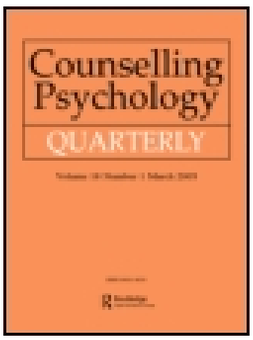

Routledge
Taylor & Francis Group

Counselling Psychology Quarterly

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ccpq20

Repairing alliance ruptures using supportive techniques in telepsychotherapy during the COVID-19 pandemic

Tohar Dolev-Amit , Liat Leibovich & Sigal Zilcha-Mano

To cite this article: Tohar Dolev-Amit , Liat Leibovich & Sigal Zilcha-Mano (2020): Repairing alliance ruptures using supportive techniques in telepsychotherapy during the COVID-19 pandemic, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2020.1777089

To link to this article: https://doi.org/10.1080/09515070.2020.1777089

COUNSELLING PSYCHOLOGY QUARTERLY
https://doi.org/10.1080/09515070.2020.1777089

Routledge
Taylor & Francis Group

ARTICLE

Repairing alliance ruptures using supportive techniques in telepsychotherapy during the COVID-19 pandemic

Tohar Dolev-Amit*, Liat Leibovich* and Sigal Zilcha-Mano

Department of Psychology, University of Haifa, Haifa, Israel

ABSTRACT

The COVID-19 pandemic shifted many traditional face-to-face treatments to telepsychotherapy, forcing many therapists worldwide to adapt effective techniques developed in face-to-face treatment to telepsychotherapy. These include supportive techniques that may be particularly important at a time of rising anxiety, loneliness, helplessness, and depression. The present paper provides detailed guidelines for therapists on how supportive techniques developed in traditional face-to-face treatment can be effectively used in telepsychotherapy to resolve alliance ruptures. To this end, we used the conceptual framework of the core conflictual relationship theme (CCRT) formulation, making adjustments for identifying and resolving ruptures in the therapeutic alliance in telepsychotherapy. We demonstrated the proposed techniques for identifying and repairing ruptures with a case study of a patient participating in an ongoing RCT, whose treatment shifted in mid-therapy to telepsychotherapy because of the COVID-19 pandemic. The techniques presented and illustrated in this article may be used in the transition to remote therapy for a range of reasons, including patient or therapist relocation and more.

ARTICLE HISTORY
Received 20 April 2020
Accepted 29 May 2020

KEYWORDS
Therapeutic Relationship; alliance ruptures; supportive Techniques; core conflictual relationship theme

The present paper was written at the height of the COVID-19 pandemic, when many therapists worldwide were forced to shift from traditional face-to-face treatments to telepsychotherapy. Different remote therapy platforms, such as telephone, e-mail, and videoconferencing can be used in telepsychotherapy (e.g., Andersson et al., 2012; Backhaus et al., 2012; Kingsley & Henning, 2015). The sudden shift in treatment setting raises challenges, however, as therapists must work in an unknown environment without having all the knowledge needed for remote treatment.

Lack of knowledge or experience with telepsychotherapy may make it difficult for therapists to identify ruptures in the alliance (Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011), including some ruptures that stem from the transition to the telepsychotherapy setting. The work of therapy regularly includes ruptures, and the transition to telepsychotherapy brings added challenges to their identification and resolution. Ruptures in the therapeutic alliance can be defined as tension or disagreement between patient and therapist on the goals of treatment, failure to collaborate on the

CONTACT Sigal Zilcha-Mano sigalzil@gmail.com
*These authors contributed equally to this study.

tasks of treatment, or a strain in the emotional bond between them (Eubanks, Lubitz, Muran, & Safran, 2019). A rupture can manifest as a severe break or a subtle tension between patient and therapist. As alliance ruptures are an integral part of treatment, evident in over 91%of traditional face-to-face sessions (Muran, 2019), it is likely they will also be present in telepsychotherapy. Ruptures can be categorized into two main subtypes: withdrawal and confrontational (Eubanks, Muran, & Safran, 2015; Safran & Muran, 2000). In withdrawal ruptures, the patient moves away from the therapist or the work of therapy, whereas in confrontation ruptures the patient moves against the therapist or the work of therapy. When identified and successfully resolved, these events can lead to better treatment outcomes (Eubanks, Muran, & Safran, 2018; Safran & Muran, 2000). Given the significance of resolving ruptures, it is important to identify and successfully resolve them in telepsychotherapy.

Safran and Muran (1996, 2000) developed an empirically tested model of alliance ruptures and repair that emphasizes the importance of identification of ruptures and resolving them. They suggested that addressing and resolving ruptures properly can be a positive opportunity for therapeutic growth. Their model suggests that by systematically exploring, understanding, and resolving alliance ruptures, the therapist can provide patients with a new constructive interpersonal experience that has the potential to modify their maladaptive interpersonal schemas. This paper extends on Safran and Muran's conceptual and empirical writing to the specific difficulties rising from the transition to telepsychotherapy.

