A Qualitative Analysis of Rupture Sessions in High and Low Outcome Brief Relational Therapy Cases

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Abstract: This study aimed to better understand the rupture resolution process in Brief Relational Therapy. Researchers were interested in refining the stage process model of rupture resolution (Safran & Muran, 1996, 2000) through the use of a detailed descriptive analysis, and in exploring differences in the rupture resolution process in high and low outcome psychotherapy cases. To this end, this study examined 44 psychotherapy sessions in which ruptures in the therapeutic alliance occurred, using primarily qualitative methods as well as some quantitative methods. Sessions were selected from 18 psychotherapy dyads, nine of which were high outcome cases and nine of which were low outcome cases. Primarily, results indicate that based on qualitative analyses, therapists more often encourage exploration of patients’ affective experience in the here and now in high outcome cases than in low outcome cases. Also, in the context of ruptures, patients more often expressed an underlying wish or need or were able to explore an interpersonal schema in high outcome cases than in the low outcome cases. Results also indicate that ruptures in the therapeutic alliance are often addressed and processed over multiple psychotherapy sessions instead of solely in the session in which they emerge.
A Qualitative Analysis of Rupture Sessions in High and Low Outcome Brief Relational Therapy Cases

by

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DEDICATION

I would like to dedicate this dissertation to my family. I want to thank my mother and father for their belief in me every step of the way. I also want to thank my husband, who has patiently witnessed this process from start to finish, for his constant love and support.
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# TABLE OF CONTENTS

Dedication .......................................................................................................................... ii  
Acknowledgements ........................................................................................................... iii  
List of Tables and Figures ................................................................................................ vi  

Chapter 1: Theoretical Basis ............................................................................................. 1  
I. The Therapeutic Alliance ............................................................................................... 1  
II. Ruptures in the Therapeutic Alliance ......................................................................... 1  
III. Brief Relational Therapy ......................................................................................... 2  
IV. Task Analysis ............................................................................................................ 3  
V. Development of Brief Relational Therapy and the Stage Process Model of Rupture  
   Resolution .................................................................................................................. 6  
VI. Evaluation of Brief Relational Therapy ................................................................... 8  
VIII. Elaboration of the Stage Process Model of Rupture Resolution ........................... 11  
VIII. Measuring Ruptures and Rupture Resolution ......................................................... 13  
IX. Use of Qualitative Methods ..................................................................................... 14  
X. Additional Contextual Information ........................................................................... 17  
XI. Concluding remarks ................................................................................................ 18  

Chapter 2: The Empirical Study ....................................................................................... 19  
I. Literature Review ........................................................................................................ 19  
   a. Research on the Therapeutic Alliance ................................................................ 19  
   b. Brief Relational Therapy and the Stage Process Model of Rupture  
      Resolution .............................................................................................................. 20  
   c. Demonstrating the Effectiveness of BRT .............................................................. 21  
   d. Task Analysis ......................................................................................................... 22  
   e. Qualitative Methods .............................................................................................. 23  
II. Hypotheses ............................................................................................................... 23  
III. Method ...................................................................................................................... 25  
   a. Data Collection ....................................................................................................... 25  
   b. Participants ............................................................................................................. 25  
   c. Patients .................................................................................................................. 26  
   d. Therapists .............................................................................................................. 27  
   e. Treatment Modality ............................................................................................... 28  
   f. Therapist Training Procedure .............................................................................. 28  
   g. Outcome Measures ............................................................................................... 28  
   h. Process Measures .................................................................................................. 30  
   i. Data selection ......................................................................................................... 32  
   j. Qualitative Data Analysis Using a Task Analytic Framework ............................... 33  
   k. Exploratory Analysis of Themes in Rupture Sessions ........................................... 36  
   l. Quantitative Analyses of Patient and Therapist Ratings of the WAI ................. 37  
   m. Quantitative Analyses of Patient and Therapist Ratings of the SEQ ............... 39  
   n. Quantitative Analyses of Patient and Therapist Ratings of the Single Item .... 40
LIST OF TABLES AND FIGURES

Table 1. Descriptors Used in Qualitative Data Analysis Using Task Analytic Framework
Table 2. Recurrent rupture topics and themes
Table 3. Presence and Frequency of Descriptors in High and Low Outcome Cases
Table 4. Comparisons of Patient and Therapist WAI Ratings in High and Low Outcome Cases Using Control Charting
Table 5. Comparison of Patient and Therapist SEQ Depth Subscale Scores in High and Low Outcome Cases Using Control Charting
Table 6. Modal Responses to the WAI
Table 7. Modal Responses to the SEQ Depth Subscale
Table 8. Modal Responses to the Single Item Resolution Question

