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Chapter

Perspective Chapter: Therapeutic Alliance, Rupture and Repair in Group Therapy

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Abstract

This chapter contains an overview of the therapeutic alliance including the purpose and importance of therapeutic alliance as well as recent research that provides knowledge on therapeutic alliance within the group therapy context. This chapter will also take a deep dive into understanding the rupture-repair model, its' connections with therapeutic alliance, and provide clinical examples of what a rupture and repair may look like in group therapy. Finally, this chapter discusses cultural considerations and includes clinical examples on rupture and repairs where individual and cultural differences are important. In conclusion, therapeutic alliance has been identified as a key contributor to positive outcomes for group therapy clients. While ruptures are expected to occur during therapy, It is important to note that both the rupture and the repair equally effect the therapeutic alliance as well as the outcome of treatment. Outcomes to therapy that align with a strong therapeutic alliance include reduced symptoms, client retention, improved outlook on life, and an improved occupational and interpersonal functioning. Outcomes of therapy associated with a successful repair involve a decrease in anxiety and depressive symptoms, increase in daily living activities, an increase in empathy for their group members, and stronger therapeutic alliance among the group.

Keywords: therapeutic alliance, repair, rupture, group therapy, cultural competence

1. Introduction

Many professionals consider therapeutic alliance to be a key hallmark of successful therapy. The quality of the working relationship or therapeutic alliance between the therapist and client is most beneficial when a strong bond is present, and the goals and tasks of therapy align. The core of exploring and understanding the therapeutic alliance is examining the client's attitude towards the therapist and the therapist's ability to engage and relate to the client. The two must mutually agree and collaborate on the goals and tasks of therapy, which takes understanding on both parts. Cultural competence plays an important role in the understanding process. Information must constantly be reviewed and evaluated for accuracy due to differences as well as similarities and how those experiences may or may not affect understanding.

This chapter explores the dynamics of therapeutic alliance in a therapeutic group setting. In a group setting the relationship or alliance exists within the whole group and the therapist leads the group through the therapeutic process.

In a group setting, there are many personalities to manage and to attempt to bring cohesion to the environment. When there is a breakdown in the alliance process, this is known as a rupture. Ruptures are a part of the process for both individual and group therapies. In a successful therapeutic alliance, the therapist and client, or group members can successfully resolve any tension or breakdowns in communication And successfully navigate difficulties in the collaboration of goals and tasks. If the rupture is not repaired correctly then it can lead to poor outcomes in therapy. We explore the types of ruptures that can occur as well as strategies to repair those ruptures correctly. Clinical examples are used to illustrate interventions used to manage ruptures and repairs to create a strong therapeutic alliance with group members.

2. Therapeutic alliance

There is a breadth of research about the benefits of alliance within therapy [1, 2]; Therapeutic alliance refers to the connection a therapist has with their clients and encapsulates a degree of trust and collaboration that sets the stage for future sessions [3]. More specifically, therapeutic alliance refers to the genuinely developed connection between therapist and client, and the degree of agreement and commitment to treatment goals used in treatment [4, 5]. A strong alliance exists when there is a strong foundational relationship that identifies each person's role in the relationship, and both agree on the goals and tools to be used.

Therapeutic alliance has emerged as one of the central contributors to positive outcomes for clients in therapy [3, 6]. The term therapeutic alliance was first mentioned by noted psychoanalyst Sigmund Freud and has since come to reflect Bordin's model, which emphasizes the need for clarity and collaboration [5]. A strong therapeutic relationship reflects the degree of agreement to working towards the mutually agreed upon treatment goals and clarifies the roles and expectations for both client and therapist [7].

Mental health professionals establish alliances with clients by providing space for vulnerability, conveying empathy, and remaining adaptable [8, 9]. Developing good therapeutic relationships requires working with the client to determine their goals while providing a judgment-free space. Additionally, studies have shown that a strong therapeutic alliance includes mutual agreement on the goals and tasks, and a willingness to make changes for the client's benefit [5, 8, 9].

