran, 1996, p. 447). The thought experiment instructions asked the therapists to draw upon their own clinical knowledge, EFT training, and past client experiences to compose a description of the steps they would take to repair an alliance rupture in EFT.

Client screening measures. The couple included in the empirical analysis were screened for inclusion in the larger clinical trial with the use of the BDI-II and the DAS in order to ensure that both partners were distressed and at least one was depressed. The BDI-II is a 21

item self-report instrument measuring the severity of depression in adults. The internal consistency reliability of the BDI-II is $\alpha=.92$ (Beck et al., 1996). The BDI-II also demonstrates good construct validity with significant correlations to other measures of depression, content validity, and factorial validity (Beck et al., 1996). The DAS is a 32-item instrument aimed at assessing the quality of marriage and similar dyads. Higher scores indicate better quality of relationship adjustment. Spanier (1976) demonstrated high reliability ($\alpha=.96$) and reported good content, criterion, and construct validity of the DAS.

Client weekly measures. In addition to the BDI-II and DAS, the SOFTA-s was administered weekly. The SOFTA-s was developed as a self-report measure to assess the quality of therapeutic alliance, which includes subscales related to Engagement in the Therapeutic Process, Emotional Connection to the Therapist, Safety Within the Therapeutic System and a Shared Sense of Purpose Within the Family. Higher scores indicate a stronger therapeutic alliance. Friedlander, Escudero, and Heatherington (2006) report the internal consistency reliability of the SOFTA-s client version to be $\alpha= .87$. Concurrent validity and predictive validity of the SOFTA-s are also reported (Friedlander, Escudero, Haar, & Higham, 2005; Friedlander et al., 2006).

Analysis

The procedure for the discovery-oriented phase of conducting a task analysis (Aspland et al., 2008; Greenberg, 2007) was utilized to identify the tasks undertaken by the EFT therapist to address ruptures in the therapeutic alliance. In the discovery-oriented phase, the goal was to construct a model of the change process, as well as a way to measure parts of the process. The first step was to specify the task being studied, which in this study is the resolution of alliance ruptures. Construction of a rational, or hypothetical, model is completed. This model serves to

propose how the problem might be solved (Greenberg, 2007). Next, the empirical analysis is undertaken. The empirical model is based upon careful observation of the in-session resolution of the problem. Finally, the rational and empirical models are synthesized (Greenberg, 2007).

Rational analysis. A rational analysis of how EFT therapists repair ruptures was formulated. This was accomplished through content analysis of data collected from a thought experiment with certified EFT therapists, in which they were asked to think about how they might address a rupture in therapeutic alliance. Based upon the therapists' responses, a map of alliance rupture repair was assembled by the coders. The researcher and second author separately read responses to the thought experiment using content analysis methods, which is concerned with the study of human communications and results in the summary of the content being analyzed (Krippendorff, 2004). Afterwards, these two coders came together to share the results of their analysis and discussed all discrepancies until consensus was reached by both coders. This initial model was then e-mailed back to the EFT therapists for validation. Based on therapist feedback, a consensus was reached on a rational model of alliance rupture repair in EFT.

Empirical analysis. In order to complete the empirical analysis, the following steps were taken. First, the couple's EFT therapist identified sessions in which the therapeutic alliance had experienced a rupture, verified by a decrease in SOFTA-s score by one or both of the partners for that session as compared to the previous session's measure score. These identified sessions were analyzed further for alliance rupture repair behaviors through the method of task analysis. Upon reviewing the videotaped sessions (session 5 and 15), rupture markers were identified. Non-rupture sessions were also reviewed by the coders to provide a baseline of session characteristics, which aided in the identification of the rupture markers. After the coders

were in agreement on the rupture markers, the researchers separately analyzed the session following the rupture markers in order to identify repair markers. In this step of the task analysis, the researchers were called upon to “look intensively at the in-session performances to discover the essential components of change” (Greenberg, 2007, p. 19). Upon further review of the repair markers and discussion between researchers, in depth descriptions of these repair markers were obtained based upon the characteristics and structure of the repair process. These observations led to the development of an empirical model of alliance rupture repair in EFT.

Synthesis of a rational-empirical model. The results of the rational and empirical models were then compared to one another by the researchers. At this point, the empirical model was used to validate, expand upon or alter the rational model (Greenberg, 2007). This process resulted in the construction of the rational-empirical model.