Figure 1. Post Session Questionnaire – Patient Version
Figure 2. Post Session Questionnaire – Therapist Version
CHAPTER 1: THEORETICAL BASIS

I. The Therapeutic Alliance

Research on the therapeutic alliance demonstrates that the relationship between patient and therapist is a crucial factor in understanding psychotherapy process and outcome. Early on, the alliance was conceptualized within psychoanalysis in terms of transference (e.g., Freud, 1913), and Ferenczi (1932) later discussed the role of the analyst’s own individual qualities in understanding the alliance. Subsequent theorists discussed the importance of the alliance for treatment effectiveness (e.g., Zetzel, 1956) and expanded upon the notion that the analyst or therapist has significant impact on the alliance (e.g., Greenson, 1971). The concept of the alliance has continued to evolve in subsequent decades. Bordin’s (1979) definition of the therapeutic alliance as being constituted by agreement on the task and goals of therapy and the presence of a positive bond between patient and therapist, has had significant influence on the ways in which the alliance is currently understood and measured (Safran & Muran, 2000). Current research on the therapeutic alliance suggests that a strong working alliance is associated with positive treatment outcome (e.g. Fluckiger, Del Re, Wampold, Symonds & Horvath, 2012; Horvath & Bedi, 2002; Krupnick et al., 1996; Martin, Garske & Davis, 2000), and that weak working alliances are associated with premature dropout from treatment (e.g., Samstag, 1998; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

II. Ruptures in the Therapeutic Alliance

Given the importance of the therapeutic alliance in psychotherapy, researchers have also explored the impact of ruptures in the therapeutic alliance. Safran and Muran
(2000) describe ruptures in the alliance as “…disagreements about the tasks or goals of therapy or…problems in the bond dimension…” (p. 16), in keeping with Bordin’s (1979) description of the alliance. Research on ruptures in the alliance has aimed to identify methods by which ruptures may be identified (e.g., Berk, Safran & Muran, 2010; Eubanks-Carter, Mitchell, Muran & Safran, 2009) and their impact on treatment measured. Research in this area has also aimed to understand the ways in which ruptures occur and are resolved, as well as the impact of the rupture and resolution process on treatment.

III. Brief Relational Therapy

Following years of research on ruptures in the therapeutic alliance, Safran and Muran (2000) developed a therapeutic modality known as Brief Relational Therapy (BRT) that aims to provide techniques by which ruptures may be addressed and resolved in treatment. In addition to focusing on the importance of understanding and addressing ruptures in the therapeutic alliance, BRT can be understood as drawing from the work of psychoanalytic theoreticians such as Ferenczi and Rank (see Safran & Muran, 2000, p. 176), among others, as well as mindfulness-based practices. BRT is described by Safran and Muran (2000) as having seven components. Included among the components that they describe, BRT

…assumes a two-person psychology…it involves an intensive focus on the here and now….it features an ongoing collaborative exploration of both patients’ and therapists’ contributions to the interaction…it makes intensive use of therapeutic metacommunication and countertransference disclosure…[and] it emphasizes the subjectivity of the therapist’s perceptions...(p. 175).
In the context of the present study, BRT’s use of an intensive focus on the here and now as well as its encouragement of therapeutic metacommunication are of particular importance. Since the time of its development, BRT has been adapted to be used in conjunction with other treatment modalities such as cognitive behavioral therapy (CBT), and is referred to as Alliance-Focused Training (AFT) in this context. That is, BRT can be used as a primary treatment modality or the techniques and interpersonal stance that BRT includes can be used along with other treatment modalities (Safran et al., 2014).

IV. Task Analysis

The development of BRT and the methodology for the present study have been strongly influenced by a research paradigm known as task analysis. Task analysis is used not only in psychology, but also, in a range of other fields, including education and engineering (Crandall, Klein & Hoffman, 2006; Hoffman & Militello, 2009), as it allows close analysis of the ways in which various kinds of practitioners approach difficulties. In task analysis, a preliminary model of the way in which a task is achieved is developed based on theory as well as clinical experience. By studying the type of event in question in detail, the model is refined in an iterative process that moves back and forth between the model and actual instances of the event in order to understand how a problem is resolved. Ultimately, the model is empirically verified (Rice & Greenberg, 1984).