2.1 Working towards alliance

Psychotherapists build strong therapeutic or working alliances with clients by establishing a sense of mutual respect, trust, and safety through social interactions [10]. Establishing and maintaining this connection requires the therapist to engage in an authentic working relationship geared towards helping the client reach specific, pre-identified goals for psychotherapy [11]. A strong therapeutic alliance exists between therapist and client when the client can express vulnerability openly [11].

The following example interaction illustrates how Joe, the therapist leading a group with the goal of developing effective communication builds alliance with the group by discussing individual goals during the first session [5].

Joe: Hello everyone and welcome to our first group session on developing effective communication skills. I'd like to start with everyone introducing themselves and giving a brief description of why you are here and what is your goal for becoming a part of this group.

Chris: Hello, my name is Chris and I'm here to improve my communication skills with the goal of communicating more effectively with my wife.

Kathy: Hi everyone. My name is Kathy and I decided to join the group so I could work to communicate more efficiently in my workplace.

Alice: Hi! My name is Alice, and I am here to work on my communication skills with the goal of repairing and improving my relationship with my adult daughter.

Although this interaction seems inconsequential, Joe knows how important it is and the impact it can make on therapeutic outcomes to develop therapeutic alliance with each individual in the group. Agreeing on the goals of treatment is one of the three essential elements that make up the therapeutic alliance [5].

2.1.1 Therapeutic alliance interventions

Interventions for establishing and maintaining therapeutic alliance in group psychotherapy include creating gender-specific groups, encouraging the formation of working relationships among members, treatment type, providing treatment options, words of encouragement from the psychotherapist-leader, and introducing mindfulness-based interventions [12–14].

In a systematic review of articles addressing therapeutic alliance, group cohesion, empathy, and goal consensus/collaboration in psychotherapeutic interventions, researchers found significant independent relationships between cohesion and rapport with positive treatment outcomes [13]. They also found studies that reported slightly increased collaboration was related to successful outcomes [13, 15]. However, a review of studies about collaboration in group psychotherapy found that this element may have an impact on treatment outcomes distinct from therapeutic alliance. The most notable impact on treatment outcomes were for those who were identified as being at risk for the likelihood of negative outcomes early on in treatment. The formal feedback during the collaboration helped to change the client's perception of change, motivation for treatment, the therapeutic relationship, and increase social support system [16].

2.2 Factors that affect therapeutic alliance

The climate of the relationship may have more impact on alliance building in group therapy than individual therapy [1, 14]. A meta-analysis of studies examining therapeutic alliance in group therapy and outcomes found a strong correlation specifically between the group leader-therapist and group members [1]. In other words, they found that the therapist's alliance with each group member was connected to their positive treatment outcomes [1]. However, when comparing the effects of alliance in group therapy compared to alliance in an individual therapy setting, results showed a slightly weaker for outcomes in group therapy. Though group therapy was found to have a slightly weaker effect on outcome than individual therapy, difference in the effect could be explained by the complex relationships that exist in group settings [1].

Another study found that individuals in group therapy pay more attention to the overall quality of their relationships with others in the group rather than everyone's

assigned roles as member or leader [17]. Additionally, researchers found that the other versus self-focus factor present within group psychotherapy also influences therapeutic alliance building [18]. Meaning, the more members are interacting and focusing on the presenting concerns of their fellow group member, the stronger the group alliance will become.

The therapeutic alliance between group leaders, or psychotherapists, and group members, or clients, was found to be related to treatment outcomes in a Swedish study by Von Greiff and Skogens [19]. They examined positive changes in clients attending a group therapy program for alcohol and substance use. Clients' responses about acceptance, trust, confidence, and partnership revealed two themes identified as: 'treatment staff' and 'treatment group' [19, 20]. These themes align with the principles and goals of therapeutic alliance where the leader and its group members have an influence on treatment outcomes. A follow-up study by Von Greiff and Skogens [20] exploring the individual differences underlying clients' descriptions of alliance in a substance use psychotherapy group found that the social roles of clients impacted the group's cohesion. This study also found that race/ethnicity, social class, and particularly gender, can play a role in the psychotherapist-leader and client-group member relationship.