Results

Rational Analysis

The rational model of alliance rupture repair that was derived from the therapist thought experiment is shown in Figure 1. The rational model presented here includes six steps which were identified by the researchers and agreed upon by the therapist participants. The analysis indicated that once an EFT therapist becomes aware of a rupture in the therapeutic alliance, the therapist verbally notices the possible rupture and raises concern regarding what has occurred. To illustrate this step, one therapist participant suggested saying the following to the client, “I see a look on your face that tells me I’ve done something that is hurtful. Can we stop and talk about that.” Another therapist said that she begins “by naming what I feel and think might be happening and check this out with the client.”

After the EFT therapist raises the concern, the therapist helps the client to explore his/her emotional reaction. The therapist does not focus on the content of the alliance rupture but on the emotional process. Focusing on the emotional process instead of the content helps to avoid escalation of the rupture and also helps to access the client's secondary and primary emotions in relation to the rupture. This might be done through the EFT techniques of evocative responding, reflection and validation. One therapist recommended to "listen to what feels bad using reflection, validation and checking out." After the emotional experience of the client had been explored, the therapist expresses remorse for his/her role in the rupture event.

The next two steps in the rational model of alliance rupture repair are more focused on engaging the couple in the rupture repair sequence. First, the therapist helps the client to explore the similarity of this rupture event to other situations in the past in both his/her past and present relationships. One EFT therapist reported that they would attempt to make the client "curious about their response and what happens to them when someone isn't present to them in the way they need to feel connected." During this step, the therapist continues to reflect and validate the client's experiences and show concern for the client. Next, the therapist checks in with the other partner in the therapy room. One EFT therapist wrote that they assist the partner to "express understanding and empathy" for the rupture event and his/her partner's experience of it. Another EFT therapist said that it is important to check in with the partner as the rupture often is similar to what occurs within the couple's interactional cycle. If so, this is used to explore the relationship pattern. The last step in the rational model is that the therapist and the couple together plan for the management of future rupture events that may occur during the course of therapy. This is done in order to create the expectation that ruptures might occur again and also to devise a way to handle them together in the future.