Rice & Greenberg (1984) applied task analysis to psychotherapy research for its utility in allowing researchers to investigate the ways in which specific clinical issues are dealt with, and the impact that this process may have on therapeutic change. Safran, Greenberg & Rice (1988) present the reasons for which techniques such as task analysis,
which require the intensive analysis of cases, should be taken seriously by the research community, instead of being viewed as less scientific than conventional hypothesis testing methods. They argue that task analysis offers a way to understand the change process at a more subtle level than traditional methods. Safran, Greenberg and Rice (1988) describe the place of task analysis in helping researchers to understand the change process saying “…Rice and Greenberg use the term ‘when-then’ performance events to capture the flavor of complex interactional sequences between patients and therapists…it is this type of subtle interactional sequencing that is not captured by traditional psychotherapy research paradigms…” (p. 5). It is the interest in the sequence in which events occur and are resolved that allows researchers to gain a more complex understanding of the processes at play that encourage change. Since Rice and Greenberg’s (1984) initiation of the use of task analysis in psychotherapy research, researchers have continued to explore the use of task analysis and to develop its use in the field of psychotherapy research (e.g., Greenberg, 2007; Pascual-Leone, Greenberg & Pascual-Leone, 2009).

A number of studies have been conducted in which task analysis is used to understand aspects of psychotherapy process and outcome. Greenberg and Foerster (1996) used task analysis to explore the process of resolving “unfinished business” in psychotherapy, using a two-chair technique. By analyzing 11 instances in which unfinished business was resolved and 11 instances in which it was not, Greenberg and Foerster (1996) were able to move from a model based on theoretical expectations of how unfinished business may be resolved to a model that took into account clinical data. The
Structural Analysis of Social Behavior (SASB; Benjamin, 1974) as well as the Experiencing Scale (EXP; Klein, Mathieu, Kiesler & Gendlin, 1969; Klein, Mathieu-Coughlin & Kiesler, 1986), among other measures, were used to understand the process of addressing unfinished business, and elements of the process that differed in those instances in which unfinished business was resolved and instances in which it was not. Greenberg and Foerster (1996) point out the ways in which task analysis allows researchers to address not only the question of whether or not a particular mode of treatment is useful, but also, the extent to which it is taken in. They say

One of the major problems with current clinical trials is that in comparing or evaluating the effects of different treatment interventions on outcome, there is a hidden intervening variable…This variable can be thought of as absorption of the treatment by the client or activation of the change process… (p. 445).

Thus, task analysis is a method by which researchers can not only explore the use of specific interventions, but also, take into account the ways in which those interventions are responded to. Through the use of task analysis, Greenberg and Foerster (1996) did not simply examine the use of the two-chair technique versus another technique, but rather, the way in which it was used by therapists and received or rejected by patients, providing a more nuanced understanding of the change process.

Bennet, Parry and Ryle (2006) used task analysis to explore the rupture resolution process in cognitive analytic therapy for individuals diagnosed with Borderline Personality Disorder. As is customary in task analysis, they were interested in moving between theory and clinical data to refine their model of the rupture resolution process. Bennet and colleagues (2006) compared good and poor outcome cases in order to address
whether or not the rupture resolution process differed by condition. They found that their revised model was more evident in good outcome cases than in poor outcome cases, such that therapists in good outcome cases often attended to and addressed ruptures productively (Bennet et al., 2006). Aspland, Llewelyn, Hardy, Barkham and Stiles (2008) applied task analysis to explore the rupture resolution process in CBT. After analyzing actual instances in which ruptures were addressed in CBT, Aspland and colleagues (2008) modified their initial model of rupture resolution to account for the findings that emerged in their clinical data. Their results suggest that in cognitive therapy, a change in the therapeutic task can be a helpful tool in addressing problems in the therapeutic relationship (Aspland et al., 2008). These studies illustrate the gradual revision of a model that can occur through task analysis, allowing researchers and clinicians to better understand how a task is best addressed in real-life settings, instead of basing models on theoretical expectations alone.