2.3 Treatment outcomes

Numerous studies have found a consistent link between therapeutic alliance and positive treatment outcomes for individuals in psychotherapy [21–23]. Specifically, the quality of the working alliance between therapist and client has been linked to successful treatment for a diverse array of clients, presenting problems, and treatment modalities [6, 21]. Four meta-analyses on therapeutic alliance conducted over two decades revealed a significant correlation between a strong working alliance between client and therapist and successful outcomes [21, 24, 25]. Although these studies examined alliances within the context of individual psychotherapy, a strong therapeutic relationship is similarly necessary for couples and group psychotherapy.

Successful outcomes connected to therapeutic alliance in psychotherapy include improved client retention, reduced symptoms, improved occupational and interpersonal functioning, and an improved outlook on life [22]. Researchers have examined the relationship between the working alliance of psychiatrists and patients and treatment outcomes [26]. Successful outcomes were evidenced by reported increased patient happiness with treatment, adherence to medication and keeping set appointments [22, 26]. Another study on therapeutic alliance between psychiatrists and patients with bipolar disorder resulted in fewer negative beliefs towards medication, diminished stigma towards bipolar disorder, and fewer manic symptoms [27]. These improved treatment outcomes are also connected to therapeutic alliance with psychotherapists.

Research focused on therapeutic alliance within group psychotherapy, or cohesion, has focused on various types of group relationships. One focus has been on the connection one member has with another member [1, 20, 28]. Findings show that individual relationships or working alliances between group members and the group leader play a significant role in group success [20, 28]. The relationship has more importance than the roles in the group.

2.4 Recent developments and future research

Though providing therapy online has existed for over 20 years, many mental health professionals first experience with teletherapy began during COVID-19.

Major reasons contributing to the resistance on doing therapy online include lack of experience, lack of training, unsuitable equipment, and difficulty managing ethical challenges. A recent study was conducted to understand the perception therapists had on building group therapy alliance online. Results showed that group therapeutic process, therapist comfort, and challenges predicted outcomes [29]. More specifically, the higher amount of therapeutic processes as well as therapist comfort level with online therapy, and the lower number of therapeutic challenges, the better the outcome. Another discovery was that group therapists reported lower satisfaction and comfort towards online therapy when comparted to in-person groups. Finally, this study reported that working through conflict and avoidance was more complicated for online groups. Even with complications, therapist continue to utilize technology to provide group therapy as even with these complications, it is evident the therapeutic processes found in face-to-face groups is also present in online groups.

Even with the breadth of research that exist on the topic of therapeutic alliance, large gaps in literature remain. Future research in this area could continue to the work of obtaining individual responses on clients and therapist to better understand how the alliance is being built, the nature of the alliance, and the overall outcomes of the therapeutic process in a qualitative nature. Future research could also lean towards a deeper investigation on the relationship between the therapeutic alliance and outcomes for specific diagnosis. Lastly, there is a lack of research focusing the culturally appropriate therapeutic alliance interventions.

3. Rupture and repair

Sometimes the communication and goals of the therapeutic approach are not aligned, and a rupture may occur in the therapeutic alliance. Any moments or period of times where breakdowns in the therapeutic alliance occur is considered to be a rupture. A rupture can be anything from a client disliking or disagreeing with something said, to a client not feeling that they are in a safe space where their deepest feelings and thoughts are free of judgment. A rupture can also include moments where a client withdraws when something is not said or addressed appropriately.

Ruptures and repairs are very common in sessions and can occur more than once during a session. Eubanks et al. [30] describes the process in which a rupture is repaired as a resolution process. This process allows the clients and therapist to work together to create therapy goals. The rupture should be addressed directly once it has been identified. Therapy cannot continue successfully if the therapeutic alliance is poor for long periods of time. The therapist may choose strategies like revealing their experience of the rift in the group or starting a new task [30]. Rupture resolution has been found to repair the harmful impact the experience may have brought on and repair the working alliance [31]. If a rupture and repair event is handled correctly, it helps to strengthen the relationship create a deeper bond. The rupture and repair event also gives insight into the client's interpersonal style, areas of defensiveness, and ability to handle conflict.