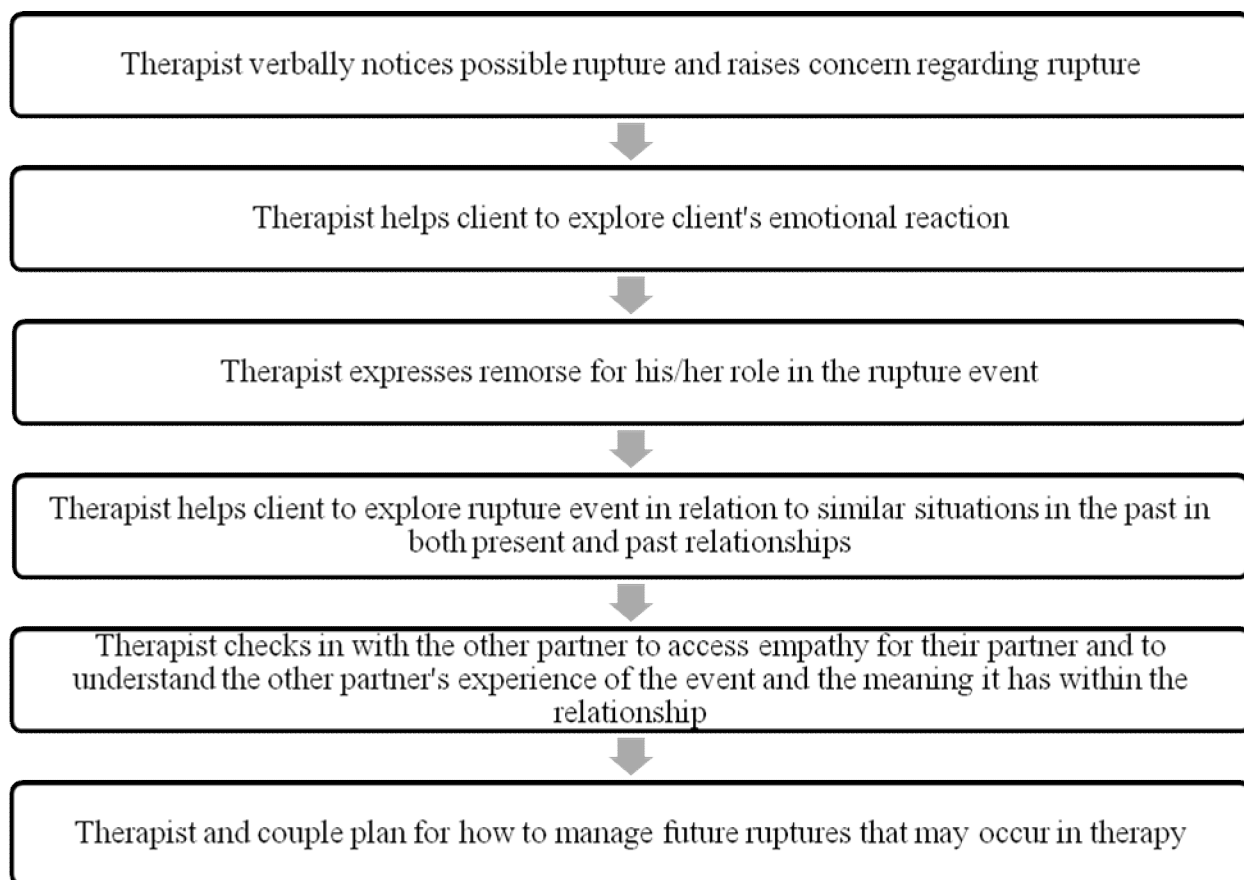


Figure 1. Rational model of alliance rupture repair in EFT

Empirical Analysis

Based upon the therapist's report, two sessions were identified as alliance rupture repair episodes (session 5 and session 15). This was verified by a decrease in SOFTA-s scores by one or both partners for that session. In session five, the therapist experiences a rupture in alliance with the wife and in session 15, there is at least one identified alliance rupture for both the husband and the wife. Session 15 is the couple's final EFT session with the therapist. Based upon analysis of these sessions, an empirical model of alliance rupture repair was devised. The empirical model can be found in Figure 2.

The first task in the empirical model is that the therapist verbally notices the possible rupture to the client and raises concern regarding the potential rupture. The second task is for the

