Rupture Resolution Rating System (3RS) Manual
November 16, 2011

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Our view of the therapeutic alliance draws on Bordin’s (1979) three-part conceptualization: the alliance is composed of 1) agreement between patient and therapist on the tasks of treatment; 2) agreement on the goals of treatment; and 3) a personal, affective bond between the patient and therapist. An alliance rupture is a deterioration in the alliance, manifested by a lack of collaboration between patient and therapist on tasks or goals, or a strain in the emotional bond.

Note that our definition of ruptures related to tasks and goals focuses on lack of collaboration rather than lack of agreement. This reflects our experience that not all disagreements between patients and therapists are ruptures. A patient can express disagreement with the therapist in an appropriate, collaborative way that does not constitute a rupture. An emphasis on collaboration over agreement is also helpful in instances when a patient has concerns about a task or goal, but expresses agreement with the therapist in an effort to appease the therapist or to avoid conflict. These surface-level agreements are actually examples of withdrawal ruptures (described below).

Ruptures are inevitable and occur in all therapies and with therapists of all skill levels. Ruptures can emerge when patients and therapists unwittingly become caught in vicious cycles or enactments. A rupture may remain outside of the patient’s and the therapist’s conscious awareness, and it may not significantly obstruct therapeutic progress. In extreme cases, however, ruptures can lead to dropout or treatment failure.

Ruptures can be organized into two main subtypes: withdrawal and confrontation ruptures (Harper, 1989a, 1989b). In differentiating between these two subtypes, we draw on Horney’s (1950) concept of responding to anxiety by moving away, toward, or against others. In withdrawal ruptures, the patient either moves away from the therapist (e.g., by avoiding the therapist’s questions), or the patient moves toward the therapist, but in a way that denies an aspect of the patient’s experience (e.g., by being overly deferential and appeasing). In confrontation ruptures, the patient moves against the therapist, either by expressing anger or dissatisfaction in a non-collaborative manner (e.g., hostile complaints about the therapist or the treatment) or by trying to pressure or control the therapist (e.g., making demands of the therapist). Some ruptures (e.g., a patient behaving seductively toward the therapist, or acting overly casual in a way that is inappropriate in a therapeutic context) do not fit into either category, and are labeled miscellaneous.

Although ruptures are a function of both patient and therapist contributions, this coding system focuses on patient behaviors as indicators or markers of ruptures. In our experience, even if a therapist behavior precipitates an alliance rupture (e.g., the therapist is critical or condescending), the patient usually responds by withdrawing or confronting the therapist; thus, we are usually still able to capture the rupture with this coding system.

The process by which a rupture is repaired is referred to as a resolution process. When ruptures occur, the therapist may attempt to initiate a resolution process by employing a resolution strategy, such as changing the task, or disclosing the therapist’s internal experience of the impasse. The 3RS tracks resolution strategies over the course of the session as potential markers of resolution processes. After viewing the entire session, the coder determines the extent to which the resolution strategies were successful in actually bringing about a resolution to the rupture or ruptures in the session.
Coding Procedure Summary

When you observe a lack of collaboration on tasks/goals or a strain in the bond:

- Decide type of rupture: confrontation, withdrawal, or a mixture of both?
- Look for efforts by the therapist to address the rupture.

Choose category of rupture marker (e.g., denial, complaint about therapist, or a mixture of both).

When the therapist addresses the rupture, choose category of resolution strategy (e.g., draw attention to problem, etc.).

Rate the clarity of the rupture marker (√, √+, √-) and note the time of the marker on the scoresheet.

Rate the clarity of the resolution strategy (√, √+, √-) and note the time of the strategy on the scoresheet.
When you finish watching the entire session:

Keep an ongoing tally of rupture markers while watching the session.

Make a 1-5 rating that reflects the frequency and clarity of each category of resolution strategy and patient response.

Make 1-5 overall withdrawal and confrontation ratings for the session.

Make a 1-5 overall rating of resolution strategy frequency.

Compare your overall withdrawal and confrontation ratings—which one is higher? Does that reflect the session?

Make a 1-5 overall rating of the degree of resolution—to what extent were ruptures actually resolved?
Coding Procedure Details

Watch the session: Watch the video recording of an entire session. You may use transcripts in addition to video, but transcripts cannot replace video because nonverbals are important for detecting ruptures and resolution events. You can stop, rewind, and review the video whenever necessary to complete the ratings. You may watch the video a second time if you feel that you need to. Second viewings are helpful if you feel that you missed something, as may be the case when there are subtle withdrawals.