In the present paper, we introduce supportive techniques to repair ruptures in the alliance during telepsychotherapy based on the Core Conflictual Relationship Theme (CCRT; Luborsky, 1995) framework. The techniques described here are intended to help therapists during the current COVID-19 pandemic and in other situations in which patients and therapists are required to use telepsychotherapy, for example, patient or therapist relocation, illness, or vacation. Following a brief introduction to the concepts of alliance ruptures, supportive techniques, and the CCRT framework, we demonstrate the proposed techniques with a clinical illustration.

Identifying and repairing alliance ruptures using supportive techniques

The shift to telepsychotherapy can be a growth opportunity for therapists who wish to adopt new techniques and to adapt existing ones to online mode. These techniques include supportive ones, which are particularly important in times of heightened anxiety, loneliness, helplessness, and depression (Leibovich, Front, McCarthy, & Zilcha-Mano, 2019). Supportive techniques, in general, aim to strengthen the patient's ego, enhance self-esteem, and facilitate exploration of emotions, while encouraging higher-level defenses (Appelbaum, 2006; Pinsker, Rosenthal, & McCullough, 1991). In psychodynamic psychotherapy, supportive techniques were shown to improve depressive symptoms through the enhancement of the therapeutic alliance (Leibovich et al., 2019). Supportive techniques include, for example, the therapist demonstrating genuine interest and respect, while choosing to maintain the patient's vital defenses, such as repression or denial of certain emotions or thoughts that help patients in their current struggles; focusing on the here-and-now and on practical issues; noting the patient's gains, supporting the patient's aim to achieve the goals of treatment, and presenting realistically hopeful attitude regarding the

attainability of these goals, and recognition of improvement toward the attainment of these goals. Therapists are advised to show their patients that they like them, believe in their strengths and ability to find solutions, and to work together with the patient as a team toward better self-understanding (Barber & Crits-Christoph, 1996; Book, 1998).

Supportive techniques may be implemented through the theoretical framework suggested by the supportive-expressive (SE) approach (Book, 1998; Leibovich, Nof, Auerbach-Barber, & Zilcha-Mano, 2018). SE psychotherapy is based on a formulation of the patients' CCRT, which includes three elements: a central wish from others (W), a perceived response from the other (RO), and a response of the self (RS) (Table 1). The CCRT is based on the fundamental assumption of psychodynamic theory that people internalize patterns in their early relationships and repeat them in later ones; thus, the purpose of psychodynamic therapy is to widen the repertoire of perceptions and responses. It has been demonstrated that alliance ruptures can be repaired by first identifying the patient's main conflictual interpersonal wish (W), then striving to actualize it in the therapeutic relationship using supportive techniques (Leibovich et al., 2018). Such implementation of supportive techniques has the potential to create a new corrective experience, enabling patients to practice new responses of their selves (RS), and can be instrumental in repairing ruptures in the alliance, both face-to-face and in telepsychotherapy.

Many therapists who are forced to switch to telepsychotherapy appear to assume that the need to use technology can interfere with the development of the alliance, and that they might be less effective in repairing ruptures when these occur (Monthuy-Blanc, Bouchard, Maïano, & Seguin, 2013; Rees & Stone, 2005). Similarly, patients may not be as inclined to attend remote sessions (Deen, Fortney, & Schroeder, 2013). Empirical evidence, however, suggests that patients' ratings of the alliance in telepsychotherapy are at least as strong as in traditional face-to-face treatment across a range of diagnostic groups (Backhaus et al., 2012; Germain, Marchand, Bouchard, Guay, & Drouin, 2010; Simpson & Reid, 2014). These findings suggest that also in telepsychotherapy, therapists can acquire skills that are effective in managing alliance ruptures. Today, when treatments are forced to move to telepsychotherapy, acquiring skills for repairing ruptures remotely is especially critical. The importance of knowledge of how repairing ruptures remotely can be acquired has been noted in the literature before (Beutel, Böhme, Banerjee, & Zwerenz, 2018; Simpson & Reid, 2014).

Table 1. The core conflictual relationship theme (CCRT; Luborsky, 1995) components and their manifestation in the present case study.

Components	Description	Manifestation in case study
Wish (W)	What the patient wanted in their relationship with another person.	Other people will show greater interest in her, care for her, and have faith in her.
Response other (RO)	How the patient believed this other person would respond if the patient were to articulate or act on his/her Wish.	Other people are all self-centered and care only for their own interests.
Response self (RS)	How the patient responded and felt in relation to/based upon the belief of the other person's response.	Sad, tired, hopeless about the future, and avoids interactions or behaviors that have the potential to hurt her.