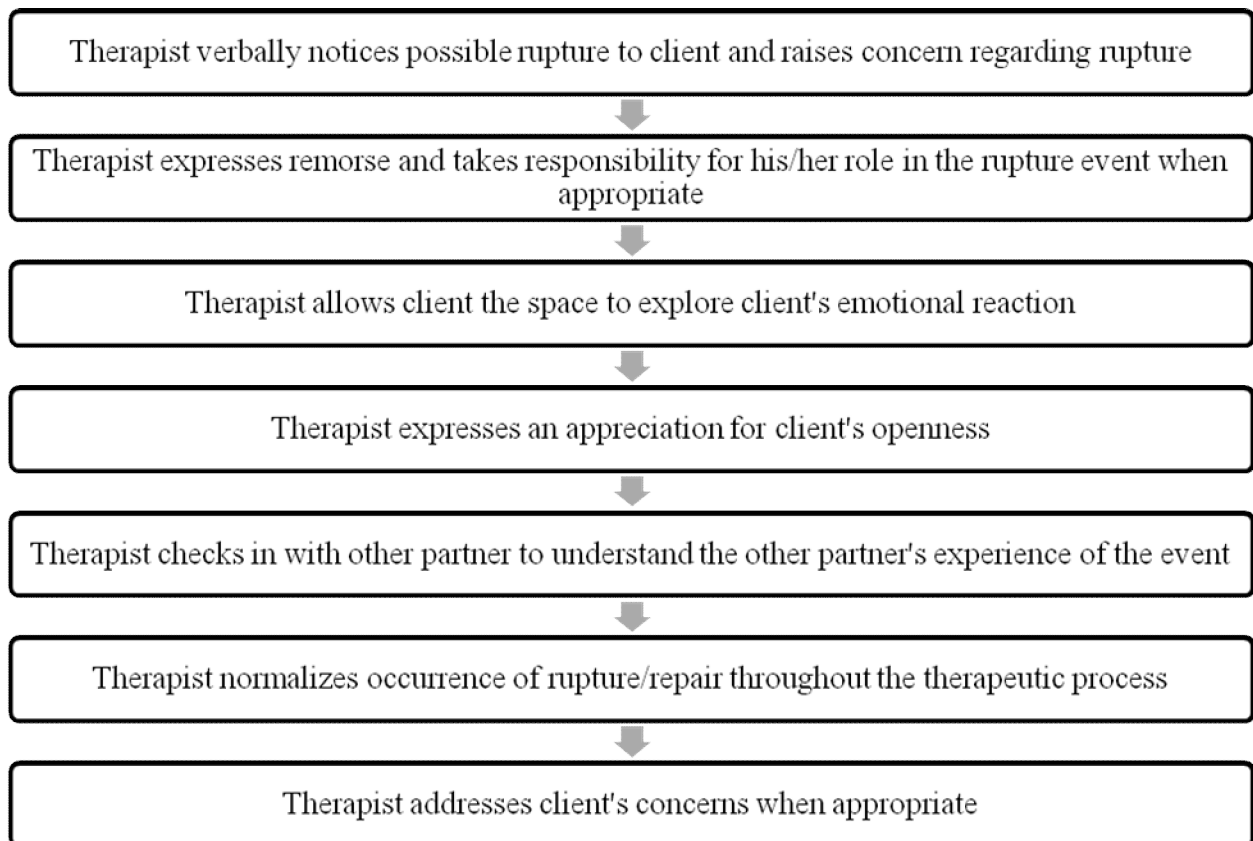


Figure 2. Empirical model of alliance rupture repair in EFT

therapist to express remorse for the rupture event and to take responsibility for his/her role in the event. Both of these tasks are illustrated in session five after the therapist had just returned from a previously scheduled vacation, during which time the wife felt “abandoned” by the therapist. Upon beginning the session, the therapist raises concern about the rupture by introducing the issue while simultaneously apologizing by saying, “I’m sorry for the hardship of my vacation. Those two weeks I know were really hard for you both.” A very short time later in the session, the therapist takes responsibility for her role in the event by stating, “I’m really sorry. I should have made a plan with both of you about if distress gets to a certain point...” Again, at the end of session 15, the therapist expresses remorse regarding a disappointment the couple mentions. She responds, “I’m sorry to hear about your disappointments and I wish the process had met your expectations better and I struggle with that...it’s important to me.”

After the therapist raises concern and expresses remorse, the therapist provides the client with the space to explore his/her emotional reactions to the rupture event. In session 5, when the client voices concern over not knowing what to expect from therapy and reports experiencing feelings of abandonment when the therapist was on vacation, the therapist gives the client ample space to express these feelings, while again continuing to express remorse. In the example from session 15, the therapist allows the couple the space to safely explore their emotions and struggles with the process of therapy, she displays a genuine desire to understand their experience, and the therapist validates and normalizes the couple's feelings.

The next two tasks in the empirical model are for the therapist to show appreciation to the client for his/her honesty and openness about the rupture event and to check in with the other partner to understand his/her experience of the rupture event. Following this, the therapist then normalizes the occurrence of alliance ruptures during the course of therapy. This sequence was observed in session 5 during the following exchange:

Therapist: Well, ok. I so appreciate you sharing so honestly with me. I...I need to hear that. I appreciate all the input you've provided. [Husband], do you want to add anything to any that [wife] has shared?

Husband: Nothing to add.

Therapist: Nothing to add, ok. I'm just really appreciating the chance to continue working with you guys and repair as we keep going and you know continually making sure that we're ok together and that you feel supported and not abandoned. I'm really sorry.

Finally, the therapist addresses the client's concern when appropriate to do so. In session 5, the wife expresses concern at not knowing what was to be expected in therapy, and so, the therapist addresses this concern by thoroughly describing what the client can expect from the treatment process. Throughout the rest of the session, the therapist was also careful to explain

steps of therapy ahead of time in order to regain the client's trust and to continue to repair the therapeutic alliance.

Rational-Empirical Model

The next stage involved the construction of a rational-empirical model, i.e. a revised model of alliance rupture repair based upon the rational and empirical analyses. The alliance rupture repair sequences from the empirical analysis were compared to one another and to the rational model composed from the therapists' thought experiment responses. The rational-empirical model is shown in Figure 3.

The final model is outlined as follows. The therapist verbally notices the possible rupture to the client and raises concern regarding the possibility of the rupture event. Following this step, the therapist then allows the client to explore his/her emotional response related to the rupture event. The therapist probes if necessary in order to facilitate exploration of emotions during this task. Once the rupture is better understood by the therapist, the therapist shows a personal concern for the client experiencing the difficult emotions caused by the rupture. When appropriate, the therapist also expresses remorse for the part that he or she has played in the rupture event. Next, the therapist checks in with the other partner to understand his/her experience of the rupture event. When possible, the therapist should help the other partner to access and express empathy for his/her partner's emotions in regards to the rupture event.

There may also be times when it is appropriate for therapists to address a client's concern related to a rupture. For example, in session 5 of the empirical analysis the therapist goes on to explain what to expect from treatment as a result of the client expressing a related concern. Finally the therapist will thank the client for his/her openness in discussing the rupture, as well as normalizing the occurrence of rupture events in therapy and planning for how to manage future ruptures in therapy.

