

Despite rapid growth in psychological therapies, the evidence guiding effective training and supervision methods remains strikingly sparse. This book brilliantly addresses this gap by presenting alliance-focused training (AFT) with remarkable clarity, making it an indispensable addition to every psychological educator's toolkit. It not only provides a lucid and practical framework for navigating some of the most challenging clinical scenarios therapists encounter, but it also introduces a structured and evidence-informed approach to supervision and deliberate practice, enabling these essential skills to become deeply ingrained. Anyone actively involved in training or supervising others to deliver psychological treatments of any type must read and learn from this book.

—**PROFESSOR PETER FONAGY, PhD, CBE, FMedSci, FBA, FAcSS,**

Head of the Division of Psychology and Language Sciences, University College London, London, England

This book rests on decades of work that have provided conceptual models, practical guidelines, and empirical research to address the clinical reality of alliance ruptures. Now, Muran, Eubanks, Wallner Samstag, and Macdonald are offering a broad, detailed, flexible, and transtheoretical system to train and supervise clinicians in identifying and repairing such ruptures. With the addition of this “chef-d'œuvre,” it is difficult to think of a more cohesive, programmatic, actionable, helpful, and visible contribution to today's field of psychotherapy.

—**LOUIS G. CASTONGUAY, PhD,** Liberal Arts Professor of Psychology, Pennsylvania State University, University Park, PA, United States

Whether you are training from a psychodynamic, cognitive behavior, emotion-focused, feminist-multicultural, or integrative perspective, this book will speak to you and enrich your supervision and training! The client-therapist alliance is one of the strongest contributors toward therapy success and therefore learning to bolster alliances and to address alliance ruptures is an essential, valuable skillset. The authors, who are leading experts in this area, bring insight, sensitivity, and clear guidance on how to conduct therapy in an alliance-focused manner. I especially enjoyed the many tips for managing the tricky issues that often arise within therapy and supervisory contexts. I will recommend that my students and colleagues rush out to obtain a copy!

—**HEIDI M. LEVITT, PhD,** Professor of Clinical Psychology, University of Massachusetts Boston, Boston, MA, United States

From the masters and leaders of AFT, this primer book provides an exceptionally comprehensive and integrative protocol that builds on human relations, alliance and emotion theories, microtheories of change, process measures, up-to-date research evidence, and a wealth of clinical expertise in practice and supervision. Educators, trainers, supervisors, trainees and practicing psychotherapists will find the step-by-step AFT protocol with its didactic instruction, experiential exercises, and profound illustrations of individual and group supervision to be engaging and eye-opening in their depth, breadth, and richness.

—**HADAS WISEMAN, PhD**, School of Therapy, Counseling, and Human Development, University of Haifa, Haifa, Israel

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INTRODUCTION

Why This Book?

With support from a grant from the National Institute of Mental Health (NIMH), three of us (JCM, CFE, LWS) worked in a research program that led to the development of an integrative alliance-focused training (AFT), which was eventually evaluated as adjunctive training for therapists providing cognitive behavior therapy (CBT) to patients diagnosed with personality disorders (Muran et al., 2018). AFT was found to effect increases in positive process and decreases in negative process that were linked to overall patient change. Among the variables assessed, AFT was shown to lead to greater patient expressiveness, which has been implicated as an important change process in other studies of diverse psychotherapies (Castonguay et al., 1996; Klug et al., 2022; Pos et al., 2009). In a secondary analysis (Muran, 2019, p. 7), therapist narrative responses to a post-training supervision survey on AFT impact were examined, specifically testimonials from various therapists whose patients demonstrated the most change on expressiveness in sessions

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by J. C. Muran, C. F. Eubanks, L. W. Samstag, and J. Macdonald
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across the course of therapy. Here is some insight into how these therapists experienced AFT:

Supervision allowed me to articulate and express a difficult internal reaction I had been having to my patient's emotional distance. Through a two-chair exercise I had the opportunity to experience that my fears of expressing negative feelings towards my patient for fear of hurting him did not sound as harsh when I actually said them. This gave me the confidence to share these thoughts with my patient in session. . . . This allowed me to more freely express myself in session . . . with more spontaneity and less deliberation.

Although I still felt somewhat stuck in sessions and my patient still seemed to respond poorly to my interventions, supervision helped me feel more free to try to express my thoughts and feelings to my patient.

We talked about my emotions a lot, so I was able to explore my emotional reactions . . . and learned some of my own limitations as a therapist.

I allowed myself to accept and tolerate the negative feelings I had felt towards my patient at times. This allowed me to gain a better understanding of what was happening in the therapy and to use that understanding in treatment.