V. Development of Brief Relational Therapy and the Stage Process Model of Rupture Resolution

The task analytic paradigm has been instrumental in the development of BRT, as it allows researchers to develop an understanding of factors that contribute to change by conducting in depth analyses of clinical data. Safran, Crocker, McMain and Murray (1990) conducted the initial steps of a task analytic investigation of rupture resolution. Through the use of recordings of incidents in which ruptures in the therapeutic alliance occurred, they identified themes that emerged across ruptures (pp. 157-159). This process informed their understanding of strategies that would assist therapists in responding effectively to alliance ruptures, which include items such as “maintaining the
stance of the participant/observer” (p. 161). This in turn contributed to the development of a preliminary model of rupture resolution. The preliminary model includes seven stages:

Stage 1: Avoidance of confrontation marker
Stage 2: Therapist empathizes with negative feelings and establishes a focus on the here and now
Stage 3: The client engages in assertive behavior, alternating with deference or dependency.
Stage 4: Therapist explores the client’s fears of expressing negative sentiments directly.
Stage 5: Client accesses fears of expressing negative sentiments and self-assertion.
Stage 6: Therapist empathizes with client’s fears
Stage 7: Client expresses negative sentiments in direct self-assertive fashion

(Safran and colleagues, 1990)

Safran and colleagues (1990) presented the above model with the intention of conducting further studies to refine and validate a model of rupture resolution. Following the development of the preliminary model of rupture resolution, a number of studies have continued to explore the ways in which ruptures are resolved.

Safran, Muran, and Samstag (1994) describe the steps that followed in developing a stage process model (SPM) of rupture resolution. In addition to studying transcripts and recordings of rupture events, observer-based measures were used to better understand the interpersonal process that occurred during rupture events, including the SASB (Benjamin, 1974), the Experiencing Scale (Klein et al., 1969; Klein et al., 1986) and the Client Vocal Quality Scale (CVQ; Rice & Kerr, 1986; Rice & Wagstaff, 1967, as cited in Safran et al., 1994, p. 232). Using a small sample for preliminary analyses, Safran and colleagues (1994) further refined the model of rupture resolution and arrived at four components: first, the rupture is attended to. In stage two, the rupture experience is
explored. In stage three, avoidance of the rupture experience is explored. In stage four, the patient engages in self-assertion (p. 244). Safran and Muran (1996) further describe the process of developing and testing the SPM of rupture resolution. For instance, Safran and Muran (1996) elaborate upon the role of stage three of the model of rupture resolution, in which avoidance is explored. They explain that through the process of returning to clinical data and through the use of observer-based measures, they were able to identify two ways in which stage three may manifest. They describe instances in which avoidance of exploration is centered around patient expectations that their therapist will respond negatively to them, as well as instances in which avoidance of exploration is centered around negative feelings about their own experience (Safran & Muran, 1996). In summary, Safran and Muran (1996) demonstrate the iterative process of moving between the model and clinical data in order to best describe the rupture resolution process.

VI. Evaluation of Brief Relational Therapy

Since the development of the SPM of rupture resolution and of BRT as a therapeutic modality that focuses attention on the emergence of ruptures and the processes by which they are resolved, the impact of rupture resolution techniques and training have been the subject of a number of studies at the Brief Psychotherapy Research Program. Safran, Muran, Samstag and Winston (2005) conducted a study in which they examined the utility of BRT for cases in which treatment drop out was a concern. Patients included in this study had been diagnosed with a cluster C personality disorder or with Personality Disorder Not Otherwise Specified according to the Diagnostic and
Statistical Manual-IV (DSM-IV) criteria (APA, 1994), in order to focus on a patient population with whom it could be particularly difficult to establish a strong therapeutic alliance (Safran et al., 2005). In the first phase of this study, patients participated in either short-term dynamic therapy (STDP) or cognitive behavioral therapy (CBT). Those who were deemed at risk of premature treatment drop out or poor treatment outcome were given the choice of changing to another form of treatment. Results indicate that BRT changed the course of treatment for those who had been experiencing difficulties. There were significantly fewer cases of treatment dropout among patients who switched to BRT than among those who were assigned to a control condition (which consisted of either CBT or STDP). In fact, all of the patients assigned to the control condition dropped out of treatment prematurely (Safran et al., 2005). Results indicate the value that BRT can have in working with patients with whom it is difficult to establish an alliance, and in preventing treatment drop out.

In an effort to empirically examine the effectiveness of BRT, Muran, Safran, Samstag, and Winston (2005) compared the effectiveness of BRT to CBT and STDP. All treatments were administered in the context of a 30-week protocol. The majority of patient participants had been diagnosed with a mood disorder, and many also suffered from anxiety disorders. All participants had been diagnosed with either a cluster C personality disorder or a Personality Disorder Not Otherwise Specified, according to the Diagnostic and Statistical Manual-IV (DSM-IV) criteria (APA, 1994). Results indicate no significant differences in the effectiveness of the three treatment modalities, however differences did arise in terms of premature treatment dropout, favoring BRT. These
findings suggest that BRT is not only as effective as other commonly practiced treatments, but also, that the use of BRT or techniques drawn from BRT may also help to reduce premature treatment dropout (Muran et al., 2005).