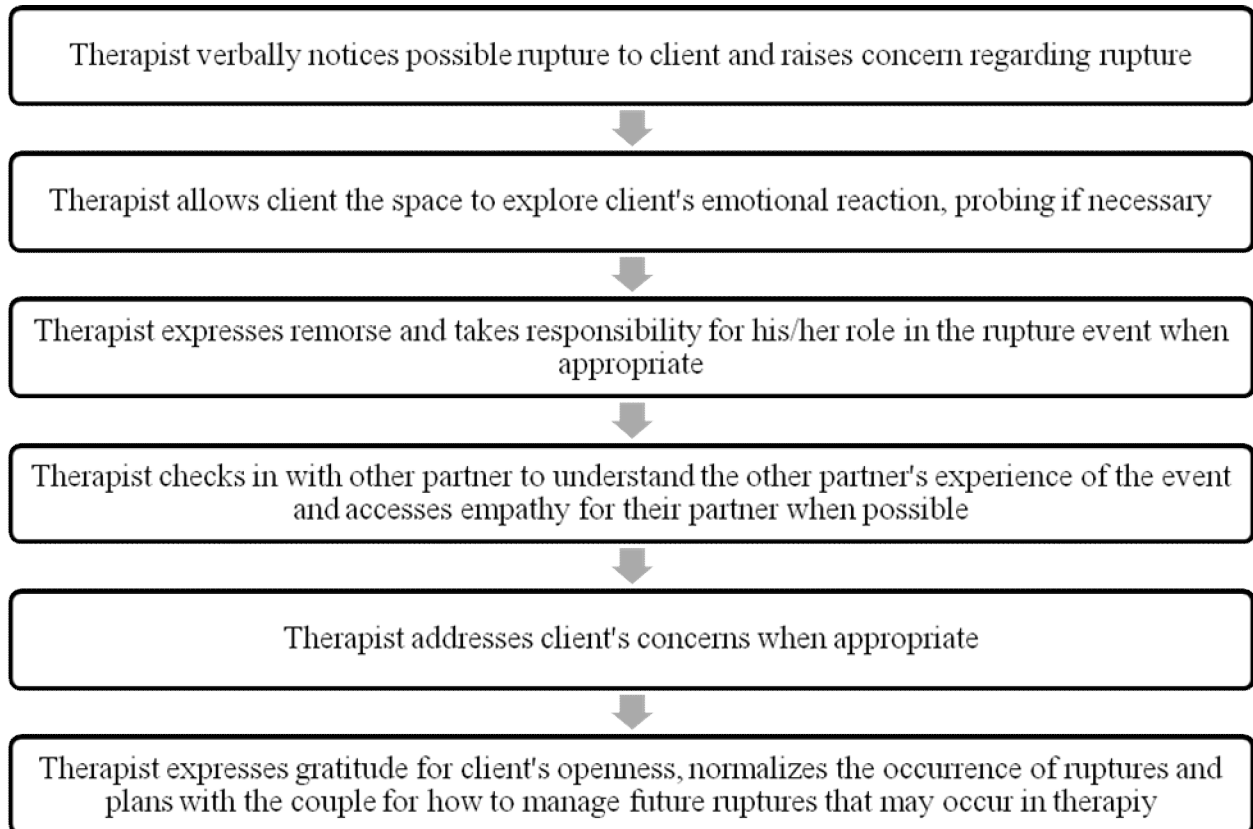


Figure 3. Rational-empirical model of alliance rupture repair in EFT

CHAPTER 5: CONCLUSIONS

The rational and empirical analysis resulted in the development of a synthesized model for repairing alliance ruptures in EFT. In the process of blending the rational and empirical models to form a rational-empirical model, several modifications were made from the original, rational model. The most substantial change from the rational model compared to the rational-empirical model is the additional step of the therapist directly addressing the client's concerns when appropriate, as observed in session five. This may not always be a part of alliance rupture repair but it was clear that by the therapist addressing the client's concern, the client felt more trust in the therapist and the therapeutic alliance began to improve. Additionally, a step that was named in the rational model was omitted from the rational-empirical model, namely the therapist helping clients to explore ruptures in relation to similar situations in past and present relationships. This step was not observed in the empirical analysis and the researchers posited that the client might be more open to exploring this after the alliance rupture was more fully repaired. Once the therapist has repaired the alliance rupture, the therapist might help the client to consider if he/she has ever had a similar experience with comparable emotional reactions with his/her partner or in other important relationships. In doing so, the therapist would be using the rupture event as a possible way to highlight the couple's interactional cycle and bring attention back to treatment as usual. As a result, this task was not included in the rational-empirical model.

In addition to these differences in models, there were several other modifications made to the rational-empirical model based upon observations from the alliance rupture repair sequences in the empirical analysis. First, the second task of helping clients to explore their emotional reaction was changed to allowing them space to do so and probing if necessary. The female

client in the videotaped sessions often did not require probing and shared her experience openly and honestly without much prompting on the part of the therapist. This was likely due to the therapist forming a strong alliance with the client prior to the rupture. In the repair session, the therapist wasn't probing, but simply created a safe space for the female client to share her experience within the session. While this was effective in this case, more probing may be necessary with other clients in order to explore their emotional experiences in relation to the rupture.