Helped me not to hold things back, that my reactions can be used therapeutically.

Lots of role plays in which to explore techniques and areas which I had not experienced before. Also, pointing out ruptures that I was not aware of . . . I was under the impression it was not okay or therapeutic to include my own reactions and I learned how to do so in a manner which could be useful to the patient.

I was afraid of my patient's anger. . . . Through supervision, I was able to use this fear. I expressed a portion of my experience of fear using metacommunication. This freed me of the constraints fear had imposed on me and allowed the patient to move deeper into his experiences of us as a dyad. (Muran, 2019, p. 7)

OUR OBJECTIVE

Much has been written about the importance of the alliance between patient and therapist in psychotherapy (e.g., Horvath & Greenberg, 1994; Muran & Barber, 2010). There have been multiple meta-analyses (e.g., Flückiger et al., 2019, 2020) demonstrating its relation to treatment success across orientations. There is also a growing literature about alliance rupture repair (e.g., Eubanks, Samstag, & Muran, 2023; Muran & Eubanks, 2020; Safran & Muran, 2000) that includes meta-analyses demonstrating its value as a critical change process (Eubanks et al., 2019). In contrast, the literature on training therapists on how to develop alliances and resolve ruptures is limited (Muran & Barber, 2010), and this includes empirical studies (Eubanks

et al., 2019; Knox & Hill, 2021). As previously mentioned, several of us have been part of a program of research that has developed and evaluated AFT (Muran et al., 2010, 2018). With this book, our objective is to present a primer on an integrative AFT protocol that can serve as a practical guide for supervisors and trainees and advance the literature on training in psychotherapy. A companion video that illustrates aspects of AFT is available through the APA PsycTHERAPY video platform, as well as in DVD form (Muran & Eubanks, 2026).

OUR RATIONALE

The empirical literature on the efficacy of psychotherapy, addressing “does therapy work?” (Barkham & Lambert, 2021), is sobering when considering there are many patients who do not respond (30%), drop out (20%), or deteriorate (5%). Thus, there remains the challenge to do better, and one way to meet this challenge is to better understand change processes, or “how does therapy work?” In this regard, the alliance (therapeutic, working, or helping) has garnered a great deal of attention, and there are many empirical studies demonstrating its relationship to treatment outcome: The Flückiger et al. (2019) meta-analysis, for example, included almost 300 independent samples with more than 30,000 participants. Many of these studies have demonstrated that the alliance predicts treatment outcome—a correlational relationship—but there is increasing attention to a causal relationship—namely, the alliance as a *change mechanism* (e.g., Barber et al., 2021).

Originally conceptualized in psychoanalytic circles to account for the real and practical aspects of patient–therapist interactions (Greenson, 1967), the alliance has come to be recognized over the past 50 years as a transtheoretical construct (Bordin, 1979), an integrative variable (Wolfe & Goldfried, 1988), change principle (Castonguay et al., 2019; Goldfried, 1980), and common factor (Frank & Frank, 1993; Wampold & Imel, 2015). Bordin’s (1979) reformulation of the alliance was most influential to this recognition and to the proliferation of empirical research, shaping the content of the measures developed and applied. Accordingly, the alliance has come to be understood as comprised of *purposeful collaboration* (on tasks and goals) and an *affective bond* (mutual respect and trust) between patient and therapist (Hatcher & Barends, 2006).

A so-called second generation of alliance research has emerged over the past 35 years with a focus on ruptures in the alliance (Safran & Muran, 2000). These have been defined as breakdowns in collaboration and deteriorations in the bond (Safran & Muran, 2006), but also as motivational and existential

conflicts as patient and therapist try to negotiate their respective needs and desires (Muran & Eubanks, 2020). Ruptures have also been attributed to inherent error and discord in human choices and relations that have been observed in the cognitive and emotion sciences (Muran & Eubanks, 2020; Muran et al., 2023). Rupture events have been shown to be quite prevalent (patient and therapist report ruptures in up to 50% of sessions; observers report them in up to 100%), and rupture repair events are also predictive of outcome (Eubanks et al., 2019; Muran, 2019). Efforts to define and evaluate rupture and repair have led to (a) stage-process models of rupture repair, (b) a manualized treatment primarily informed by rupture repair, and (c) the AFT protocol to develop therapist abilities to build alliances and repair ruptures (for an overview, see Muran, 2002, 2019).