Most recently, Safran et al. (2014) examined the effect of alliance – focused training (AFT), which is based on BRT and can be used in conjunction with other treatment modalities, on cases in which CBT was the initial mode of treatment. In this study, participants first participated in either eight or 16 weeks of CBT and then their therapists entered into an alliance – focused supervision. Results indicate that as measured by the SASB (Benjamin, 1974), AFT impacted the nature of the interpersonal process between patients and therapists. In the AFT portion of the treatment, therapists demonstrated reduced controlling behaviors and increased disclosures as well as affirmation of patient experience. Also in the AFT portion of the treatment, patients demonstrated a reduction in deferential and submissive behavior and a reduction in hostile communications as well as an increase in assertiveness and disclosure of their experience (Safran et al., 2014).

Safran and colleagues (2014) were also interested in therapists’ engagement in reflective thinking in the context of work with their patients. As AFT encourages therapists to develop awareness of their own experience, including their countertransference, and to use this understanding in their clinical work, Safran and colleagues examined therapist reflectivity using the Experiencing Scale (Klein et al., 1969; Klein et al., 1986). This study utilized research interviews conducted with therapists about their relationship with their patients in order to best understand the ways
in which therapists reflect upon and process experiences with their patients. As was expected, results indicate that when therapists participated in AFT, they were better able to talk about and reflect upon their experiences with their patients while taking into consideration their own contributions to the dyad (Safran et al., 2014).

VII. Elaboration of the Stage Process Model of Rupture Resolution

As previously discussed, the SPM of rupture resolution (e.g., Safran & Muran, 1996, 2000) has been developed and refined through a series of studies using task analysis that aimed to understand the ways in which ruptures are resolved. The generic model of rupture resolution (Safran & Muran, 1996) describes four stages. First, a rupture marker occurs and is attended to. In stage two, patient and therapist explore the rupture experience. In stage three, patient and therapist explore avoidance associated with the rupture experience. In stage four, the patient’s wish or need emerges and is addressed with the therapist (Safran & Muran, 1996). The SPM (Safran & Muran, 2000) has also been elaborated to describe a series of stages of rupture resolution for two types of ruptures: those that are characterized by confrontation and those that are characterized by withdrawal (Safran & Muran, 2000). The conceptualization of withdrawal and confrontation markers has been influenced by the work of Heather Harper (1989a, 1989b), who suggested this division. Confrontation ruptures are those in which patients verbalize feelings such as “…anger, resentment, or dissatisfaction…” (Safran & Muran, 2000, p. 141), among other negative feelings, within the psychotherapy session. Unlike withdrawal ruptures, confrontation ruptures are typically immediately evident to the therapist. Withdrawal ruptures tend to be more subtle expressions of problems and can
be difficult for therapists to detect. Withdrawal ruptures may be highlighted by behaviors such as topic changing and minimal response on the part of the patient (see Safran & Muran, 2000, p. 141). While ruptures can often be characterized as more in keeping with patterns of withdrawal or more in keeping with patterns of confrontation, features of both can present themselves within a rupture, making it difficult at times to categorically distinguish between the two rupture styles.

Much of the SPM for the resolution of withdrawal ruptures (Safran & Muran, 2000) is in keeping with the generic model of rupture resolution as described by Safran and Muran (1996). However, the model specific to withdrawal ruptures specifies a third stage known as “qualified assertion,” a fourth stage known as “avoidance,” and characterizes the resolution stage as including elements of “self-assertion.” The third stage captures individuals’ difficulties directly expressing their concerns and doing so in a cautious, incomplete manner. Safran and Muran (2000) provide examples of qualified assertion such as a patient saying “I’m feeling a little irritated, but it’s not a big deal” (p. 145). In the fourth stage, in the context of difficulties with directly expressing concerns to their therapist, patients may use avoidance instead of continuing forward in exploring the rupture directly. The final stage in the model of rupture resolution for withdrawal ruptures includes instances in which patients are able to self-assert by directly expressing their needs within the psychotherapy session (Safran & Muran, 2000, pp. 142-148).

