Use of Relational Strategies to Repair Alliance Ruptures: How Responsive Supervisors Train Responsive Psychotherapists

Myrna L. Friedlander
University at Albany

Inasmuch as therapist responsiveness is the crucial ingredient in psychotherapy success, teaching supervisees to be optimally responsive to their clients is the primary function of supervision. Responsive supervision is particularly critical when a trainee experiences a faltering or problematic working alliance with a client. In this article, I describe and illustrate how supervisors can work responsively, both explicitly (through instruction) and implicitly (through modeling) when their supervisees report a serious alliance rupture. Next, I illustrate, with the same case example, how quickly ruptures in the therapeutic alliance can lead to ruptures in the supervisory alliance when the supervisor is not sufficiently responsive to the trainee’s needs and, instead, relies exclusively on case management. Throughout the article, I discuss how the construct of responsiveness fits within the substantial body of theory and research on relational processes in supervision.

Keywords: supervision relationship, responsiveness, working alliance, interpersonal supervision, alliance rupture

“My client Suzanne, who just started last week, left a message with the secretary that she won’t be coming back. I tried phoning her three times, but she didn’t return any of my calls.”

“Well, actually he hasn’t done any of the homework I assigned. Each week when we talk about a new assignment, he insists he’ll get to it, that he’ll make time for it and knows it’s important, but then when he comes back in for the next session, he says he hasn’t done it.”

“He just clammed up in the session! For the last 15 minutes, no matter what I tried, he wouldn’t answer me. And then he just fell asleep and started snoring! I can’t believe how mad I am... I know I’m overreacting, but...”

“The woman, Allie, said she doesn’t think their couples therapy is going anywhere, that it’s more like individual therapy for Jack, always focused on his legal problems, with her just watching me talk with him. She said that none of what bothers her about their relationship ever gets talked about. I didn’t know what to say to her.”

All of these comments, although not verbatim, reflect ones I have heard from novice psychotherapy trainees over the course of my career. Each statement describes a rupture in the working alliance (e.g., Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011) with a client, signaling a critical point in the therapeutic process. The first example suggests that the alliance rupture was severe enough for the client to drop out of therapy after one session. The second and third examples suggest less severe ruptures, due perhaps to inadequate negotiation of the goals and tasks of treatment. The last example reflects a “split alliance” in couple therapy, which occurs when the partners have different levels of emotional connection with the therapist (e.g., Friedlander, Escudero, & Heatherington, 2006).

In each situation, the rupture needs to be directly addressed in order for the therapy to get back on track (Safran et al., 2011). Repairing a rupture requires not only technical skill but also an openness and willingness to discuss the role the therapist played in the relational impasse. When the therapist is in training, his or her willingness to examine mistakes is complicated by an acute awareness of the evaluative and gatekeeping role of the clinical supervisor.

Naturally, there are many approaches a supervisor can take when a trainee describes an alliance rupture with a client. One approach is simply to prescribe what the trainee should do with the client. This kind of case management tends to be the default approach in handling many alliance problems. Case management, however, does little to facilitate the trainee’s learning. At best, case management teaches supervisees how to behave professionally in challenging situations. At worst, case management results in supervisees feeling incompetent.

Rather, an explicitly relational approach to the alliance repair process is needed. Alliance repair goes to the heart of what Stiles, Honos-Webb, and Surko (1998) called therapist responsiveness, which is, interpersonal behavior that is context dependent rather...
than theoretically prescribed. In order to be maximally responsive to clients, psychotherapists need to be exquisitely attuned to the moment-by-moment relational dance, shifting their levels of authority and intimacy with each step in the dance. This is not an easy skill to learn, but it is an essential one, especially now that research has made it abundantly clear that responsiveness plays a more important role in therapeutic success than does theoretical allegiance (e.g., Wampold, 2001).

**Responsiveness: At the Heart of Rupture Repair**

In a recent article (Friedlander, 2012), I argued that if responsiveness is at the heart of good psychotherapy, then responsiveness is at the heart of good supervision. That is, a primary function of supervision is to teach novice therapists to be optimally responsive to their clients. To do so, effective supervisors teach responsiveness explicitly and model responsiveness implicitly by being attuned and responsive to their supervisees’ complex and changing needs.

Arguably, nowhere is responsiveness more critical than when a rupture in the working alliance has taken place. That is, when a supervisee describes client behavior that signals a troubled alliance, the supervisor needs to be dually responsive—responsive not only to the therapy that is in jeopardy, but also to the supervisee’s reactions to the therapeutic rupture (Friedlander, 2012). Typically, supervisees in this situation need to learn a complex technical skill (alliance repair); they also need reassurance that ruptures are a natural, expected event in the therapeutic process, and that their occurrence does not invariably lead to treatment failure.