The principles of AFT were derived from not only research on rupture repair but also research on cognition and emotion and developments in interpersonal and intersubjective theory (Muran & Eubanks, 2020). Thus, AFT is integrative in its orientation: It was developed to improve the effect of therapies across orientations. AFT can serve as an adjunct to different therapeutic approaches by enabling therapists to fine-tune their interventions to the current state of the alliance. AFT can improve treatment outcomes by helping therapists more readily recognize and resolve ruptures, which have been shown to be risk factors for treatment failure (Eubanks et al., 2019).

Some key principles of AFT are the following: (a) It assumes that ruptures result from patients and therapists becoming unwittingly hooked in negative interpersonal cycles with one another; (b) there is an intensive focus on the here-and-now of the therapeutic relationship; (c) there is a collaborative exploration of both patients' and therapists' contributions to the interaction; (d) it emphasizes in-depth exploration of patients' experience in the context of their relationship with the therapist; (e) it assumes interpersonal meaning to all interventions; (f) it emphasizes the subjectivity of the therapist's perceptions; and (g) it makes extensive use of therapeutic *meta-communication* (i.e., communicating about the communication process as it immediately unfolds in patient–therapist interaction; Kiesler, 1996; Safran & Muran, 2000)—that is, any attempt to step outside of and bring awareness to bear on the interpersonal cycle that is currently being enacted by treating it as the focus of collaborative exploration.

AFT includes *didactic instruction*, which introduces the definition of rupture events and resolution principles but also (and especially) emphasizes *experiential learning* and self-exploration. In AFT, therapists are trained to attend to, regulate, and explore their own feelings as important sources of information

about what is going on in the alliance. AFT uses awareness-oriented role-plays to provide therapists with the opportunity to simulate working with difficult process and to experiment with the principle of metacommunication—that is, to practice technical skills and to develop the skill of exploring their own internal experience and conflicts as they emerge during alliance ruptures.

In addition, AFT employs mindfulness training to help therapists refine their capacity to observe their own inner experience, as well as the nature of their own contributions to the interpersonal process, with curiosity and without too much self-criticism. All supervision sessions devote some time to mindfulness training, and therapists are encouraged to develop an ongoing mindfulness practice on their own between training sessions. Through this training, therapists develop a greater attentiveness and sensitivity to their own experience and actions as they unfold in their alliances with patients. In fact, metacommunication is conceptualized as a type of “mindfulness in interaction.” An important byproduct of mindfulness practice is the discovery of *internal space* (i.e., the subjective and emotional landscape within an individual where self-reflection can occur) and the development of *emotion regulation* (that is, the management of emotions through greater reflection and understanding).

The emphasis on the experiential in AFT is due to several influences. The first can be traced to Ferenczi and Rank (1924/2010), who influenced the humanistic orientation (Gendlin, 1962; Perls et al., 1951; Rogers, 1951; including its contemporary emotion-focused expression, Greenberg, 2017) and the relational revolution (Mitchell, 1988; Safran, 1998) that brought greater attention to immediate emotional experience in the context of the patient–therapist relationship. The experiential emphasis was also greatly informed by the educational and performance sciences, especially with regard to the notions of the zone of proximal development (Vygotsky, 1930/1980) and reflection-in-action (Schön, 1983), and to the research on judgment under stress (Kahneman, 2011), performance under pressure (Beilock, 2010), and deliberate practice (Ericsson & Pool, 2016).

Based on an NIMH-funded clinical trial that implemented a multiple baseline design to control for individual and dyadic differences (Muran et al., 2018), AFT was shown to have an additive effect on the interpersonal process of a CBT for personality disorders. More specifically, AFT facilitated decreases in negative process (in therapist controlling and patient-dependent behaviors), plus positive increases in positive process (in patient and therapist expressiveness and therapist affirmation). Several of these changes were linked to positive treatment outcome. These findings are consistent

with previous research in CBT and analytic therapy, especially where greater patient expressiveness (including emotional expression and exploration) was linked to better outcome (Castonguay et al., 1996; Henry et al., 1986, 1990; Klug et al., 2022). In secondary analyses of therapist post-training interviews, AFT was shown to increase therapist emotional insight and to promote experiential depth (Eubanks, Muran, & Samstag, 2023; Muran, 2019). These findings are also consistent with other research demonstrating how expressiveness begets expressiveness (e.g., Coker & Burgoon, 1987; Morrey et al., 2020; see Chapter 1, this volume, for more in this regard).