Identifying and repairing alliance ruptures using supportive techniques in telepsychotherapy

Two steps are involved in repairing alliance ruptures: identifying the ruptures and repairing them (Safran & Muran, 2000). Previous research and clinical practice have shown that unnoticed and therefore unresolved ruptures can lead to deterioration of the alliance and dropout (Eubanks et al., 2019). Confrontation ruptures are easier to detect because they are characterized by overt expression of anger and dissatisfaction (Eubanks et al., 2015), and therefore may be easier to identify in telepsychotherapy. By contrast, withdrawal ruptures can go unnoticed by therapists in telepsychotherapy and face-to-face treatment alike (Eubanks et al., 2018). Withdrawal ruptures can manifest as the patient being laconic, silent, and giving short responses; showing flat, superficial, or detached emotions; changing or avoiding topics; or showing quick agreement. In the transition to telepsychotherapy, identifying ruptures, especially withdrawal ruptures, may be even more challenging. The therapists themselves might feel remote and frustrated for having to connect through a computer screen, and may confuse their feelings with an actual rupture.

Additionally, telepsychotherapy may result in technical difficulties that challenge the identification of ruptures, such as lack of body movement information, unclear facial nuances, lack of adequate sound quality, or video lags due to delay in the Internet connection, which may mask silence length. Ruptures may arise that are specific to telepsychotherapy, such as patients withdrawing because of having difficulty maintaining eye contact through the screen or reading text messages popping up on their computer. Patients can also avoid the work of therapy by doing housework, talking with other people in their surroundings, or attending to their pets during the session.

Despite the special difficulties in identifying ruptures in telepsychotherapy, therapists can use two techniques to enhance their ability to identify ruptures. The first is creating an appropriate setting and basic technical conditions, and the second is paying greater attention to the nuances of the patients' in-session behavior. Before starting telepsychotherapy, the therapist can prepare and make sure the setting and basic technical conditions are clear to the patient. The setting should be a quiet and private space, free from distractions. If this is difficult to achieve or it is not available to the patient, the therapist can help suggest a different setting, such as a car. Several basic technical solutions must be in place to help identify the ruptures in telepsychotherapy, making sure that the patient and therapist both have a stable Internet or phone connection, adequate lighting for the camera, and proper microphones.

The therapist must also attend to the nuances of the patients' in-session behavior, in the characteristics available to them, in order to identify ruptures, especially to identify withdrawal ruptures. For example, if the therapist is unable to see the patient's body movements or if the sound is unclear, greater attention must be paid to other characteristics, such as change in facial expressions or avoidance of eye contact. If the therapist is unable to see the patient or if there is a video delay, special consideration should be given to acoustic measures, such as becoming unresponsive, change in speech rate, unsteady or trembling voice quality, or longer silences (Dolev-Amit, Nof, Asaad, Tchizick, & Zilcha-Mano, in press). Therapists should also be aware of the contribution of the patient's new surroundings to the ruptures rising in treatment. If the patients are in their own home during the session while family members, romantic partners or roommates, are present,

the therapist should pay more attention to topics the patients are reluctant or withdrawn from discussing. For example, this can be identified by more silences or shifting of topics. In addition, the therapists' awareness of their own feelings or reactions in the countertransference may also be a marker that a rupture has occurred (Safran & Muran, 2000). Ruptures can manifest as a feeling of detachment, a wish to avoid the situation or to be someplace else, boredom, pressure to find topics to talk about and to fill the session, or difficulty staying focused on the screen.

Once a rupture in the alliance has been detected in telepsychotherapy, the therapist should use the CCRT formulation to determine whether this is an enactment or a relational theme that is being reconstructed. It may be best to try to discover the patient's wish (W) that does not receive a satisfying response. The reason may be that the new situation and distance in remote treatment creates new opportunities for enactment and disappointment. In telepsychotherapy it is important for therapists to take more time to think about their countertransference feelings and reactions, and try to understand the patient's withdrawal as part of their dynamics and past experiences. The therapist can be inspired by Symington's (1983) concept of "act of freedom," which means that the therapist is looking for an act of freeing himself or herself from the "lasso" of the patient's relational enactment, and letting some new air and space into the therapy. This kind of "Act of Freedom" may be necessitated even more by the shift to telepsychotherapy.

With the transition to telepsychotherapy, the therapist may need to deal more directly with ruptures. To encourage talk about possible ruptures, therapists are advised to initiate a discussion about possible difficulties in the new setting right after the change to the online setting, and to end the first online session with a question about how the patient felt talking online. Actions of this type signal to the patient that the therapist expects difficulties and wants to talk about them. Another technique is to reflect the possible difficulty of the change in the conversation style as being connected to the online change, in a non-judgmental manner, such as "I think our conversation is less fluid today. Do you feel this too?" This technique extends an invitation to notice the changes and deal with possible ruptures (Safran & Muran, 2000).