Another modified step within the rational-empirical model is in the therapist's expression of remorse and taking responsibility for his/her role. This change in language was meant to reflect the possibility that the therapist might express remorse because of the discomfort that the rupture event may have caused for the client, but also they may be expressing remorse for something they did or did not do leading up to the rupture event, and in doing so, taking responsibility for his/her role in the alliance rupture. In expressing remorse for the client's experience of the rupture, the therapist is showing the client that he/she has heard and understood the client's experience and is letting the client know that the therapist values the therapeutic relationship. Additionally, the therapist taking responsibility for his/her role in the rupture also conveys to the client that the therapist understands and values the client. In other situations, however, it may be important for the therapist to express remorse for the client's perception of him/her during the negative event, while not accepting responsibility for something in which he/she does not feel at fault.

In the rational-empirical model, the task of expressing remorse was identified as occurring after having allowed the client the space to explore her emotional experience of the rupture, which was supported by the analysis of session 15. However, in session five, the

therapist quickly expresses remorse to the client before exploring her emotional experience. The researchers discussed the order of these steps at length and concluded that perhaps the order would depend upon the client and the reason for the rupture. The researchers hypothesized that in order for the client to explore the rupture openly, they might first need to hear the therapist express remorse for the client's emotional experience and/or take responsibility for his/her role in the rupture event. For this reason, the final model included this step early in the process. On the other hand, however, it is possible that the client's expression of emotion could be stifled if the therapist were to quickly apologize to the client. Perhaps, the therapist would need to evaluate the client's needs in each rupture event. If the client seems more agitated due to a rupture, the therapist may need to express remorse and/or take responsibility more quickly in order to begin the repair process with the client and to enable further exploration of the client's emotions.

The task in which the therapist checks in with the other partner was also modified in the rational-empirical model. In the rational analysis, it was found that the therapist would check in with the other partner to access empathy for his/her partner, to understand the other partner's experience of the rupture event and to explore the meaning the rupture has within the couple's relationship. There was no evidence from the empirical analysis to support exploration of the meaning the rupture has within the relationship, and so, this part of the task was not included in the final, rational-empirical model. The therapist trying to understand the other partner's experience of the rupture was found to be part of the alliance rupture repair process in session five. Although the therapist did not explicitly help the partner access empathy for the partner in these situations, it may be appropriate with other clients and/or in different alliance rupture scenarios than the ones presented here.

The final difference between the rational model and the rational-empirical model can be found in the final step. In addition to planning for future ruptures with the couple, there was also support from the video recordings for the therapist to express gratitude for the client's openness as well as normalizing the occurrences of alliance ruptures and therefore setting up the expectation that it can occur during therapy. As mentioned previously, the EFT therapist may find it more therapeutically appropriate to address the alliance rupture by incorporating the steps outlined here in a different sequence than has been presented based on characteristics of the client and rupture event.

There are also aspects of the therapeutic stance that are not directly linked to a particular step in the rational-empirical model but are important throughout the alliance rupture repair process, as emphasized by the EFT therapists involved in the construction of the rational model and observed in the empirical analysis. One overarching theme is the ability of the therapist to have an open stance which should encourage the client to share honestly with the therapist without fear of negative consequences. In other words, the therapist would not respond defensively, but display a person concern for the client and his/her experience and feelings related to the rupture event. In the same vein, the therapist should also convey empathy for the client throughout the process of alliance rupture repair.

There are several commonalities between this study's rational-empirical model of alliance rupture repair in EFT and the alliance rupture repair models of Safran and Muran (1996) and Aspland et al. (2008). First, each model suggests that the therapist should bring the client's attention to the here and now experience of the rupture event. Safran and Muran (1996) recommend that therapist's facilitate clients' asserting their feelings to the therapist by the therapist "acknowledging his/her own contribution to the interaction" (p. 451). This finding is

similar to the study's task of the therapist expressing remorse and taking responsibility for his/her role in the rupture event. Like Aspland et al. (2008), the present study's model of alliance rupture repair also encourages the use of exploration of the rupture event, validation of the client's experience, and affirmation of the client having shared his/her concern with the therapist.

Despite these commonalities, there are also findings which distinguish this study from other models of alliance rupture repair (Aspland et al., 2008, Safran & Muran, 1996). As this study was undertaken within a couple therapy setting, this study's model of alliance rupture repair includes the other partner in the repair sequence, first by checking in with him/her about his/her own experience of the rupture and then by encouraging the partner to express empathy for the client who experienced the alliance rupture. As suggested in the rational analysis, it may very well be that the process of alliance rupture in therapy also reflects part of the couple's process. Since the other partner is present in the therapy room during the alliance rupture event, that partner may gain insight into his or her partner's experience of similar events that take place within the couple relationship. After the rupture has been attended to, there may be an opportunity later in therapy to use what has been learned from the alliance rupture repair event to attend to an aspect of the couple's cycle of interaction.