To help supervisees learn this complex skill, supervisors rely not only on direct instruction (to understand the client, to learn new techniques, and so on), but also on modeling. That is, within the supervision relationship, effective supervisors model how to collaborate, how to promote autonomy, and how to validate another person’s experience (cf. Szymanski, 2003).

Supervision as modeling is by no means a novel idea, as it reflects one aspect of the parallel process phenomenon, which was first described by psychoanalysts in the mid-1900s. In a recent empirical demonstration of parallel processes, Tracey, Bludworth, and Glidden-Tracey (2012) showed that, the “trainee takes the interaction pattern [experienced] in supervision back into the therapy session as the therapist, now enacting the supervisor’s role” (p. 330). More compelling yet, Tracey et al. showed that client outcome is enhanced when, over time, the trainee’s behavior regarding, affiliation and power becomes more similar to the supervisor’s.

Psychoanalytic authors defined parallel processes as unconscious processes in a supervisee’s therapy relationships that are played out in the supervision relationship, and vice versa (e.g., Eckstein & Wallerstein, 1972; Kell & Mueller, 1966). More recent authors, however, refer to parallel processes as complementary interactions in therapy, such as helpless client/directive therapist, that carry over to the supervisory relationship—for example, helpless supervisee/directive supervisor, and vice versa. The explanation for this phenomenon is that supervisees are in a position of authority (“one up”) in their therapy relationships but are in a subordinate position (“one down”) with their supervisors (e.g., Friedlander, Siegel, & Brenock, 1989).

Paying attention to issues of authority when exploring parallel processes is essential when working with critical events in supervision (Ladany, Friedlander, & Nelson, 2005), such as when a supervisee describes a rupture in the therapeutic alliance. In exploring parallel processes, supervisors move back and forth between a focus on the supervisory relationship and a focus on the supervisee’s therapy relationship(s), as in the figure/ground phenomenon (Ladany et al., 2005). As illustrated in the following vignette, which concerns “Lynn’s” ruptured alliance with her new client, at times, the therapy relationship is the figure (e.g., when the supervisee’s interactions with her client are being discussed), and the supervisory relationship is the ground. At other times, however, the supervisory relationship is the figure (e.g., when the supervisee’s feelings are being discussed), and the therapy relationship is the ground.

Specifically, the vignette illustrates how the discussion of Lynn’s discomfort over a ruptured therapy relationship evolves from a focus on the probable cause of the rupture to a discussion of Lynn’s internal experience. Focusing on the rupture itself, the supervisor begins by eliciting Lynn’s feelings as she watches the video of her session, utilizing an interpersonal process recall method (Kagan, 1984). Next, the supervisor explicitly instructs Lynn how to be more responsive to clients (watch for nonverbal cues, offer feedback at the end of a session, inquire if the intake session went as expected). Finally, the supervisor models responsiveness by being sensitive to Lynn’s concern about how her clinical skills are being evaluated in light of the alliance rupture.

Lynn: My client Suzanne, the one who just started last week, left a message with the secretary that she won’t be coming back. I tried phoning her three times, but she didn’t return any of my calls.

Supervisor: I can imagine you’re disappointed. I recall how eager you were to work with Suzanne. (By using the word “disappointed,” the supervisor simultaneously assesses Lynn’s readiness to explore her feelings about the alliance rupture and gives Lynn permission to discuss those feelings.)

Lynn: Yes, I was! Now I’m at a loss to understand what went wrong.

Supervisor: What do you recall of how the intake ended last week? (Even though Lynn agreed that “disappointment” is an accurate reflection of her feelings, the supervisor decides to focus instead on the therapy process, as Lynn also indicated feeling confused about why the client dropped out. The supervisor judges that Lynn is not yet ready to talk about her feelings regarding this treatment failure.)

Lynn: As best I recall, I summed up what I thought she’d been saying about her problems at work with her boss, and then gave her another appointment.

Supervisor: Let’s take a look at the last 10 min of the session on the video, okay? Maybe we can see something that’ll give us a clue about how she expe-
renced the intake. (Because Lynn seems to be focusing on her own behavior rather than on the client, the supervisor considers that by observing the video, Lynn might be able to see signs of the alliance rupture. Indeed, Lynn’s last comment suggests that she probably did not notice any cues that signaled the client’s discomfort with returning for another session. Note the supervisor’s use of the term, “. . . give us a clue . . . ,” which implies collaboration.)