During the transition to telepsychotherapy if the therapist feels that the patient was hurt by some of the therapist's actions, such as not agreeing to a face-to-face meeting, the therapist should talk about it directly, take responsibility, and allow the patient to express negative feelings, enabling overt negotiation of the alliance. This is particularly crucial because of the physical distance between the two. The therapist can also use supportive techniques that deal with alliance directly, such as discussing treatment goals and movement toward these goals, or admiring the patient's ability and willingness to move into an unfamiliar setting, which can enhance the alliance. Other supportive techniques, such as showing genuine interest and noticing gains, may enable the patient's specific CCRT wish to be better fulfilled in the therapeutic relationship, enhancing the alliance and repairing the rupture indirectly. In telepsychotherapy, the therapist must be more active than usual, taking charge of the session and showing greater interest, so that the patient feels the therapist's presence, to compensate for the missing therapeutic setting (quiet and comfortable room and reassuring physical presence).

In sum, we propose a four-step model for dealing with withdrawal ruptures in telepsychotherapy. In the first step, the therapist should make all the necessary preparations for the patient before switching to the online setting. In the second step, during first

online meeting, the therapist should take time to comment about the change and initiate a conversation about possible ruptures. In the third step, during the remote sessions, the therapist should try to determine whether a rupture occurred. This will be based on cues in the elements of treatment that are available, such as facial expressions, eye contact, acoustic changes, and the therapist's own countertransference feelings.

In the fourth step, the therapist can choose to attend to the rupture directly, or indirectly. The therapist can address the rupture directly, by assuming responsibility or by initiating a talk about the goals and changing tasks of treatment due to the transition to telepsychotherapy. The therapist can also choose to attend to the rupture indirectly, by trying to better fulfill the patient's CCRT wish with indirect supportive techniques, which are adequate for telepsychotherapy, such as showing genuine interest in the patient or pointing out the patients' strengths and gains in dealing with their difficulties, especially during stressful times. The identification of a withdrawal rupture in telepsychotherapy and its resolution can be an opportunity for change and progress in the therapy process, as the following clinical illustration shows.

Clinical illustration

The following clinical illustration demonstrates the identification of ruptures and their resolution using supportive techniques.

Design

The clinical illustration below uses a case study from an ongoing randomized controlled trial (RCT) involving SE therapy for depression (Zilcha-Mano, Dolev, Leibovich, & Barber, 2018). Patients who met inclusion and exclusion criteria received 16 sessions of short-term psychodynamic treatment with either a supportive or an expressive focus. All patients provided informed consent before participating in the study, including agreeing to all treatment sessions being recorded. All background details are disguised to ensure the anonymity of the patient and therapist.

Measures

The following measures were used for the patient's description from the pretreatment assessment: Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967), a 17-item clinical evaluation of depressive symptoms in which patients are assigned an overall score (e.g. depressed mood, feelings of guilt, insomnia); the Inventory of Interpersonal Problems – Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), a 32-item self-report inventory assessing behaviors related to interpersonal problems, in which patients are assigned an overall score and a score for each of eight octants (domineering, vindictive, cold, socially avoidant, non-assertive, exploitable, overly nurturant, and intrusive); the Experience in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998), a 36-item self-report measure assessing attachment orientation, in which patients are assigned a score for two primary dimensions (attachment anxiety, and attachment avoidance); the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), a 12-item self-report measure assessing the therapeutic alliance, in which patients are

assigned an overall score and a score for three subscales (bond between patient and therapist, agreement on tasks and agreement on goals of treatment); and two items from the Post Session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 2001, 2012), the first item indicates whether or not an alliance rupture occurred in the session ("Did you experience any tension or misunderstanding in your relationship with your (therapist/patient) during the session?") and the second refers to the extent to which the rupture was resolved ("To what degree do you feel the problem was resolved by the end of the session?").

Sessions were coded with the Rupture Resolution Rating System (3RS; Eubanks et al., 2015) to assess the ruptures. Coders watched recorded video sessions and detected events of tension or lack of collaboration between patient and therapist. Identified ruptures were coded as a confrontation or withdrawal. Each rupture was rated for clarity as a check minus (a weak or somewhat unclear example of the marker), a check (a solid example of the marker), or a check plus (a very clear, "textbook" example of the marker). All coders received six months of training from an experienced coder. During the coding phase, all coders received weekly supervision to maintain reliability. Inter-rater agreement reliability was .92 for withdrawal and .93 for confrontation.

Patient

Amy is a 21 years old Caucasian student, the youngest child in her family. She felt that her parents were already tired and "worn out" when she was born, and did not have much energy for her, so in her own description, "I kind of grew up by myself." Her immediate reason for coming to therapy was feeling lonely and frustrated for not being able to concentrate on her studies. Amy felt isolated from her friends and family after moving to a new city the year before, to begin her studies. She had just broken up with her boyfriend. She felt that no one in the faculty (teachers and students) knew her or cared about her. For some time, she had been feeling passive, hopeless, and lacking energy. The treatment goals seemed to be obvious to Amy: being less passive in her studies and being less lonely. She reported pretreatment that she was non-assertive and avoidant in her relationships (non-assertive IIP subscale = 14; avoidant ECR subscale = 4.54). Her pretreatment HRSD was 22, indicating severe depression.