Ruptures

Observing a rupture: A rupture is a deterioration in the alliance between patient and therapist, manifested by a lack of collaboration on tasks or goals or a strain in the emotional bond. In a rupture, the patient either moves away from the therapist (withdrawal), moves toward the therapist in a way that denies the patient’s own experience (also withdrawal), or the patient moves against the therapist (confrontation).

Note that patients may express hopelessness without withdrawing, and may express disappointment or dissatisfaction without being confrontative. In order to constitute a rupture marker, the patient’s statements must have negative implications for the relationship with the therapist.

The word “rupture” may call to mind a major argument or conflict in a session. However, with this coding system, we are coding minor tensions and strains as well as major disagreements. Even good sessions with skillful therapists may contain some degree of tension or strain. That being said, you will likely find that at least some sessions do not contain any ruptures.

The following are some indications of a rupture:

- Patient and therapist are not working together collaboratively and productively. They are “not on the same page.”
- There is strain, tension, or awkwardness between patient and therapist.
- Patient and therapist are misaligned or misattuned.
- Patient and therapist seem distant from each other.
- Patient and therapist are working at cross purposes.
- Patient and therapist are acting friendly, but you sense tension or disagreement beneath the surface, such that the friendliness seems to be a pseudoalliance.
- Patient and therapist seem to be caught in a vicious cycle or enactment.

Coding tip: You feel very bored while watching a session. This might be a sign that a withdrawal rupture is occurring, and the patient is avoiding talking about genuine feelings and concerns.

Deciding type of rupture:

- Withdrawal: patient is moving away from the therapist, or patient is moving toward the therapist in a way that denies the patient’s own experience. The patient may be dissatisfied with the therapist or the treatment, but is trying to avoid expressing that dissatisfaction.
- Confrontation: patient is moving against the therapist. There is a sense that the patient is attacking the therapist. If the patient is expressing dissatisfaction in a collaborative way,
trying to reach out to the therapist to work together to resolve a problem, you should not code it as a confrontation rupture because the patient is not moving against the therapist.

- Mixture of withdrawal and confrontation: patient moves away from and against the therapist in the same move. For example, patient gives a curt, one-word response to a therapist’s efforts to explore and understand the patient’s experience (withdrawal, minimal response), and that one-word response is spoken in a hostile tone that mocks the therapist’s effort to intervene (confrontation, patient rejects therapist intervention).

- Miscellaneous: a rupture that fits none of the above categories. These are rare.

Choosing category of rupture marker: See the category definitions and examples on p. 10. Coding is not limited by speech turns: a single speech turn can contain multiple rupture markers. For example:

Patient: *I don’t like this ridiculous homework, and I don’t like the way you keep nagging me to do it.*

This one speech turn contains two rupture markers and should receive two confrontation codes (complaint about activities and complaint about therapist).

However, you should try to avoid giving multiple codes to a single behavior. For example:

Patient: *I don’t like this.*

This utterance is one patient behavior, and thus should receive only one code. The appropriate code depends on what “this” refers to—for example, it could be a reference to the activities of therapy, or to the parameters of therapy. Coders must decide which of these two options is a better fit—they should not code both.

The only exception to this rule is when a single behavior contains both withdrawal and confrontation elements.

Therapist: *Can you tell me more about that?*

Patient: (sneering) *No!* (patient goes silent).

The one patient behavior ("No!") contains elements of both withdrawal (minimal response) and confrontation (patient rejects therapist intervention), and can be given both codes.

Rating the clarity of the rupture marker: In the appropriate category row on the scoresheet, give a clarity rating for each marker using check, check plus, or check minus.

- ✓+ A very clear, “textbook” example of the marker.
- ✓ A solid example of the marker.
- ✓- A weak or somewhat unclear example of the marker.

Also note the time in the session at which each marker occurred. Noting the time will enable coding leaders and researchers to determine whether coders agreed on when rupture and resolution markers occurred.

Overall Withdrawal and Confrontation ratings: When you finish watching the session rate overall Withdrawal and Confrontation. For both of these ratings, use the scale below.