As with the SPM for withdrawal ruptures, much of the SPM for the resolution of confrontation ruptures (Safran & Muran, 2000) is in keeping with the generic model of rupture resolution as described by Safran and Muran (1996). The model specific to
confrontation ruptures specifies a third stage known as “exploration of construal,” a
fourth stage known as “avoidance of aggression,” a fifth stage known as “avoidance of
vulnerability,” and characterizes the resolution stage as including elements of expression
of vulnerability (Safran & Muran, 2000, p. 156). In the third stage, the dyad works to
understand each of their experiences of what led to conflict in their relationship. In stage
four, patients may avoid their own aggression, and in stage five, they may avoid their
feelings of vulnerability. The final stage in the model of rupture resolution for
confrontation ruptures includes instances in which patients are able to express underlying
vulnerability within the context of the psychotherapy session (Safran & Muran, 2000, pp.
154-163). It is important to note that in both the generic SPM and the SPMs specific to
withdrawal and confrontation ruptures, it is understood that patient – therapist dyads may
cycle between the stages outlined, rather than simply moving from one to the next in the
order in which they are presented (Safran & Muran, 2000, p. 140).

VIII. Measuring Ruptures and the Rupture Resolution Process Over Time

Given the importance of addressing and working toward the resolution of ruptures
in the therapeutic alliance for treatment outcome, researchers have examined strategies by
which ruptures in the therapeutic alliance may be identified. In addition to patient and
therapist self-report methods such as direct questions about whether or not a rupture
occurred in a given session or patient and therapist ratings on the Working Alliance
Inventory (WAI; Horvath & Greenberg, 1989), researchers have sought out observer-
based methods for identifying ruptures. One available method for identifying ruptures in
the alliance is the Segmented Working Alliance Inventory – Observer (SWAI-O; Berk et
al., 2010), which can identify where in a given session a rupture occurs and where (if ever) in the course of treatment the alliance improves. Another tool is the Rupture Resolution Rating System (3RS; Eubanks-Carter et al., 2009), which identifies confrontation and withdrawal ruptures as well as resolution strategies used in rupture events. Given discrepancies in findings based on self-report and observer-based methods, Coutinho, Ribeiro, Sousa and Safran (2014) compared ruptures as indicated by patient scores on the WAI and ruptures as observed by reliable coders using the 3RS. Their findings indicate that the 3RS is able to pick up on ruptures that corresponding WAI scores may not suggest are occurring (Coutinho et al., 2014). This study, among others, points to the importance of exploring a range of methodologies for identifying alliance ruptures, and for using caution when relying solely on patient or therapist report.

A number of studies have looked at a series of ruptures over the course of treatment in order to understand the rupture resolution process. For instance, Coutinho, Ribeiro, Hill and Safran (2011) explored the rupture process using the first 15 sessions of treatment and Coutinho and colleagues (2014) used first and final sessions as well as every other session over the course of treatment. However, there is a dearth of research that takes into consideration the rupture resolution process over the entirety of psychotherapy cases. Though the present study limited its analyses to two to three rupture sessions from each of 18 cases, it represents one step in the movement toward future studies in which the entirety of psychotherapy cases may be explored in order to gain a greater understanding of how ruptures occur and are addressed over time.

IX. Use of Qualitative Methods
The present study draws primarily from task analysis as well as from other qualitative systems in its methodology, and can be understood within the task analytic framework. Task analysis encompasses four components. As described by Rice and Greenberg (1984), the first is a “selection and description of the task and task environment…” (p. 30) followed by a “rational analysis leading to an ‘idealized’ performance model” (p. 30). Once a rational model has been developed, “detailed moment-by moment descriptions of a series of actual client performances” (p. 30) are conducted and are then used in a “comparison of…actual performances with the idealized model…” (p. 30). This process allows researchers to develop a complex understanding of how a given task is achieved by moving between the predicted process and actual instances of the task. That is, a model is constructed, (the rational model) revised and refined (the rational-empirical model) over a series of studies, and ultimately, verification studies are conducted in order to systematically check the accuracy of the model (Rice & Greenberg, 1984). The SPM of rupture resolution that is of interest in the present study has already gone through the process of model development as well as cycles of observation. Thus, the present study can be understood as one step in the process of refinement of the rational-empirical model, through the use of detailed descriptive analyses based on close observation of psychotherapy sessions.

In addition to task analysis, the present study has also been influenced by thematic analysis (Boyatzis, 1998, as cited by Mcleod, 2011). Thematic analysis emphasizes the identification of themes of importance that emerge over multiple narratives having to do with a topic of interest. By first reviewing individual narratives for themes, researchers
then work to identify themes that recur across cases (Mcleod, 2011). In the present study, the attention to recurrent themes that emerge from patient and therapist narratives across multiple cases was influenced by thematic analysis.