Therapist

Terry is Caucasian and is in her 40 s. She holds more than 20 years of experience in psychodynamic therapy, and more specifically 5 years of experience in short-term SE therapy for depression.

Case formulation

Terry conceptualized Amy's CCRT after the first four sessions, as recommended in the treatment protocol (Book, 1998). The CCRT consisted of a wish that other people show greater interest in her, care for her, and have faith in her (W), but instead, it seemed to her that people were all self-centered and cared only for their own interests (RO). She felt sad and tired, hopeless about the future, and avoided interactions or behaviors that had the potential of further hurting her (RS) (Table 1).

Course of treatment

Amy started therapy face-to-face. At the first session she declared that she already felt better, that she decided not to let things affect her so much, began to allocate more time for her studies, started exercising, and signed up again on dating apps. It seemed that starting therapy for the first time encouraged and helped her feel that she was doing something for herself, without letting herself expect that the therapist will be caring or otherwise helpful, so as not to be disappointed once again. Nevertheless, during the therapy sessions Amy was emotionally withdrawn and laconic. In particular, at the start of therapy she denied the importance of interpersonal relationships and of events that were relevant to the work of therapy. An example of such a rupture occurred at session 2. Amy continued to talk about the recent breakup with her boyfriend, but when the therapist showed empathy, saying "You seem to be still upset about the breakup," Amy responded: "I don't really care about him. I'm fine," without adding anything and avoiding eye contact. This exchange was coded using the 3RS as a check plus for a denial and minimal response rupture (Eubanks et al., 2015). The therapist tried to show genuine interest in Amy. She noticed Amy's withdrawal style but did not confront her with a direct interpretation. Instead, she sought to attend to her wish by showing genuine interest, caring, and authentic admiration of her abilities to take care of herself. Amy seemed to respond to these efforts, but she remained laconic, showing evidence of withdrawal ruptures. These dynamics characterized the first half of the therapy (the first eight sessions).

After eight weeks in therapy, as a result of the COVID-19 pandemic, the government imposed social distancing, which ruled out face-to-face meetings. The therapist offered to change over to telepsychotherapy. In session 8 before the change, Amy rated the alliance as WAI = 5.58, and Terry as WAI = 4.41. The switch at session 9 went smoothly. Before the shift, Terry made sure that Amy had a private room, a stable Internet connection, and a working camera and microphone. Amy stayed in her dorm where she felt it was easier for her to continue studying, and since her roommates decided to leave the dorm, she had considerable privacy. She was comfortable using a computer in her everyday life and did not show any uneasiness or concern about the change. Terry conducted the sessions from a private room in her home, and was somewhat worried that her children, who were also home, would distract her, but they did not. Nevertheless, the dynamic of withdrawal evident in the face-to-face sessions was intensified after the transition to telepsychotherapy. Terry asked Amy at the beginning of the session to talk about any discomfort or other feelings related to the change to online therapy, but Amy dismissed her and said she had no problems. The interaction became even more laconic, and Terry found that she was bored and tired. She made an effort to select topics for conversation that would demonstrate her interest in Amy's life. Amy was overly accommodating toward the therapist, in an appeasing manner. She was smiling without a reason during the session, saying "yes" to everything Terry suggested. For example, Amy said "I started talking to a new guy this week. You're probably sick of hearing me talk about this every time." Terry answered "I'm not sick of it at all." Amy responded "I'm kidding, you're always so helpful." This was coded as a check for a deferential and appeasing rupture (Eubanks et al., 2015). Terry could not see whether Amy's body movements showed discomfort, but was able to hear Amy's voice changing as she talked, becoming more cynical, and noticed that she avoided eye contact.

Other types of ruptures that did not manifest in the face-to-face interaction started to evolve. Connecting to Amy through the computer screen made it even less lively for Terry, and new ruptures occurred. Amy started to withdraw even more, and during the session Terry was not sure whether or not Amy was looking at other messages that were popping up on her screen or on her cell phone. She did not maintain eye contact, and Terry could see her eyes were moving across the screen, and could not see her hands. Amy was disengaging from Terry and the work of treatment, which was coded as a check plus for minimal response rupture (Eubanks et al., 2015). Terry tried to attend to the rupture directly, by asking Amy whether she was looking at messages on the computer screen. She tried to sound inviting rather than accusing, but Amy dismissed this attempt by saying she was just taking a second answering her boss that she would get back to him later. After the transition, the alliance ratings did not meaningfully differ from before the transition for both Amy (WAI = 5.58) and Terry (4.58). However, both identified a rupture has occurred, as rated in the PSQ.