Limitations

There are several limitations to this study that need to be recognized. First, the certified EFT therapists involved in the rational model were not asked about the extent to which they were familiar with existing literature on alliance rupture repair models, which may have influenced their responses to the thought experiment. If they had prior knowledge of research findings regarding alliance rupture repair, their responses might have reflected this information, in

addition to their EFT experience in training and in practice with clients which they were asked to draw upon to formulate their responses. Also, it is important to note that the empirical analysis included the review of session videotape of a single couple, and likewise, one therapist.

Therefore, the results from this stage of analysis may be reflective of this therapist's style and approach to alliance rupture repair. Similarly, the findings from the empirical model are also reflective of the characteristics of this particular couple. The wife of this couple in particular is very straightforward and forthcoming with her thoughts. It is possible that this led the therapist to be less directive in the alliance rupture repair process. As to the specific rupture events in the empirical analysis, each rupture repair sequence which was analyzed was most closely related to disagreement about tasks of therapy. If we had analyzed alliance rupture repair sequences where the primary issue was related to the goals of therapy or the bond between therapist and client, it is possible that a different empirical model may have emerged based upon varied disagreements leading to the alliance rupture. . Additionally, the couple selected for analysis represents a case with successful outcomes based upon BDI-II and DAS scores. No comparison to an unsuccessful case in EFT was made which could have provided additional insight into which repair strategies are effective and which are ineffective. Despite these limitations, the use of several therapists in the rational analysis enhances the findings from the empirical analysis.

Further research is needed to continue to refine this preliminary model.

Future Research

As we continue to recognize the importance of alliance and therapeutic outcome, as well as the meaningful experiences that alliance ruptures can become in treatment, better understanding of the process of alliance rupture repair in different treatment modalities should be useful to clinical work. In particular, as EFT continues to grow as a mode of couple therapy and

given the importance of expressing vulnerable emotions within this treatment modality, it would be helpful to expand upon what this study has found regarding the tasks of alliance rupture repair in EFT. Future research should first look to analyze more alliance rupture repair sequences with videotaped therapy sessions of several certified EFT therapists practicing couple therapy to see if a larger study would obtain similar findings.

After completing a larger scale task analysis of alliance rupture repair in EFT, it would then be of benefit for researchers to undertake the validation-oriented phase of task analysis. This stage seeks to validate the model obtained from the synthesis of the rational and empirical models by further analysis of audiotape or videotape in which the task of interest is occurring, which in this case is alliance rupture repair. Review of successful and unsuccessful attempts at alliance rupture repair would be needed for this phase of task analysis. The second and final step of this validation-oriented phase would be to relate the process of alliance rupture repair to therapeutic outcome (Greenberg, 2007).

Conclusion

As we continue to gain a greater understanding of how EFT therapists work to repair alliance ruptures, EFT therapists may better address alliance ruptures in therapy and consequently turn sequences of alliance rupture repair into a positive experience for clients. A greater understanding of a model of alliance rupture repair in EFT may have an impact on how EFT therapists are trained to address these often difficult moments in therapy. A validated model of alliance rupture repair can help to guide EFT therapists in working through alliance ruptures with clients, while the therapist continues to modify this model of alliance rupture repair to fit his/her clients' particular needs. This study has provided a preliminary model of alliance rupture repair in EFT, which would benefit from further testing via the task analysis method.

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APPENDIX A

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Repairing Alliance Ruptures in Emotionally Focused Therapy (EFT)

Principle Investigator: Andrea Wittenborn, Ph.D.

I. Purpose of Research

The purpose of this study is to develop a model of how a trained EFT therapist repairs alliance ruptures during the course of couple treatment. We are interested in learning about the tasks that an EFT therapist might utilize to repair an alliance rupture once they are aware that such a rupture has occurred.

II. Procedures

You will be asked to take part in a thought experiment considering how you, a trained EFT therapist, would approach an alliance rupture. You will be asked to complete a short therapist questionnaire and to consider the step-by-step process you would utilize to repair a rupture in therapeutic alliance upon becoming aware that an alliance rupture has occurred in therapy. You should expect that this may take you 30 to 45 minutes to complete these tasks. Once you have developed this step-by-step model, you will e-mail your responses to project coordinator, Lauren Russo, at her provided e-mail address. Upon review of all participant responses a provisional model of alliance rupture repair in EFT will be sent back to you by e-mail for further comment, modification and confirmation, which should take an additional 10 to 15 minutes to complete. If you wish to discontinue your participation in this study at any time, you may do so without facing any adverse consequences.