The present study has also been influenced by Consensual Qualitative Research (CQR; e.g., Hill, C., 2012; Hill, Thompson & Williams, 1997). In CQR, data is collected by conducting interviews with participants on the topic of interest, and is then analyzed by a team that strives to achieve consensus in the process of identifying themes that emerge from the data, which are broken down into domains and core ideas that are explored across the sample. In addition to working toward consensus within the research team, CQR uses an auditor to review the team’s findings (Hill et al., 1997). CQR’s development of terminology to describe the frequency with which themes emerge in the data has been influential in the development of the methodology for this dissertation.

In addition to drawing from task analysis and thematic analysis as well as aspects of CQR, the methodology for the present study can be understood as a phenomenological and hermeneutic process in which a detailed descriptive analysis as well as some interpretation of patient and therapist narratives informed the examination of ruptures in the therapeutic alliance. This study also draws from constructivism, in seeing the qualitative research process as one that is influenced not only by the data but by the researcher and in acknowledging the notion than reality is not fixed but rather, constructed on an ongoing basis (see Mcleod, 2011, for a discussion of the role of phenomenology, hermeneutics and constructivism in qualitative research, and Hill and colleagues, 2005, for a discussion of constructivism in qualitative research).
**X. Additional Contextual Information**

In the interest of further contextualizing this study, three recent dissertations from the Brief Psychotherapy Research Program will be discussed as their work was also interested in the rupture resolution process in high and low outcome BRT cases and used a similar dataset to the present study. Glick (2010) examined psychotherapy sessions in which ruptures had occurred, from both high and low outcome cases. With an interest in the ways in which relational themes are articulated and addressed in psychotherapy, Glick (2010) used the Experiencing Scale (Klein et al., 1969; Klein et al., 1986) to assess sessions. Glick (2010) found that patients demonstrated higher levels of Experiencing in high outcome cases than in low outcome cases. This suggests that patients and therapists in high outcome cases were better able to address and process ruptures together during their sessions than those in low outcome cases (Glick, 2010).

Elvy (2010) examined therapists’ capacity to negotiate ruptures in the alliance in a range of treatment outcome conditions. This study also utilized a similar dataset to the present study, and examined high and low outcome cases as well as cases in which patients dropped out of treatment before completing the 30 session course. Using a modified version of the Therapist Experiencing Scale (Klein et al., 1969; Klein et al., 1986), Elvy (2010) found that therapists’ scores predicted outcome condition between high outcome, low outcome, and early dropouts, with higher levels of Experiencing associated with better treatment outcome. This suggests that therapists demonstrated a greater capacity to negotiate patient and therapist intersubjective experience in session in high outcome cases.
Finally, Banthin (2011) examined the rupture and resolution process in high and low outcome cases using the Psychotherapy Process Q-Set (Jones, 1985). While quantitative analyses did not identify significant differences between high and low outcome cases, qualitative analyses suggest that high outcome dyads demonstrated more consistency with the BRT model than low outcome cases, and that the stages of Safran & Muran’s (1996, 2000) SPM of rupture resolution were more evident in high outcome cases than in low outcome cases (Banthin, 2011).

**XI. Concluding Remarks**

Following the lines of work described above, the present study is one component of the line of research on BRT specifically and on the rupture resolution process in general. This study aims to contribute to the refinement of the SPM of rupture resolution (Safran & Muran, 1996, 2000) through close observation and detailed descriptive analysis, and in so doing, to contribute to research on the ways in which therapeutic alliance ruptures are addressed and resolved.
CHAPTER 2: THE EMPIRICAL STUDY