After the session, Terry reflected on these ruptures and her unsuccessful attempts to repair them. She thought about the reenactment of the CCRT dynamics and conflict, and was searching for an act of freedom from the enactment (Symington, 1983). Terry wished for something new that would enable her to resolve the recurring withdrawal ruptures as well as those that started to appear as the result of the transition to telepsychotherapy, to enhance the therapeutic alliance. Terry felt that it would not be beneficial to talk to Amy directly about the rupture because Amy might not be aware that something was wrong and feel accused or embarrassed. She was looking for an indirect path to better actualize Amy's wish to be cared for, and to feel others show interest and have faith in her.

The opportunity presented itself at session 10. The session began laconically, as usual, and Terry soon found herself tired, bored, looking at the clock on the computer screen, and feeling stressed that there will not be enough material to fill the session, and she would have to end it soon. Amy was continuing to withdraw. She was silent or minimal in her responses and kept saying that nothing was happening, since she did not go out of her apartment or meet anyone, so she had nothing to talk about. Amy began reporting on her last conversation on the dating app. A week earlier she started a conversation with a guy who seemed promising. But the day before he suggested that since they cannot meet because of the pandemic, although they lived close to each other, they should hold off their conversation until things get back to normal. Amy agreed, and Terry, rather tired and losing hope herself, also agreed that it was a reasonable step. Then Terry felt something rebelling inside her. She felt alive again, and she felt that she could do something different. The following conversation ensued, attesting to her identification of the ruptures and their resolutions using supportive techniques:

Terry: I hear you agree with him. You're probably worried you will get hurt again [validating, trying to explore together Amy's feelings].

Amy: Yes, maybe you're right, there's a right time for everything [withdrawal rupture of deference and appeasement].

Terry: Maybe (not interpreting the defense(. But I feel you might want something else. I feel like helping you go for it, don't just dismiss it by saying it's not so important. It's

super important for you! It drags you down when you don't have it and lifts you up when you do have it [Terry is supporting the patient's treatment goal, and by being caring she also actualizes the CCRT wish].

Amy: Well that's true (smiling).

Terry: It's OK to say this is important for me. You're the kind of person who will go out of their way for her boyfriend, and will invest a lot into the relationship [Terry shows she believes in Amy's strengths].

Amy: I'm not sure he's the kind of guy who will appreciate this kind of investment.

Terry: I think most people appreciate it.

Amy: Well, he did write that he looks for someone caring (said in a livelier tone).

Terry: (smiling) So let yourself be that someone, and if he doesn't appreciate it, move on! You're allowed to want a relationship, it's OK to feel bad that you're alone. It's not natural for a person to be so alone. It's very difficult, and the restrictions now make it much worse [showing genuine respect and validating the difficulties to stress the strengths].

Amy: That's right (looks relieved).

Terry: You're a person who has a lot to give, and there's no reason for you to be on hold now. You're doing so much for this, for finding a relationship, your life is happening now, no reason to wait [recognition of improvement toward the attainment of the goals of the therapy].

Amy: Yes.

Terry: There are a million guys out there waiting for someone like you. Believe me, I personally know a few (smiling) [presenting a realistically hopeful attitude that these goals can be achieved, and humor always helps].

Amy: (laughing, and for the first time raising her head and looking directly at Terry) It's not that I got my expectations high with him [withdrawal rupture of denial].

Terry: I know, but with every promising message the expectation rises, it's just natural [explores emotions together, working as a team].

Amy: Yes, I suppose you're right. I'll get out of my room now and breathe some fresh air.

Terry: You need someone who likes your kind of creativity and caring. If he doesn't appreciate it, then you need someone else [stressing Amy's strengths and hopeful that her goals can be achieved].

Amy: That's right! And he made me more creative. I told you, the messages we sent to each other were not the usual stuff [Amy feels better and shows Terry she believes that Terry takes genuine interest in her].

Terry: That is right. You told me that. You have a chance here.

This exchange demonstrates how the ruptures were identified and repaired in an indirect way, using the CCRT framework and supportive techniques in an online session of telepsychotherapy. Terry noticed the recurring withdrawal ruptures based on the cues that were available to her. She felt the familiar countertransference of being tired, bored, and worried, and she could see Amy's denial and minimal response. She was able to identify the deferential and appeasing ruptures based on Amy's eye movements and acoustic change. Terry used her CCRT formulation to understand the reenactment, in particular the wish that did not receive an adequate response. Terry decided not to confront the rupture directly but work with it indirectly, using a variety of supportive techniques that can be deployed in telepsychotherapy. She was showing genuine interest and respect, without addressing Amy's vital defenses directly. She focused on the here-and-now and on practical issues, without going back to the patient's earlier dynamics and history. She noted the patient's gains, efforts, and improvement in moving to attain the goals of her therapy, supporting and being realistically hopeful about Amy achieving these goals. At this point in the therapy, Terry could genuinely show Amy that she liked her, and that she believed in her strengths and in her ability to cope with the difficult situation she was in. Although Terry was quite active and somewhat directive, and although Amy was far away and alone, Amy seems to have gotten the message that the two were working together as a team. Terry actualized Amy's wish of being cared for and not forgotten. She did so despite Amy's behavior, which rejected these efforts, as manifest in the withdrawal ruptures. Amy appears to have had a corrective emotional experience of being cared for. She became livelier as the interaction developed, and for the first time looked directly at Terry. The WAI improved for both Amy (WAI = 6.16) and Terry (WAI = 4.66) after the session and both identified that a positive resolution had occurred, as rated by the PSQ.