OUR CONCEPTION

As described in the preface, AFT was conceived in the study of rupture repair and influenced by various literatures on psychotherapy training and experiential learning. This book presents and illustrates the various principles and strategies of AFT that have been empirically tested and demonstrated, as well as some additional strategies and recommendations that are based on our clinical experiences as AFT supervisors and trainees. To our knowledge, this is the first book entirely dedicated to AFT. Given that AFT is focused on the alliance and rupture repair, which are relevant and impactful across theoretical orientations, this book is essentially integrative and *meta-therapeutic*. Furthermore, AFT is empirically supported (Muran et al., 2018). Our target audience includes professionals (especially supervisors and educators) in clinical and counseling psychology, counselor education, social work, and psychiatry from diverse orientations to advance training of their students. The book is written with a practical bent and in relatively theoretically neutral language, aiming to be transtheoretical and sometimes relying on the cognitive, affective, and performance sciences to do so. Throughout the book, we include examples of AFT based on actual transcripts of AFT sessions. This clinical material has been adequately disguised to protect patient and trainee confidentiality.

OUR STRUCTURE

We begin with some critical considerations of the training science, including research on decision making and cognitive and affective confounds. We lay the groundwork for our application of experiential learning to training in psychotherapy. We then present our understanding of the alliance and its

development as an organizing framework for our approach to rupture repair and to training therapists to better build and repair their alliances.

Chapter 1. Research on Training: Some Critical Considerations

In this chapter, we review in brief the relevant research on training in general and in psychotherapy specifically to establish the empirical foundation of AFT. Our review begins with some considerations of expertise and decision making: Experts intuitively recognize patterns of information that guide skillful action, and even expert judgment is fraught with error, both systematic and random, especially in the face of ambiguity and stress. Human relations are unpredictable, “wicked” environments to navigate. We discuss experiential learning, defined in terms of reflective and deliberate practice, and its relevance for psychotherapy, including the development of mental representations and pattern recognition abilities. Emotion and emotion regulation are considered constructed experience with cooperative function. Finally, the psychotherapy research literature is reviewed regarding efforts to redress negative process and improve alliances. We conclude with the empirical evidence for AFT.

Chapter 2. Alliance as a Change Process: Some Organizing Formulations

Here we introduce the alliance as an ongoing interpersonal process in which patient and therapist ongoingly collaborate on tasks and goals and negotiate their respective needs and identities—where ruptures are inevitable and ubiquitous. We understand the individual as comprising multiple selves or identities that shape needs for agency and communion. We understand human relations as fraught with tensions and collisions as individuals negotiate needs and identities in relation to each other. We describe various challenges these formulations suggest for patient–therapist interactions and their alliances in psychotherapy, including what are termed as *motivational tensions*, *interpersonal transformations*, *existential struggles*, *identity collisions*, *affective misattunements*, and *empathic failures*. All these have implications for the *supervisory alliance* or relationship as well. We conclude by describing some challenges often faced by supervisors: *collapse of internal space*, *experiential avoidance*, *emotion dysregulation*, *cognitive inflexibility*, and *self–other negation*.

Part I. Alliance-Focused Training Protocol

In this part, we introduce the details of our training protocol regarding the didactic and experiential work around rupture recognition and resolution.

Chapter 3. Rupture Recognition: Didactic Instruction

Before therapists can repair ruptures, they need to be able to recognize them; hence, AFT begins with didactic instruction to develop therapists' abilities to recognize ruptures, specifically what can be seen. The objective is to facilitate sensitivity—to develop an optimal observational stance. In this chapter, we present definitions of *negative process* and *interpersonal markers* of rupture and exercises to facilitate sensitivity. We describe how psychotherapy process measures, specifically the Structural Analysis of Social Behavior (SASB; Benjamin, 1974) and the Experiencing Scale (EXP; Klein et al., 1969), can be used to define negative process operationally. We introduce the Rupture Resolution Rating System (3RS; Eubanks & Muran, 2022) to define ruptures as interpersonal markers (patient and therapist behaviors) that include *withdrawal* (movements away from the work or other) and *confrontation* (movements against the work or other) ruptures. Therapists can use these measures to code audio or video of their therapy sessions to support rupture recognition. We conclude by considering some of the challenges of didactic training in this regard, including under- and overrecognizing ruptures.

Chapter 4. Rupture Recognition: Experiential Exercises

Here we present our experiential approach to developing rupture recognition: facilitating therapists' use of their emotional experience, their abilities to recognize *intrapersonal markers* or what can be felt. The chapter considers emotions as constructions from a combination of individual experiences, cultural context, and social interactions. Emotions are intrapersonal markers that include basic (primary vs. secondary) and complex (self-conscious) emotions. We then describe exercises used to develop therapist awareness of their emotional states: (a) mindfulness and felt sense inductions; (b) video and audio analysis; and (c) journal recording (of therapist emotion states). We conclude by considering some of the challenges of experiential training in rupture recognition, including supervisor choice points regarding modeling, disclosing, and balancing member needs in a group format.