III. Risks

Risks in participating in this program are minimal. While unlikely, some discomfort may occur when answering the questions since you will be asked to recall moments in therapy when your alliance with clients was ruptured.

IV. Benefits

The information you provide will contribute to our knowledge of alliance rupture repair in EFT and may advance our knowledge on clinical training.

V. Extent of Anonymity and Confidentiality

Strict confidentiality of information will be preserved. This means that we won't tell anyone what you have said in your responses. You will be assigned an identification number that will be kept separate from any identifying information, and your responses will contain only this identification number. Names will not be used on any reports or publications that are developed from the results of this study.

VI. Compensation

No compensation will be provided.

VII. Freedom to withdraw

You do not have to participate in this research study. If you agree to participate, you can withdraw your participation at any time without penalty.

VIII. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibility:

1. I will complete a therapist background questionnaire to the best of my ability.
2. I will take part in a thought experiment which will include tasks that I, as a trained EFT therapist, would utilize to repair an alliance rupture, and will provide further comment and modification to the provisional model as needed.

IX. Participant's Permission

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

Participant's Signature

Date

Participant's Name (please print)

Researcher's Signature

Date

If you have any questions about this research study or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Andrea Wittenborn, Ph.D.

Investigator

David M. Moore

Chair, Virginia Tech Institutional Review
Board for the Protection of Human Subjects
Office of Research Compliance
2000 Kraft Drive, Suite 2000 (0497)
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APPENDIX B
THERAPIST QUESTIONNAIRE

ID#: _____

Directions: Please circle or write in your answer for each question.

Today's Date: Month ___ Day ___ Year ___ ___

How old are you? _____ years

What is your gender? Male Female

What is your racial or ethnic background?

African American Asian Hispanic Native American Caucasian
Other _____

What is your relationship status?

Single Married Separated Divorced Widowed Other _____

What is your religious affiliation?

Catholic Protestant Jewish Buddhist Hindu Mormon/LDS
Agnostic Atheist Other _____

What is the highest level of education you have completed?

Bachelor's degree Master's degree Doctoral degree Other _____

What are your educational degrees held in? _____

How many years of experience do you have practicing in the mental health field? _____ years

How many years of experience do you have in EFT? _____ years

What type of mental health license do you hold? _____

What is your current state of employment?

Employed full-time Employed part-time Retired Not employed Other _____

How many cases do you see in therapy per week? _____

How many EFT cases do you see in therapy per week? _____

What percentage of your cases are:

Individual cases _____% Couple cases _____% Family cases _____%

APPENDIX C
THOUGHT EXPERIMENT

I am a Master's student at Virginia Tech's Marriage and Family Therapy program. For my thesis, I am researching the tasks that a trained EFT therapist would use to repair a rupture in therapeutic alliance during the course of EFT treatment with a couple. Alliance ruptures can be understood as "deteriorations in the relationship between therapist and patient" (Safran & Muran, 1996, p. 447).

As a trained EFT therapist, please reflect upon the following:

During the course of EFT treatment, you (a trained EFT therapist) become aware of a rupture in therapeutic alliance with one partner in the couple you are currently seeing. Please consider the step-by-step process that you would utilize to repair the therapeutic alliance with this couple. Please list the steps and interventions in the order in which you would approach the couple. Again, these steps and interventions are things that *you* as the therapist would enlist to repair an alliance in EFT.

Please draw on your clinical knowledge, EFT training and/or past client experiences to describe steps that you would take in the situation described above. Please send your response via e-mail by (DATE).

Thank you for your time and assistance.

APPENDIX D**IRB APPROVAL LETTER****MEMORANDUM****DATE:** May 25, 2010**TO:** Andrea Wittenborn, Lauren Russo**FROM:** Virginia Tech Institutional Review Board (FWA00000572, expires June 13, 2011) **PROTOCOL TITLE:** Repairing Alliance Ruptures in Emotionally Focused Therapy**IRB NUMBER: 10-473**

Effective May 21, 2010, the Virginia Tech IRB Chair, Dr. David M. Moore, approved the new protocol for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at <http://www.irb.vt.edu/pages/responsibilities.htm> (please review before the commencement of your research).

PROTOCOL INFORMATION:Approved as: **Expedited, under 45 CFR 46.110 category(ies) 7**Protocol Approval Date: **5/21/2010**

Protocol Expiration Date:

5/20/2011 Continuing Review DueDate*: **5/6/2011**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals / work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.