In a study conducted on clients with post-traumatic stress disorder, the researchers identified that ruptures in alliance were quite common (46%) [32]. As stated earlier, the therapeutic alliance can be a key factor in therapeutic outcomes for clients. As we understand what a rupture is in the context of a therapeutic relationship, we must also consider how our clients may feel if there is a rupture that is not repaired between

the client and therapist [32], suggesting that the experience of an unrepaired rupture relates to poorer PTSD treatment outcome. Gersh et al., [33] identified a significant relationship between the time of the rupture in the therapy process. This study identified, in clients with borderline personality disorder, early treatment ruptures were associated with poor outcome whereas greater late treatment resolution was associated with better outcomes.

In this clinical example, Joe, Chris, Kathy, and Alice to show a rupture in a communication skills group setting evidenced by the client becoming defensive and rejecting the intervention [30].

Joe and Alice are discussing her fractured relationship with her adult daughter. Joe asks Alice if she was able to use the new communication skills they had discussed last week to attempt to resolve an argument she had with her daughter. Alice answers that she has not talked to her daughter this week. Joe asks, "Isn't one of your major goals for attending this group to repair your relationship with your daughter? Is there a reason why you chose not to reach out to your daughter this week?" Alice becomes visibly agitated and says, "I don't see how the new skill will help anyway. I'm not really sure why I'm here anymore. I don't appreciate you judging me, and I am not even the one who should be trying to repair the relationship. She is the one who ruined our relationship to begin with!"

3.1 Repair interventions

There have been a few interventions that therapists can use to repair alliance ruptures which center around the rupture and resolution model created by Safran and Muran [34]. Safran and Muran [34] stated that the interventions depend on metacommunication of the current situation. They referred to metacommunication as the act in which the therapist is constantly mindful of the client-therapist action. Safran and Muran [34] contributed to resolving therapeutic ruptures by creating direct and indirect interventions therapists can use. Direct interventions are considered as interventions where the client is actively engaged and aware of the intervention. Conversely, an indirect intervention are interventions that affect therapeutics alliance and covert in nature. Safran and Muran [34] suggested the following rupture resolution strategy model (see **Figure 1**).

A1a. Therapeutic Rationale and Tasks: This intervention consists of outlining or repeating the rationale of treatment [34]. If there is a rupture, therapists can check with clients to ensure they understand the goals and rationale of treatment and render explanations for clarity. Therapists can do this by employing therapeutic tasks/exercises that can help clients process therapeutic change.

A1b. Interpersonal Themes, Disagreements, and Tasks: Related to the goals and tasks of therapy, a client may disagree with the therapist, and it causes them to unintentionally process and explore interpersonal matters that may be affecting their treatment.

A2a. Clearing Misunderstandings: The therapist can clarify any misunderstanding a client may experience from therapy. This can look like the therapist helping the client resolve why they may feel a sense of discomfort.

A2b. Interpersonal Themes: Similar to A1b., this relates to how internal processes related to interpersonal matters can affect the bond between therapist and client.

B1a. Changing Goals and Tasks: The therapist works to change goals and tasks that are more relatable to the client(s) that that carry the possibility of increasing their willingness to participate in other tasks that more closely align with the therapist's goals for the group.