Lynn: [after having observed the end of the session on the video] Wow! Now I think I know what may have been the problem. I seem much more abrupt than I remember being, right there at the end.

Supervisor: What are you seeing exactly, Lynn, which makes you say that? (The supervisor decides to draw out Lynn’s self-critical observation, noting that Lynn still is more focused on her own behavior than on the client’s.)

Lynn: Suzanne is shifting around a bit in her chair, and when I said I’d see her the same time next week, she looked away. Yikes, I missed all that at the time.

Supervisor: Any idea what you were thinking or feeling in that moment? (Now that Lynn has noticed how the client’s nonverbal behavior possibly reflects an alliance rupture, the supervisor focuses Lynn on her internal experience.)

Lynn: I know I was really conscious of the time running out. We talked last time in supervision about how I have trouble ending a session on time. Maybe I rushed her. I remember thinking that we needed to stop.

Supervisor: Hmm . . . that could be it, or part of what was going on for her. As I was watching, I was wondering too if she got what she needed from the intake. You did a nice job of summarizing her problems at work . . . (The supervisor senses that Lynn needs some positive feedback at this point. Lynn had been trying to improve in an area that was previously discussed in supervision, i.e., ending sessions on time, and this justification suggests that she is feeling uncomfortable after having noticed her “abruptness” with the client.)

Lynn: . . . right.

Supervisor: . . . but what I didn’t see—or maybe it happened earlier?—was some feedback, some alternate way of looking at her problems that might suggest a goal for the therapy. (The supervisor decides to offer a hypothesis about what might have caused or contributed to the client’s discomfort. Rather than focus on what Lynn failed to do, which likely would result in Lynn feeling more self-critical, the supervisor suggests an approach to use when wrapping up an intake session.)

Lynn: You mean, like what we would be working on?

Supervisor: Exactly. And why . . . some way she might view her situation a bit differently. See, this is a client who came because someone else is giving her grief. From what I recall of our discussion last week, she didn’t identify any problem within herself other than stress about the job . . . or did she? (Here the supervisor is providing Lynn with a hint about how to view the client’s presentation, in hopes that Lynn can figure out for herself what she might have done differently at the end of her session with Suzanne.)

Lynn: No, she didn’t. [silence] I see! I could’ve done more than just restate what she told me. Like, maybe if I’d suggested that we work on ways to cope with the situation better, and that I would be a support for her while she’s going through the crisis . . . ?

Supervisor: Precisely. I think that would have been very helpful—especially the “crisis” bit. (The supervisor provides some encouragement, adopting Lynn’s word “crisis” to indicate that she is on the right track.) It’s generally a good idea at the end of an intake to ask the client if what took place in the session was what they expected. (This comment is an explicit instruction about how to be responsive to a client in a particular situation.) I’m not so sure she saw it as a “crisis,” though, or did she? I mean, was that your interpretation, or was that her description of her experience? (Here the supervisor is assessing whether Lynn’s conceptualization of the client’s problems as a “crisis” is her own, which would indicate Lynn’s conceptual ability, or whether Lynn is simply restating the client’s description of her situation as a “crisis.”)

Lynn: [thoughtful] Hmm . . . no, no. [lengthy silence]

Supervisor: Where have your thoughts gone just now, Lynn? (The supervisor is unsure of Lynn’s here-and-now experience and is sensitive to the likelihood that Lynn is feeling highly self-critical. This open-ended question allows Lynn to continue the discussion wherever she feels comfortable and models responsiveness during a lengthy silence.)

Lynn: [softly] I’m sort of embarrassed, really. I missed so much! And no wonder she didn’t want to come back. I didn’t really give her what she needed, and she probably thought, “How’s this going to get me anywhere?”
In modeling responsiveness, the supervisor used five of Ladany et al.'s (2005) 11 interpersonal sequences for resolving critical events. Through focusing on Lynn’s understanding of the alliance rupture, therapy skills, clinical training, and supervisory experience, the supervisor (a) normalizes Lynn’s experience (Yes, I suspect that’s what a lot of students think when this kind of thing happens. And it’s not so unusual, really, for clients to drop out after an intake). (b) focuses on Lynn’s self-efficacy (… can we talk about your confidence level—how’s that?), (c) explores Lynn’s feelings (… can we talk about your feeling embarrassed?), (d) focuses on the therapy relationship (Let’s take a look at the last 10 minutes of the session on the video, okay? Maybe we can see something that’ll give us a clue about how she experienced the intake and it’s generally a good idea at the end of an intake to ask the client if what took place in the session was what they expected); and (e) focuses on the supervisory alliance (And let’s also talk about how supervision is going, and how I can best help out when you don’t feel so good about your skills, okay?).