- For Overall Withdrawal/Confrontation ratings, focus on the significance of rupture markers for the alliance: in other words, to what extent did this category of markers indicate a strain in the bond and/or a problem with collaboration on tasks and goals? Please note that you are rating significance/severity, not frequency or duration. Thus, a
session that began smoothly but then led to a significant impasse in the final few minutes would receive a high rating, whereas a session marked by numerous minor ruptures would likely receive a low rating. Similarly, a session where a significant rupture occurred, but was then resolved, would receive a high rating. Do not lower a rupture rating because the rupture was resolved.

- Overall Withdrawal and Confrontation ratings should informed by the Rupture Marker ratings, but they should not be a mean or tally of them. For example, a session that included one type of withdrawal (e.g., minimal response) that was highly significant could receive a higher overall Withdrawal score than a session that had many, less significant examples of several different categories of withdrawal markers.

- Once you have made the overall Withdrawal and Confrontation ratings, compare them and make certain that the difference between them reflects your overall sense of the session. For example, if the session was marked more by withdrawal than confrontation in terms of significance for the alliance, then your overall Withdrawal score should be higher than your overall Confrontation score.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Significance for the Alliance</th>
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<tbody>
<tr>
<td>1</td>
<td>No significance for the alliance: No rupture markers, or only very minor ones that did not indicate problems in the alliance.</td>
</tr>
<tr>
<td>2</td>
<td>Possible but unclear significance: Markers indicated possible problems in the alliance.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate significance: Markers indicated moderate problems in the alliance; patient and therapist generally able to work together during the rupture(s).</td>
</tr>
<tr>
<td>4</td>
<td>High significance: Markers indicated significant problems in the alliance; patient and therapist had difficulty working together during the rupture(s).</td>
</tr>
<tr>
<td>5</td>
<td>Very high significance: Markers indicated serious problems in the alliance; patient and therapist were at an impasse during the rupture(s).</td>
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</table>
Resolution

Observing resolution: When a rupture is repaired or resolved, there is a shift in a positive direction. Whereas the patient and therapist had seemed stuck, or locked in a vicious cycle, drifting apart, or working against one another, now they begin to come together, to understand each other, and to work collaboratively.

In order for an event to constitute a resolution marker, it must be in the context of a rupture. Usually, that will mean that a rupture occurred prior to the resolution attempt. In some cases, a therapist may refer to a rupture from a prior session or from earlier in the same session, and then commence a resolution attempt. If you did not observe a rupture, and there was no reference to a prior rupture, then there can be no resolution. Therapists may employ interventions that are included in our list of resolution strategies outside of the context of a rupture (e.g., a therapist decides to change tasks, but not in response to any concern or complaint from the patient)—these should not be coded as resolution markers.

While resolutions will usually occur following a rupture, they will not correspond one to one. In other words, there will not be a resolution for every rupture. Also, resolutions may not follow directly after ruptures—there can be a rupture at the beginning of the session, and a resolution for that rupture may come at the end of the session. Or one resolution event may address a series of ruptures. For these reasons, we have found it easier to track attempts to resolve ruptures as we watch the session by coding therapists’ use of resolution strategies. We also have two codes for patients’ responses to the use of these strategies. Only after watching the entire session do we make global ratings of the extent to which the resolution attempts succeeded in resolving ruptures.

Choosing category of resolution strategy: See the category definitions and examples on p. 12. As with the rupture markers, coding is not limited by speech turn, but coders should avoid giving multiple codes to a single behavior. For example:

Therapist: It makes sense that you are frustrated with me right now. I think I haven’t been sensitive enough to your concerns about the homework.

The therapist’s response is one speech turn that contains two resolution markers (justifying the patient’s defensive posture and acknowledging responsibility for the problem in the relationship).

Rating the clarity of the resolution marker: In the appropriate category row on the scoresheet, give a clarity rating for each marker using check, check plus, or check minus.

- ✓+ A very clear, “textbook” example of the marker.
- ✓ A solid example of the marker.
- ✓- A weak or somewhat unclear example of the marker.

Also note the time in the session at which each marker occurred. Noting the time will enable coding leaders and researchers to determine whether coders agreed on when rupture and resolution markers occurred.

Likert-type frequency ratings for each resolution marker category: When you finish watching the session, make a Likert-type rating for each category of resolution marker (both resolution strategies and the two patient response items). These ratings will differ from the 1-5 ratings for each rupture category. Instead of coding significance for the alliance, you will code frequency using the following scale:
Resolution Category Rating | Frequency
---|---
1 | Marker did not occur.
2 | Marker may have occurred (e.g., a few weak or unclear examples).
3 | Marker occurred (at least one clear example, or several weak examples).
4 | Marker occurred several times (a few clear examples).
5 | Marker occurred a great deal (several clear examples).