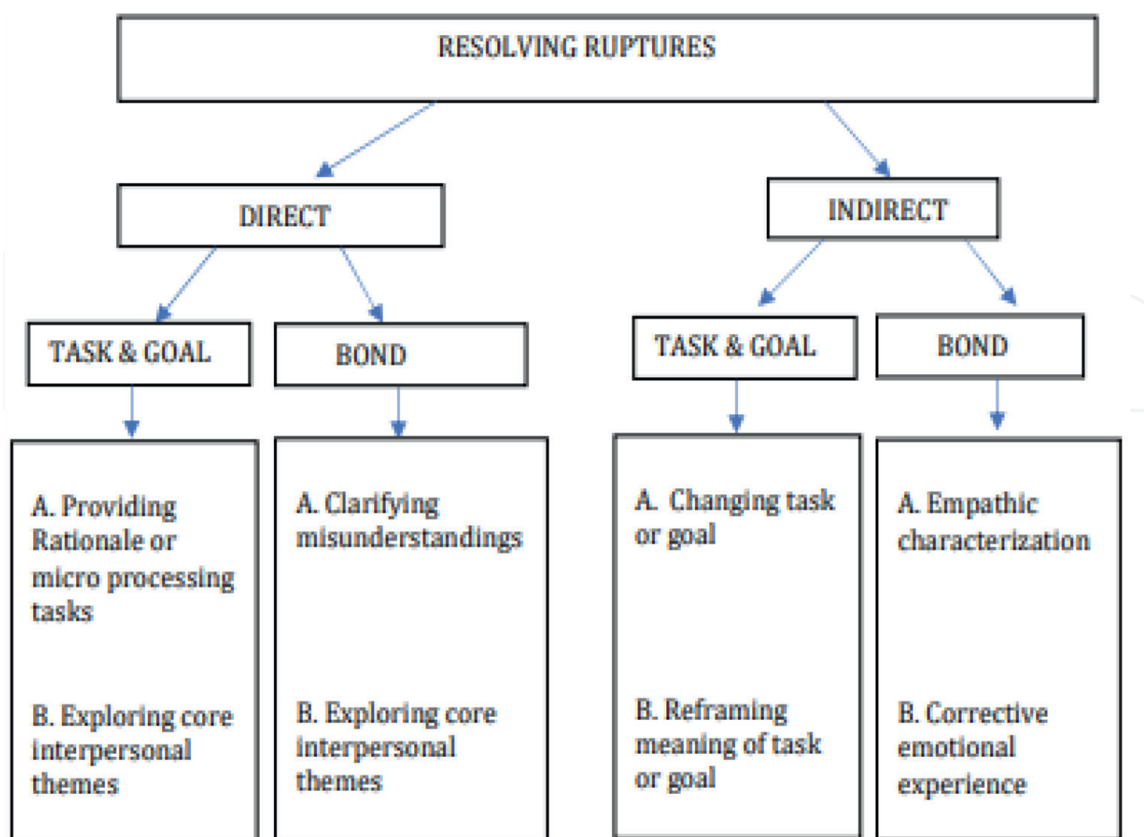

Figure 1.
Therapeutic alliance intervention strategies [32].

B1b. Reframing Goals and Tasks: This intervention involves reframing the goals and tasks to increase meaning and purpose for the client and increase the client's motivation to engage in the interventions.

B2a. Empathy: The therapist can take an empathetic approach and reframe the rupture in a positive outlook.

B2b. Emotional Experiences: The therapist can implicitly address the connection element of an alliance in a way that offers a different, beneficial interpersonal experience for the client.

Their goal in creating these strategies were to clear any misunderstandings among the group members and therapist, to adjust any goals and tasks of the group if deemed necessary, and to justify an intervention.

3.2 Treatment outcomes

Effective rupture resolution can impact the group, and other positive outcomes can be found [37]. Such positive outcomes include lessened anxiety and depressive symptoms, increase in daily living activities, and can lead to a stronger therapeutic alliance among the group. The group is provided with the tools necessary to move forward in the therapeutic process by sympathizing with other clients' issues and can lead the individual to see their negative self-appraisal of their internal beliefs [36].

In this repair example, Joe links Alice's defensiveness to the larger interpersonal communication patterns that have caused her problems in her past relationships [30] and works with Alice so she can recognize these patterns and develop alternative communication.