Concluding remarks

The transition to telepsychotherapy requires therapists to work in a new environment, outside their familiar setting, and to acquire new skills. Ruptures often occur in treatment and may be exacerbated during telepsychotherapy because of technical difficulties, dissatisfaction, or disappointment with the limited interaction. A model for rupture identification in remote treatment was demonstrated together with supportive techniques used to resolve the ruptures. This model extends on Safran and Muran's model (1996, 2000) of alliance rupture and repair, adjusting it for the specific difficulties rising in telepsychotherapy. The utility of the CCRT formulation as a basis for thinking about ruptures and about their possible resolutions was at the center of our suggested model. The identification of ruptures and their repair in telepsychotherapy is more difficult than in traditional face-to-face treatment. Our model showed techniques to enhance the ability to identify ruptures and supportive techniques aimed at resolving them. The model and techniques presented can help therapists in the transition to telepsychotherapy during the current COVID-19 pandemic as well as in other cases in which face-to-face treatment is not possible.

The model suggested in this article for identifying and repairing ruptures in telepsychotherapy is an addition to Safran and Muran's (1996, 2000)) classical model of identifying and repairing ruptures in the therapeutic alliance. It adds to the currently suggested models that address rupture identification and repair in given therapeutic situations or populations,

such as the Identification Countertransference Empathy Freedom model (ICEF; Leibovich et al., 2018), which serves to enhance the alliance with depressed patients using supportive techniques, or the Child Alliance Focused Approach (CAFA; Nof, Dolev, Leibovich, & Zilcha-Mano, 2019), which is designed to enhance alliance and repair ruptures in children's therapy. These models, as well as the one suggested above, combine evidence-based principles with knowledge gathered from clinical practice, and bridge the gap between clinical practice and research. Ruptures in the alliance are problematic because they may lead to deterioration in the therapeutic process and to dropout, but they can also provide an opportunity for growth and development in the therapeutic process. As Leonard Cohen said, "There is a crack in everything. That's how the light gets in."

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

The research was supported by a grant from the Israel Science Foundation (Grant no. 186/15).

Notes on contributors

Tohar Dolev-Amit is a Doctoral Candidate on a president's scholarship in the University of Hafia, Israel, and a researcher and lab manager in Dr. Sigal Zilcha-Mano's lab. Her research focuses on processes of therapeutic change, and more specifically on the effect of the patient's interpersonal style on the alliance, ruptures and resolutions and outcome of treatment.

Dr. Liat Leibovich is a licensed clinical psychologist and supervisor in Israel, working in "Ahava" children's home and in private practice, and lecturing at the Department of Clinical Psychology, in Ruppin Academic Center. Her research focuses on psychodynamic techniques and especially on the role of supportive techniques in enhancing the alliance and contributing to interpretive techniques in psychodynamic psychotherapy for depression.

Dr. Sigal Zilcha-Mano is an Associate Professor of Clinical Psychology and heads the Psychotherapy Research Lab in the Department of Psychology, University of Haifa. She is Associate Editor of the Journal of Counseling Psychology, and on the editorial board of Journal of Consulting and Clinical Psychology, Journal of Clinical Psychology, Psychotherapy, and Psychotherapy Research. She is a licensed clinical psychologist.Dr. Zilcha-Mano is the recipient of several career awards, including the International Society for Psychotherapy Research Outstanding Early Career Achievement Award, the American Psychological Foundation's 2019 Division 29 Early Career Award, the International Society for the Exploration of Psychotherapy Integration New Researcher Award, and the Dusty and Ettie Miller Fellowship for Outstanding Young Scholars. She has received many research grants to support her work, including three research and equipment grants from the Israel Science Foundation, the U.S.-Israel Binational Science Foundation Grant (BSF), the JOY Ventures: Innovative Nero Wellness Grant, the MIT-Israel Zuckerman Award, the Society of Psychotherapy Research Grant, the Norine Johnson Psychotherapy Research Early Career Grant, Society for the Advancement of Psychotherapy, APA, and the Charles J. Gelso Grant, Society for the Advancement of Psychotherapy, APA. Dr. Zilcha-Mano has published over 85 peer reviewed papers in the past 6 years focusing on psychotherapy research and precision medicine in leading journals in these fields.

References

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment*, *55*, 521–536.