**Overall Resolution Rating**: use the scale below. This rating is your global assessment of the extent to which resolution actually occurred across all the ruptures in the session. *This will often differ from your Resolution Marker Frequency rating.* A session may include numerous attempts to resolve ruptures (high Resolution Marker Frequency), but those attempts may not be successful (low Overall Resolution). Note that this assesses degree of resolution, not frequency. Thus, a session with only one rupture that is resolved completely with only one resolution strategy should receive a high resolution score. Sessions may include some ruptures that are resolved and some that are not; pick the rating that best captures your global sense of the session. Also, please note that if there were no ruptures in a session, then overall resolution should be scored as N/A.

<table>
<thead>
<tr>
<th>Overall Resolution Rating</th>
<th>Degree to which ruptures were resolved.</th>
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</thead>
<tbody>
<tr>
<td>N/A</td>
<td>There were no ruptures in the session.</td>
</tr>
<tr>
<td>1</td>
<td>Ruptures were not resolved.</td>
</tr>
<tr>
<td>2</td>
<td>Ruptures may have been partly resolved.</td>
</tr>
<tr>
<td>3</td>
<td>Ruptures were partly resolved.</td>
</tr>
<tr>
<td>4</td>
<td>Ruptures were moderately resolved.</td>
</tr>
<tr>
<td>5</td>
<td>Ruptures were substantially resolved.</td>
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### SUMMARY DEFINITIONS AND EXAMPLES OF RUPTURE MARKERS

Note: for every category, the patient must engage in the behavior in a manner that interferes with collaboration on tasks or goals, or that reveals a strain in the bond.