Joe takes a moment and nods. Joe says, "I assure you that my intention was not to judge you. I am curious, though, do you think that becoming defensive in the past has impacted your relationship with your daughter in a negative way?" Alice thinks about this carefully and says, "our last argument ended with me feeling judged and getting defensive with my daughter." Joe nods again and asks, "why do you feel the need to defend yourself in these situations? Are there other ways you can communicate what you need from the conversation without becoming defensive?"

3.3 Recent development and future research

Although there have been developments in psychotherapy research and practice with individuals, research in alliance ruptures and repairs regarding group psychotherapy is behind [37]. The challenge of research in groups is that the group structure is more complex than individual therapy. Group therapy offers a complicated set of interactions between members of the group, members to members, and group member to the therapist unlike individual therapy [36]. Unique to group therapy, interpersonal relationships and how they learn from one another is a factor to consider [18, 38]. It has been suggested that group psychotherapists can create a safe therapeutic environment by encouraging members who have experienced ruptures due to their interpersonal disregards (bitterness, intrusiveness, etc.) to bring the issue to the group, reflect on the ruptures impact on themselves and the rest of the group, and to learn positive ways to interact with the group members and therapist [18, 38]. A limited number of studies have investigated alliance in group therapy and no studies have explored the rupture and repair processes in real-time but instead have focused on alliance ratings within the group [37]. One current study by Garceau et al. [39], evaluated the usefulness and practicability of the Rupture Resolution Rating System (3RS) within a group psychotherapy context. This scale was used to explore whether and how the 3RS could apply to group therapy with a specific goal of assessing the interactions that occur in group therapy. Other goals included helping group therapists to better identify and repair rupture, informing research on the usefulness of managing ruptures and repair as they happen. Lastly, this study sought to identify possible modifications needed to make the 3RS compatible for the use of group therapy [39].

The 3RS is an observer-rated instrument system that is used to code ruptures and repairs in the individual psychotherapy context through videos or transcripts. The 3RS system counts the frequency in which there are withdrawal ruptures or confrontation ruptures. Withdrawal ruptures can look like the client "shutting down" or disengaging. Confrontation ruptures can look like the client challenging or controlling the therapist, or by confronting their frustrations. Once the codes are counted and rated, the session is then given an overall rating regarding the ruptures impact, how the ruptures were repaired, and the impact the therapist made on the ruptures [30, 40]. The instrument does not code every disagreement between the therapist and client as a rupture if the therapist and client acknowledge and discuss the rupture together [39]. As of this study, no other research has been conducted on the efficacy of using the 3RS system in a group psychotherapy setting.

4. Cultural considerations

To enhance group alliance, members and the group leader need to understand one another. Cultural differences play a role in the dynamics of understanding and

building mutually agreed upon goals and tasks. Cultural competence was a term first introduced in 1989 by Dr. Terry Cross titled A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed [41]. This piece of literature influenced the next generation of studies that investigated the impact of culture in systems of care. Since Cross [41], the integration of cultural competence into theoretical orientations, interventions, research approaches and methodologies has been expanded to more accurately address the impact of culture on outcomes [42–46].

The multicultural movement has been explained as the fourth major force in psychology behind psychoanalysis, behaviorism, and humanism [47]. The multicultural movement was developed in response to research that demonstrated mental health disparities among racial and ethnic minority groups [48]. In recent years, the exploration and investigation from the multicultural movement has required additional development and growth from clinicians. This growth requires a shift in the language of cultural competence into what is now understood as the framework of multicultural orientation [49]. The multicultural orientation framework centers three core concepts: Cultural Humility, Cultural Comfort and Cultural opportunities. Cultural humility includes recognizing that power differences exist between therapist and client on multiple levels, recognizing that these power differences include the power to define what is important and salient for others. The cultural humility framework also emphasizes the importance of understanding cultural differences influence assessment, diagnosis, treatment, and research [50].

Cultural comfort and cultural opportunities, the second and third core concept, are considered to be the behavioral representation of cultural humility. Cultural opportunities are indicators during therapy that provide an opportunity for the client's cultural identity to be explored [49]. These moments are usually initiated by the client and can involve their values and beliefs. Only when appropriate the therapist can also initiates a cultural explorative conversation. It is these conversations that lean into the concept of cultural comfort. Cultural comfort is defined as the mental and emotional experience therapist experience before, during, and after engaging in a cultural opportunity with their client. More specifically, cultural comfort is regarded as feeling open, calm, and present while also noting and accepting discomfort during culturally sensitive exchanges [49].