Andersson, G., Paxling, B., Roch-Norlund, P., Östman, G., Norgren, A., Almlöv, J., … Silverberg, F. (2012). Internetbased psychodynamic versus cognitive behavioral guided self-help for generalized anxiety disorder: A randomized controlled trial. *Psychotherapy and Psychosomatics*, *81*(6), 344–355.

Appelbaum, A. H. (2006). Supportive psychoanalysis psychotherapy for borderline patients: An empirical approach. *The American Journal of Psychoanalysis*, *66*(4), 317–332.

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., … Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services*, *9*(2), 111–131.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a therapist adherence/competence rating scale for supportive-expressive dynamic psychotherapy: A preliminary report. *Psychotherapy Research*, *6*(2), 81–94.

Beutel, M. E., Böhme, K., Banerjee, M., & Zwerenz, R. (2018). Psychodynamic online treatment following supportive expressive therapy (SET) therapeutic rationale, interventions and treatment process. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, *64*(2), 186–197.

Book, H. E. (1998). *How to practice brief psychodynamic therapy: The core conflictual relationship theme method*. Washington, DC: American Psychological Association Press.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). New-York, NY: Guilford Press.

Deen, T. L., Fortney, J. C., & Schroeder, G. (2013). Patient acceptance of and initiation and engagement in telepsychotherapy in primary care. *Psychiatric Services*, *64*(4), 380–384.

Dolev-Amit, T.*, Nof, A.*, Asaad, A., Tchizick, A., & Zilcha-Mano, S. (in press). *The melody of ruptures - identifying ruptures through acoustic markers*. Unpublished Manuscript.

Eubanks, C. F., Lubitz, J., Muran, J. C., & Safran, J. D. (2019). Rupture Resolution Rating System (3RS): Development and validation. *Psychotherapy Research*, *29*(3), 306–319.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2015). *Rupture resolution rating system (3RS): Manual*. Unpublished Manuscript, Mount Sinai-Beth Israel Medical Center, New York.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy*, *55*(4), 508–519.

Germain, V., Marchand, A., Bouchard, S., Guay, S., & Drouin, M. S. (2010). Assessment of the therapeutic alliance in face-to-face or videoconference treatment for posttraumatic stress disorder. *Cyberpsychology, Behavior, and Social Networking*, *13*(1), 29–35.

Hamilton, M. A. X. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, *6*(4), 278–296.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, *56*(6), 885–892.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology*, *36*(2), 223–233.

Kingsley, A., & Henning, J. A. (2015). Online and phone therapy: Challenges and opportunities. *The Journal of Individual Psychology*, *71*(2), 185–194.

Leibovich, L., Front, O., McCarthy, K. S., & Zilcha-Mano, S. (2019). How do supportive techniques bring about therapeutic change: The role of therapeutic alliance as a potential mediator. *Psychotherapy*. doi:10.1037/pst0000253.

Leibovich, L., Nof, A., Auerbach-Barber, S., & Zilcha-Mano, S. (2018). A practical clinical suggestion for strengthening the alliance based on a supportive–expressive framework. *Psychotherapy*, *55*(3), 231–240.

Luborsky, L. (1995). Supportive-Expressive dynamic psychotherapy of depression: A time-limited version. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders* (pp. 41–83). New-York, NY: Basic Books.

Monthuy-Blanc, J., Bouchard, S., Maïano, C., & Seguin, M. (2013). Factors influencing mental health providers' intention to use telepsychotherapy in first nations communities. *Transcultural Psychiatry*, *50*(2), 323–343.

Muran, J. C. (2019). Confessions of a New York rupture researcher: An insider's guide and critique. *Psychotherapy Research*, *29*(1), 1–14.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2001). *Patient and therapist post-session questionnaires, version 2001*. New-York, NY: Beth Israel Medical Center.

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2012). *Patient and therapist post-session questionnaires, version 2012*. New-York, NY: Beth Israel Medical Center.

Nof, A., Dolev, T., Leibovich, L., & Zilcha-Mano, S. (2019). If you believe that breaking is possible, believe also that fixing is possible: A framework for rupture and repair in child psychotherapy. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *22*, 45–57.

Pinsker, H., Rosenthal, R., & McCullough, L. (1991). Dynamic supportive psychotherapy. In P. Crits-Christoph & J. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 220–247). New-York, NY: Basic Books.

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice*, *36*(6), 649–653.

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

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

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

Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, *22*(6), 280–299.

Symington, N. (1983). The analyst's act of freedom as agent of therapeutic change. *International Review of Psycho-Analysis*, *10*, 283–291.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(3), 207–210.

Zilcha-Mano, S., Dolev, T., Leibovich, L., & Barber, J. P. (2018). Identifying the most suitable treatment for depression based on patients' attachment: Study protocol for a randomized controlled trial of supportive-expressive vs. supportive treatments. *BMC Psychiatry*, *18*(1), 362–370.