Chapter 5. Rupture Repair: Didactic Instruction

In this chapter, we present our didactic approach to training in rupture resolution—to facilitate therapist responsiveness to rupture and to sensitize therapists to possible resolution processes. We recommend several training exercises. The chapter begins by describing the movement toward *positive*

process, which we define using the SASB and EXP process measures. We then define *rupture repair* strategies on the 3RS and present rupture repair pathways or models that have been empirically demonstrated. These pathways include reattunement movements (from misattunement to reattunement) and two stage-process models (introduction of repair processes): (a) renegotiation of tasks or goals (to reestablish collaboration) and (b) exploration of rupture (to clarify core relational themes). We highlight the complexity (or messiness) of rupture repair and conclude by considering some of the challenges of training in this regard, including when to be didactic and how to guard against being prescriptive.

Chapter 6. Rupture Repair: Experiential Exercises

Here we present our experiential approach to training in rupture resolution—our efforts to sensitize therapists to the principle of metacommunication. The chapter begins with a review of metacommunication, including fundamental attitudes (being metacommunication) and basic strategies (doing metacommunication). We share some structural considerations and organizing principles for training and supervision (both individual and group). We then describe the various experiential exercises that are central to AFT, including *mindfulness practices* (towards developing an optimal observational stance toward self and other), *role-play enactments* (towards experimenting with various strategies and experiences), *two-chair work* (towards exploring therapist fears and expectations regarding self and patient), and *single-chair focusing* (towards exploring therapist emotional experience). We conclude by addressing some supervisory challenges, including negotiating messiness, constructing awareness exercises, minding boundaries, training trainers, leading and coleading, and addressing supervisory ruptures and parallel process.

Part II. Alliance-Focused Training Illustration

In this part, we present illustrations of AFT conducted in individual and group formats. Each chapter includes case descriptions and transcript material from our research program that we hope brings AFT to life. Each chapter highlights how supervisors conduct the training and illustrates the following training principles: (a) recognize the relational context (individual alliance and group cohesion/climate); (b) emphasize self-exploration and experiential focus; (c) practice out of the trainee's comfort zone but respect developmental

trajectories and be responsive; and (d) provide a secure base or safe space. We address how ruptures are negotiated in supervision, including consideration of supervisor anxieties and frustrations, withdrawals and confrontations, as well as trainee states and behaviors in this regard.

Chapter 7. Individual Supervision Process

This chapter focuses on AFT conducted as a form of individual supervision or consultation. We review the main components of an AFT supervision session: mindful awareness, detailed analysis of a rupture event (preferably video- or audio-recorded), and awareness-oriented exercises (focusing, empty- or two-chair, and role-play). We illustrate these with three clinical vignettes.

Chapter 8. Group Supervision Process

Here we present AFT when conducted as a form of group supervision or consultation. We briefly review empirical studies of AFT in a group format. We review the components of an AFT session and how supervisors can use them to facilitate group engagement and cohesion. This chapter presents four clinical illustrations, including annotated transcripts that detail the use of awareness exercises in group supervision.

Chapter 9. Rupture Repair in Supervision

In this chapter, we address the question of how to negotiate ruptures in the supervision process, individual or group. Because supervision occurs in a relational context in which the participants' agreement on tasks and goals, mutual respect and trust, and negotiations of respective needs are in play, the supervisory alliance (alliances or cohesion in a group format) is integral, the potential for ruptures are ever present, and their negotiation is par for the supervision course. We present various rupture markers (trainee and supervisor expressions) and repair strategies (explanation, validation, management, and exploration) and then conclude with illustrations of supervisory ruptures and repairs in action.

Conclusion: What Have We Learned?

We conclude with a summary of recommendations and lessons learned from our research program and clinical experience regarding training and supervision. These are for both supervisors and therapists.

OUR ASPIRATION

We have been writing about AFT for years (for some of us, decades) in summary fashion (describing it in a method section or book chapter) and regarding empirical findings (reporting on its impact on psychotherapy process and therapist experience). We hope this book brings to life what AFT is and how it actually works, sharing in richer detail how it breathes and moves. We also recognize that understanding is greatly enhanced by doing. This is fundamental to experiential learning and essential to our AFT. So we also hope this book will serve as a platform for experiential work and inspires the reader to do (and “reflect in practice”).