Hal et al., 2016 in their review of meta-analysis on cultural adaptations of psychological interventions found that, "culturally adapted interventions would produce greater reductions in psychopathology than another intervention or no intervention was supported." [51]. Hal et al., demonstrates the relationship between adapting or shifting interventions improves client psychopathology [51]. For example, a client may curse, or use swear words while responding during a group therapy session. Cursing can be an expression of the client's culture, experience and cursing can be an expression of culture[52]. The cultural responsiveness and humility of the counselor can provide an open stance to allow the client to communicate in the way that feels most comfortable to them [49]. This openness to allow the client to communicate in their own voice provides opportunity for deeper connection and improves the therapeutic alliance [53, 54].

The following clinical example illustrates a rupture where individual and cultural difference were important to attend to in a group setting as evidenced by a group member withdrawing from the group and from the work of therapy [30]. *Joe is a Black male therapist and is the leader of the group. The group is focused on developing effective communication skills. The group members include Chris, Kathy, and Alice. Chris is a 42-year-old White male. He joined the group with the goal to communicate more*

effectively with his wife. Kathy is a 37-year-old Black female. She became a part of the group to learn to communicate more efficiently in her workplace. Alice is a 53-year-old White female. Alice joined this group with the goal of developing her communication skills to assist in improving her relationship with her adult daughter.

In this session, Joe, Chris, and Kathy are engaged in a group discussion. Kathy brings up an interaction she had at the airport earlier in the week. She expresses frustration because a security guard put his hands in her hair with no warning when she was going through airport security. Kathy expresses that this practice is discriminatory, dehumanizing, and disrespectful. The group can see that Kathy is visibly frustrated by this interaction.

Chris asserts, "Airport security searches everyone. I don't see how this practice is evidence of discrimination. They are just trying to keep us safe while flying." Chris then changes the topic to discuss an experience that he encountered this week that he was wanting to discuss with the group. Joe does not address this change in topic nor how Kathy's concerns are dismissed in this interaction. Kathy visibly withdraws from interactions with the group as the group continues to discuss how they used different communication skills throughout the week. This goes on for the rest of the session and this rupture is not addressed by Joe. Thus, Kathy feels unheard and invalidated both by other group members and by Joe, the facilitator of the group.

4.1 Repair

Though the research on repair within black, indigenous, and people of color (BIPOC) is scarce, the existing research does confirm engaging in the repair resolution process is integral to the rupture process within BIPOC population. A study completed by Yeo and Torress-Harding, found that microaggressions have a significantly negative effect on the therapeutic alliance [35]. Yeo and Torress-Harding also found that when therapist recognized, acknowledged, and invited a discussion of a rupture, where the therapist committed a microaggression towards the client, the therapeutic relationship was positively impacted [35]. Additionally, the participants emphasized a need for therapist to be more flexible in their approach, empathetic, and to increase their cultural sensitivity as well as knowledge.

The communication skills group that we observed in our earlier clinical example is meeting for their next session. In this example, Joe works to repair the rupture by acknowledging his contribution to the rupture [30] and apologizing for his role in the rupture. Joe also uses appropriate self-disclosure to bring discriminatory and uncomfortable search practices to the forefront of the conversation. Chris follows suit and also apologizes for causing the rupture by invalidating Kathy's experience. *Kathy is still actively withdrawn from the group, giving short answers only when necessary. Joe notices this and addresses his observations to the group, letting Kathy know that he has noticed her withdrawing from the group. It is clear that Kathy is visibly hesitant to answer, but after some time she says, "I was discussing what happened at airport security last session and my experience was dismissed by Chris." Joe says, "I'm sorry that your experience was overlooked last session and I apologize for not helping to maintain focus on your encounter." Joe looks at the group and asks, "has anyone here experienced discriminatory or even uncomfortable practices during a security procedure at an airport or elsewhere?" Chris and Alice shake their heads. Joe discloses, "I get 'randomly' searched frequently when I fly. I've never had anyone touch my hair in security, though. These experiences are not the same, but my experience does help me to be more empathetic regarding your incident. It is important to acknowledge that the intersection of your identity as a Black female isn't one that is shared by anyone in this group, and it is important for us to remember that when we*