<table>
<thead>
<tr>
<th>Withdrawal</th>
<th>Description</th>
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| Denial                   | Patient denies a feeling state that is *manifestly* evident, or patient denies the importance of interpersonal relationships or events (e.g., rationalization). Note that this is not the same as “being in denial” or denial as a defense mechanism.  
Therapist: *You look upset.*  
Patient: *I’ll be fine. Don’t worry about me.* |
| Minimal response         | Patient gives minimal responses to therapist’s efforts to explore and understand patient’s experience (e.g., patient responds with short, clipped answers to open-ended, exploratory questions). Giving no response—going silent—would be the ultimate minimal response. However, note that the minimal response must be in the context of a withdrawal—a short response that is appropriate to the situation is not coded here.  
Therapist: *That sounds like it was very difficult. How did it make you feel?*  
Patient: *(Shrugs.)* |
| Abstract Communication   | Patient avoids contacting painful or negative feelings by using abstract language when talking about difficult interpersonal situations or issues. The patient may intellectualize by focusing on rational concepts and complex terminology. Or the patient may make vague, global statements that allude to an issue that is relevant to the therapeutic relationship, rather than directly stating his/her true feelings.  
Therapist: *Did it bother you when I said that?*  
Patient: *I was confused, but I think it’s OK for things to be confusing a little every once in a while. It makes you think about it more and you can learn from it.* |
| Avoidant Storytelling and/or Shifting Topic | Patient tells stories and/or shifts the topic in an effort to avoid distressing topics or issues or situations. This can include trying to avoid conflict with the therapist by telling entertaining stories. These stories may be long and overly elaborate, or they can be relatively brief. They may go off on a tangent, or they may eventually return back to the topic at hand. The key is that by shifting the topic and/or telling a story, the patient avoids clear, direct communication with the therapist.  
Remember that the story or topic shift must be part of a withdrawal. Thus, for example, if a patient shifts the topic not to avoid, but rather to enhance the work of therapy, this would not be coded here (e.g., “I know that we were talking about my job, but I just remembered something that happened with my boyfriend that I really want to discuss with you…”).  
A story that is relevant and productive, but still seems to have an avoidant quality (e.g., somewhat circumstantial, somehow shutting out the therapist), could receive a check minus.  
Talking about someone else’s reactions or the reactions of “most people” in an effort to avoid talking about oneself should also be coded here.  
Therapist: *How do you think things are going so far in our work together?*  
Patient: *That sounds like a performance review question. I had a performance review at work last week, and it was so stressful…* |
| Deferential and appeasing | Patient appears *overly* compliant and submits to the therapist in an *excessively* deferential manner.  
Therapist: *How was the homework?*  
Patient: *Oh, it was so helpful. You give such wonderful advice.* |
| Content/Affect split | Content of patient’s narrative does not match his/her affective expression  
Therapist: *It’s hard for you to tell me about those sad feelings.*  
Patient (smiling): Yes, it is. *It’s not easy to talk about.* |
|---------------------|------------------------------------------------------------------|
| Self-criticism and/or hopelessness | The patient withdraws from the interaction with the therapist by becoming absorbed in a depressive process of self-criticism and/or hopelessness that seems to shut out the therapist and close off any possibility that the therapist or the treatment can help the patient. The patient may engage in this process as a means of avoiding conflict with the therapist.  
Note that patients can be self-critical or hopeless but still be engaged in the interaction with the therapist, and can explore these feelings with the therapist in a collaborative way. To receive the self-criticism/hopelessness code, the patient’s behavior must be contributing to a withdrawal.  
Therapist: *That sounds important. Can you tell me more about that?*  
Patient: (Sighs). *What’s the point? It’s not going to make me feel better. I’m too far gone.* |
| Confrontation | Patient feels negatively about or toward the therapist. Patient may feel negative feelings (e.g., angry, impatient, distrustful, manipulated, hurt, judged, controlled, rejected), or may feel that therapist has failed to support, encourage, or respect him/her. The patient may criticize the therapist’s interpersonal style, or express doubts about the therapist’s competence.  
Patient: *I was thinking about some of the things that you said last week. I wasn’t very happy about them. Not so much what you said, actually, more the way you said them. You were pushing me into a corner. I wouldn’t have thought that was the way to go about helping people.* |
| Patient rejects therapist formulation or interpretation in a non-collaborative manner | Patient rejects or dismisses the therapist’s view or interpretation of the patient and/or his/her situation, or the patient rejects or dismisses the therapist’s efforts to intervene (e.g., therapist tries to offer support and patient rebuffs therapist in a hostile manner). This rejection must be non-collaborative—it obstructs or hinders a good working relationship between patient and therapist (e.g., patient is very hostile, or condescending). If the patient disagrees with a therapist’s interpretation or formulation, but is able to express this in a collaborative way (e.g., “no, I don’t think that’s what is causing my anxiety. It’s more like this…”), then this is NOT a rupture and should not be coded here.  
If the patient disagrees with, dismisses or rejects a task—an activity that the therapist wishes the patient to participate in, such as completing a thought record or doing a two-chair exercise—then rate Complaint/concern about activities.  
Therapist: *It sounds like you are concerned about him.*  
Patient: (hostile tone) *No, that is not it at all.* |
| Complaints/concerns about the activities of therapy | Patient expresses dissatisfaction or discomfort with therapy tasks and/or goals in a noncollaborative manner.  
Patient: *I really don’t understand what you’re asking me to do on these thought records. I don’t see the point of them at all.* |
| Complaints/concerns about the parameters of therapy | This includes complaints and concerns about the therapy schedule (e.g., appointment times, session length, number and frequency of sessions) and the research contract (e.g., completing questionnaires, being videotaped).  
Patient: (hostile tone) *Once a week is not enough. How on earth can I get better if I only come once a week?* |
<table>
<thead>
<tr>
<th>Complaints/concerns about progress in therapy</th>
<th>Patient is doubtful of the progress that can be made or has been made in therapy. Patient: <em>I’ve been coming here for four weeks now, and I really can’t think of anything that has changed. Maybe this has all been a waste of time.</em></th>
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</table>
| Patient defends self against therapist | Patient defends his/her thoughts, feelings, or behavior against what he/she *perceives* to be the therapist’s criticism or judgment of the patient. Do not code if the patient is defending him or herself against criticism from another person. Note that the therapist does not have to actually criticize the patient for the patient to anticipate criticism and become defensive.  
Therapist: *That makes a lot of sense.*  
Patient: *Of course it does! I’m not an idiot!* |
| Direct efforts to control/pressure therapist | Patient directly attempts to control the therapist, e.g., patient tells the therapist what to do, patient puts pressure on therapist to fix the patient’s problems quickly.  
Patient: *I’m tired of wasting time. I want to know how this therapy works. Tell me how it’s going to help me with my problems. And none of that fancy therapist talk; I want a direct answer.* |
<p>| Miscellaneous | A rupture that does not fit in any of the above categories. Ruptures where the patient seems to be doing something inappropriate in the context of the therapy relationship fit here. For example, patient is flirtatious and seductive; patient calls the therapist “hon”; patient says “Yo, what’s up?” to the therapist in a way that feels inappropriately casual. |</p>
<table>
<thead>
<tr>
<th>Resolution Strategies</th>
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<tbody>
<tr>
<td>Therapist clarifies a misunderstanding.</td>
<td>Therapist clarifies a misunderstanding. Generally, the resolution effort stops here; the therapist does not go on to explore the underlying significance of the misunderstanding or to try to link it to the patient’s core themes.</td>
</tr>
<tr>
<td>Therapist: <em>You seem a little distant right now.</em></td>
<td>Patient: <em>Well, I guess I was a little bothered about what you said about how I should apologize to my sister.</em> Therapist: <em>No, no. I said that I think your sister should apologize to you.</em> Patient: <em>Oh (smiling). I must have misheard you. I wish she would apologize...</em></td>
</tr>
<tr>
<td>Patient: <em>We’re getting off track again. I don’t think this is getting us anywhere.</em> Therapist: <em>I’m willing to follow your lead right now. What direction would you like to go in?</em></td>
<td></td>
</tr>
<tr>
<td>Therapist illustrates tasks or provides a rationale for treatment.</td>
<td>This resolution strategy involves providing a justification of the treatment. Do not code if the therapist simply demonstrates how to do homework, for example. The therapist must take an additional step of providing an explanation or rationale for how the task or treatment works.</td>
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<tr>
<td>Therapist: <em>I’d like to spend some time trying to understand what’s going on between us right now. My hope is that this type of exploration may provide us with some clues as to what may go on for you in your relationship with other people.</em></td>
<td>Sometimes this may be in the form of reframing the meaning of tasks or goals in response to the patient’s concerns/complaints. When the therapist reframes the meaning of tasks or goals, he/she describes the tasks or goals in a way that is more appealing to the patient.</td>
</tr>
<tr>
<td><em>A patient is reluctant to complete a homework assignment that involves increasing social contact because he fears rejection. The therapist reframes the assignment as “putting yourself into the anxiety-provoking situation in order to self-monitor your cognitive processes.”</em></td>
<td></td>
</tr>
<tr>
<td>Within the context of a rupture, the therapist invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy.</td>
<td>The therapist invites the patient to directly express negative sentiments or vulnerability that the patient has been communicating in an indirect or equivocal manner. This involves more than simply reflecting the patient’s negative or vulnerable feelings; the therapist actively encourages the patient to stand behind a complaint or to contact vulnerable feelings. Patient: <em>I’m feeling a little irritated, but it’s not a big deal.</em> Therapist: <em>I understand that you’re uncertain about how important your concerns are. But if you’re willing to go into it, I’d be interested in hearing more.</em></td>
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</table>
Within the context of a rupture, the therapist discloses his/her internal experience of the relationship.