This critical event in supervision ends with a discussion about whether and how to follow-up with Suzanne. After agreeing on how to handle the case, the supervisor inquires about Lynn’s experience of their discussion. With this inquiry, the supervisor models how Lynn might approach the end of her sessions with clients.

**Ruptures Also Occur in the Supervisory Alliance**

As a reader, you may well have seen Lynn’s supervisor as overly cautious and unduly concerned about Lynn’s vulnerability. As supervisors, however, we should not underestimate the power of our role and the necessity to make it safe for supervisees to express their doubts and fears. Our authority as supervisors carries with it the weight and responsibility of gatekeeping—a point that is not lost on our supervisees.

Until this point, I have discussed explicit and implicit responsiveness when a supervisee indicates having experienced a rupture in the working alliance with a client. Similar responsive processes are required when the supervisory alliance falters (Bordin, 1983). In fact, a rupture in the working alliance with a client can rapidly turn into a rupture in the supervisory alliance. Indeed, by virtue of its evaluative nature, supervisory alliances are arguably more ripe for ruptures than are psychotherapy alliances.

Let’s imagine that the foregoing vignette had ended with a lengthy discussion of Lynn’s lack of confidence but no discussion about whether and how Lynn should continue to try contacting Suzanne. Even if Lynn had felt reassured by her supervisor that dips in self-efficacy are normal when a client drops out, Lynn might well have gone away from the supervision session worried about whether or not to pursue Suzanne. If Lynn were still feeling vulnerable, she might be hesitant to ask her supervisor for advice in this regard. Lynn’s sense of “being left hanging” would constitute a supervision rupture, one that could have been avoided if the supervisor had intuited Lynn’s need for closure on her therapy case.

Now let’s consider how rapidly a rupture in the supervisory alliance could have occurred if the supervisor had simply taken a case management approach with Lynn:

**Lynn:** My client Suzanne, the one who just started last week, left a message with the secretary that she won’t be coming back. I tried phoning her three times, but she didn’t return any of my calls.

**Supervisor:** Well, she seems to have decided that she’s not ready or she doesn’t want therapy, which can happen with clients. I think you could just write her a letter, telling her that you got her message about not continuing, that you’d like to speak with her to discuss her options, but if she prefers not to do so, that she is welcome to return to the clinic at any time in the future. I’d like to see the letter before you send it out. (Having decided
that no repair is possible, but without explaining why, the supervisor instructs Lynn how to manage the client’s premature termination.

Lynn: okay. [long silence]

Supervisor: Do you have another client we can talk about? (Lynn’s passive response and her silence suggest that a rupture in the supervisory alliance has occurred. It is not, however, apparent to the supervisor, who continues to push forward.)

Lynn: [silence]

Supervisor: I’m sensing that you’re uncomfortable . . . ? (The supervisor focuses on the here and now, beginning to recognize a problem and hoping to elicit Lynn’s feelings about what has just occurred between them.)

Lynn: No, really, it’s okay. [pause] I’ll write Suzanne the letter. And I’ll show it to you first.

Lynn cannot drop out of supervision, as her client, Suzanne, did from the therapy relationship. Due to the involuntary, evaluative nature of supervision, ruptures in the supervisory alliance are similar, but not identical, to ruptures in the therapeutic alliance. Whereas ruptures in psychotherapy are often signaled by clients directly challenging their therapists (Safran & Muran, 2000), supervisees are arguably less likely to challenge their supervisors. In supervision, passive withdrawal tends to be more commonplace than direct challenge.

Lynn’s reluctance to give voice to her discomfort is not solely due to her “one-down” vulnerability in the supervision relationship. The rupture began when the supervisor failed to help Lynn understand what might have gone awry in her intake session with Suzanne and did not attend to Lynn’s feelings about the therapy failure. The rupture worsened when the supervisor approached the situation only as a case to be managed rather than as a supervisee whose confidence had been sorely shaken.

Here is an example of how the supervisor could begin to address the alliance rupture:

Supervisor: Right now I’m thinking that I rushed into that solution without giving you the opportunity to say what you think should be done about her dropping out. (The supervisor suspects that Lynn’s discomfort has to do with what is occurring between them. By acknowledging the error, the supervisor hopes to encourage Lynn to directly state how she is experiencing their current interaction.)

Lynn: It’s just that I feel bad about what happened with her and it makes me doubt myself.