DOI: http://dx.doi.org/10.5772/intechopen.110700

are discussing different experiences. Chris, do you have any thoughts on the matter?" Chris takes some time to consider and then apologizes for dismissing Kathy's experience. Chris says, "I'm sorry that I didn't stop to think about how that experience made you feel. I also brushed off your assertion that the practice is discriminatory. Like Joe, I have never had my hair searched at airport security or anywhere else. Unlike Joe, I have never been randomly searched at airport security either."

A key role in the therapeutic relationship is modeling the behavior that helps our clients tune in to and grow from the rupture and repair model [55, 56]. The relationship we have with our clients is both a reflection of their interactions with the outer world and a model for the type of behavior we wish to see our clients represent during and after the therapeutic process. The rupture-repair process in therapy better equips our clients with the ability to learn how to react, structure and respond to ruptures in other areas of their life. As helping professionals, clinicians have a responsibility to continue to develop our ability to understand various presentations of symptoms, diagnosis, and interventions accurately and critically.

5. Conclusion

The focus of this chapter is on understanding the role therapeutic alliance plays in group therapy. When a breakdown in the therapeutic alliance occurs, it must be addressed appropriately. This process is known as rupture and repair. The following are key areas to take away from this chapter.

- Therapeutic alliance has emerged as one of the central contributors to positive outcomes for clients in therapy. Having a strong therapeutic relationship reflects the degree of agreement in working towards the mutually agreed upon treatment goals and clarifies the roles and expectations for both client and therapist.

- Successful outcomes connected to therapeutic alliance in psychotherapy include improved client retention, reduced symptoms, improved occupational and interpersonal functioning, an improved outlook on life, increased client happiness with treatment, adherence to medication, and keeping set appointments.

- Research about therapeutic alliance within group psychotherapy, or cohesion, has focused on various types of group relationships such as the connection one member has with another. This indicates that individual relationships or working alliances between group members and with the group leader play a significant role in group success.

- Interventions for establishing and maintaining therapeutic alliance in group psychotherapy include creating gender-specific groups, encouraging the formation of working relationships among members, treatment type, providing treatment options, words of encouragement from the psychotherapist-leader, and introducing mindfulness-based interventions.

- Individuals in group therapy pay more attention to the quality of their relationships with others in the group rather than everyone's assigned roles as member or leader.

- The other versus self-focus factor present within group psychotherapy also influences therapeutic alliance building.
- Withdrawal ruptures can look like the client "shutting down" or disengaging. Confrontation ruptures can look like the client challenging or controlling the therapist, or by confronting their frustrations.
- Rupture resolution has been found to repair the harmful impact the experience may have brought on and repair the working alliance.
- Effective rupture resolution can impact the group, and other positive outcomes can be found. Those positive outcomes can include lessened anxiety and depressive symptoms, an increase in daily living activities, stronger therapeutic alliance among the group, and sympathizing with other clients' issues can lead the individual to see their negative self-appraisal of their internal beliefs.
- The 3RS is an observer-rated instrument system that is used to code ruptures and repairs in the individual psychotherapy context through videos or transcripts. The 3RS system counts the frequency in which there are withdrawal ruptures or confrontation ruptures.
- Though the research on repair within black, indigenous, and people of color (BIPOC) population is scarce, the existing research does confirm that engaging in the repair resolution process is integral when a rupture occurs.

Conflict of interest

The authors declare no conflict of interest.

Notes/thanks/other declarations

Many thanks to our loved ones and mentors for bringing us to this point of our journey.

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