Therapist 3: I’m trying to answer your question, but I get the sense that nothing I say to you will be satisfying right now. I’m concerned I will antagonize you further if I continue to try.

Within the context of a rupture, the therapist explicitly acknowledges his/her contribution to a problem in the relationship

Therapist 1: I could see how this could be frustrating for you. You’re asking me for a direct answer and I keep putting the ball back in your court
Therapist 2: I’m aware of my attention wandering right now… I’m not sure what is going on but I think it may have something to do with the distant sound in your voice.

Therapist links the rupture to larger interpersonal patterns between the patient and the therapist.

The patient has difficulty articulating what she wants to focus on in the session, and criticizes herself for being confused and disorganized. The therapist observes how the patient tends to blame herself for any misunderstandings that arise between them.

Therapist links the rupture to larger interpersonal patterns in the patient’s other relationships.

The patient has difficulty asking the therapist for a different session time. The therapist links this to the patient’s lack of assertiveness in her relationships with her family and co-workers.

Therapist justifies the patient’s defensive posture.

Therapist allies with the resistance. Instead of challenging the patient’s defensive behaviors, the therapist validates the ways in which they are understandable and adaptive. This is more than just reflecting back the patient’s own explanations for his/her behavior—this involves explicitly stating that the patient’s position is legitimate and valid. A patient cries in session, and then becomes self-conscious and begins to speak in a distant, intellectualized fashion. The therapist observes that the patient now seems distant from her pain, and says, “Perhaps it’s adaptive for you to have some distance from it right now.”