Supervisor: Quite understandable. All therapists have doubts when clients drop out. I certainly do, myself. (Noting that Lynn has opened up somewhat about her feelings about what transpired with Suzanne, the supervisor tries to reduce their power imbalance by normalizing Lynn’s feelings of self-doubt.)

Lynn: Well, I guess so.

Supervisor: Can we talk about what’s happening between us, right now? (Recognizing Lynn’s return to passivity and suspecting that she is still uncomfortable, the supervisor explicitly gives her permission to discuss their interaction, modeling here-and-now communication.)

Lynn: It’s just that I don’t know what you think of how I’m doing.

Supervisor: And you’re wondering if I’m judging you poorly because Suzanne dropped out? (The supervisor is struggling to understand what’s going on for Lynn in the moment, realizing the need to give voice, albeit tentatively, to Lynn’s experience to begin repairing what is now clearly a rupture in their alliance.)

Lynn: Yes! But also I’m judging myself poorly!

At this point, the supervisor can say something like, “Then perhaps we should talk about all that, as I realize I may not have been giving you the amount or the kind of feedback you’re looking for.” By acknowledging an error, the supervisor mirrors self-correction, a responsiveness skill that all therapists need to acquire to begin repairing a rupture in the therapeutic alliance with clients, regardless of their theoretical orientation (e.g., Safran et al., 2011).

Now that the focus has switched to the supervisory alliance, the session may evolve in various ways. By opening the door for Lynn to take the conversation in any number of different directions, the supervisor is modeling restraint and a sharing of power. It may turn out that Lynn wants specific feedback on her handling of Suzanne’s case but is not generally feeling a lack of support from the supervisor. Alternately, the issue may be Lynn’s harsh self-criticism; she may simply need some guidance about how to assess her strengths and weaknesses in working with clients, along with some reassurance that even the most experienced therapists have clients who drop out from time to time.

In our critical events model, we illustrated various ways in which discussions of events in supervisees’ therapy relationships can strain the supervisory relationship (Ladany et al., 2005). Perhaps the most common alliance ruptures result from role conflict, which occurs when supervisor and supervisee have opposing expectations for what should take place in supervision. Role conflict occurs, for example, when a supervisee is irritated with a client yet thinks that the supervisor’s insistence on discussing her countertransference is not legitimate or appropriate. Alternatively, a supervisee might want to explore his strong reaction to a new client and is put off when the supervisor focuses on the client’s diagnosis and development of a treatment plan.

Despite evidence that strong supervisory alliances are associated with strong therapeutic alliances (Patton & Kivlighan, 1997; Tracey et al., 2012), as well as with satisfaction in supervision (Inman, 2006; Ladany, Ellis, & Friedlander, 1999), to date authors have had little to say about alliance ruptures in supervision. Given solid evidence that many supervisees feel harmed by their supervisors (e.g., Ellis et al., 2013; Gray, Ladany, Walker, & Ancis, 2001; Nelson & Friedlander, 2001), it is clear that alliance ruptures do in fact occur in supervision and that failure to repair them can have serious emotional and professional consequences for supervisees (Nelson, Barnes, Evans, & Triggiano, 2008).
Some Final Thoughts

A substantial body of research, qualitative as well as quantitative, highlights the crucial importance of the relationship in supervision (cf. Ellis, 2010). However, despite theorizing and a fair number of studies on the supervisory working alliance, little is known about the specific strategies, interventions, and behaviors that constitute an explicitly relational approach to supervision (Shaffer & Friedlander, 2012).

In a recent review of 28 years of research, Ellis (2010) concluded that the major theories of supervision do not pay adequate attention to the relationship, and that these theories are actually lacking in empirical support. With a growing number of constructs that support the importance of interpersonally oriented supervision—feminist supervision (e.g., Szymanski, 2003); parallel process (e.g., Tracey et al., 2012); supervisory working alliance (cf. Bahrick, 1990; Patton & Kivlighan, 1997); role conflict (e.g., Friedlander, Keller, Peca-Baker, & Olk, 1986; Ladany & Friedlander, 1995; Olk & Friedlander, 1992); interpersonally sensitive supervisory style (e.g., Friedlander & Ward, 1984; Nelson & Friedlander, 2001; Shaffer & Friedlander, 2012); relational supervision strategies (Ladany et al., 2005; Shaffer & Friedlander, 2012); and supervisory collaboration (Rousmaniere & Ellis, 2013; Szymanski, 2003)—we now have ample building blocks to construct a theory of relational psychotherapy supervision. It just needs to be done.

References


Received January 18, 2014
Revision received March 10, 2014
Accepted March 14, 2014