I. Literature Review

a. Research on the Therapeutic Alliance

The relationship between patient and therapist, or, the therapeutic alliance, has been a subject of interest for clinicians and researchers since the development of psychoanalysis. Since being conceptualized within psychoanalytic theory (e.g., Freud, 1913; Ferenczi, 1932), subsequent theorists such as Zetzel (1956) discussed the importance of the alliance for treatment effectiveness and expanded upon the role of the therapist in the strength of the alliance (e.g., Greenson, 1971). Highly influential to modern psychotherapy research, Bordin’s (1979) definition of the therapeutic alliance sees it as being constituted by agreement on the task and goals of therapy and the presence of a positive bond between patient and therapist (Safran & Muran, 2000). Much research has since been conducted demonstrating that the patient-therapist relationship is an important factor in understanding psychotherapy process and outcome. A strong working alliance is associated with positive treatment outcome (e.g., Fluckiger et al., 2012; Horvath & Bedi, 2002; Krupnick et al., 1996; Martin et al., 2000), and a weak working alliance is associated with premature dropout from treatment (e.g. Samstag, 1998; Samstag et al., 1998). Given the high value placed on a strong therapeutic alliance, researchers have also taken interest in the impact of ruptures in the therapeutic alliance. Ruptures are described by Safran and Muran (2000) as “…disagreements about the tasks or goals of therapy or…problems in the bond dimension…” (16). Psychotherapy researchers are interested in the ways in which ruptures in the therapeutic alliance alter
the treatment process as well as their impact on treatment outcome. Further, researchers are working to develop more nuanced understandings of the rupture and resolution process.

b. Brief Relational Therapy and the Stage Process Model of Rupture Resolution

Safran and Muran developed a therapeutic modality known as Brief Relational Therapy (BRT) that aims to provide techniques by which ruptures may be addressed and resolved in treatment (e.g., Safran & Muran, 2000). BRT draws from the work of psychoanalytic theoreticians such as Ferenczi and Rank (see Safran & Muran, 2000, p. 176), among others, as well as mindfulness-based practices. BRT can function as a treatment modality on its own or BRT techniques can be used along with other treatment modalities (e.g., Safran et al., 2014).

BRT was developed through the use of a research paradigm known as task analysis that allows researchers to develop an understanding of factors that contribute to change by conducting in depth analyses of clinical data. Task analysis uses an iterative process that moves between a theoretically – based model of the way in which a particular task is resolved, and clinical data (Rice & Greenberg, 1984). The Stage Process Model (SPM) of rupture resolution (Safran & Muran, 1996, 2000) has been developed and refined through a series of studies using task analysis that aimed to understand the ways in which ruptures are resolved. The generic SPM of rupture resolution (Safran & Muran, 1996) describes four stages. In stage one, a rupture marker occurs and is attended to. In stage two, patient and therapist explore the rupture experience. In stage three, patient and therapist explore avoidance associated with the
rupture experience. In stage four, the patient is able to express an underlying wish or need and addresses it with their therapist in the context of a rupture (Safran & Muran, 1996). The SPM (Safran & Muran, 2000) has also been elaborated to describe a series of stages of rupture resolution for two types of ruptures: those that are characterized by confrontation and those that are characterized by withdrawal (Safran & Muran, 2000). It is important to note that in both the generic SPM and in the models specific to withdrawal and confrontation ruptures, it is understood that patient – therapist dyads may cycle between the stages outlined, rather than simply moving from one to the next in the order in which they are presented (Safran & Muran, 2000, p. 140).

c. **Demonstrating the Effectiveness of BRT**

Since the development of the SPM of rupture resolution and of BRT as a therapeutic modality that focuses attention on the emergence of ruptures and the processes by which they are resolved, the impact of rupture resolution techniques and training have been the subject of a number of studies at the Brief Psychotherapy Research Program. Safran and colleagues (2005) as well as Muran and colleagues (2005) found that BRT may reduce treatment dropout rates and has been found to be equally effective as cognitive behavioral therapy (CBT) and short-term dynamic psychotherapy (STDP).

Safran and colleagues (2014) were interested in the effect of adding BRT techniques when CBT was the initial mode of treatment. Results indicate that, based on Structural Analysis of Social Behavior scores (SASB; Benjamin, 1974), BRT techniques altered patient – therapist interactions. Briefly, therapists became less controlling and more disclosing with their patients, and more often offered affirmations of their patients’
experiences. Also, patients became less deferential and submissive (and more assertive), engaged in more disclosing, and were less hostile within the therapeutic dyad (Safran et al., 2014). Further, based on therapist scores on the Experiencing Scale (EXP; Klein et al., 1969; Klein et al., 1986), therapists’ ability to reflect on their experiences with their patients while taking into consideration their own contributions to the dyad improved after the addition of BRT techniques (Safran et al., 2014).

d. Task Analysis

The development of BRT has been strongly influenced by a research paradigm known as task analysis, and the task analytic framework has informed the present study’s methodology. As previously described, in task analysis, a preliminary model of the way in which a task is achieved is developed based on theory as well as clinical experience. The model is refined and verified in an iterative process that moves back and forth between the model and actual instances of the event in order to understand how a problem is resolved (Rice & Greenberg, 1984). Through Rice and Greenberg’s (1984) application of task analysis to psychotherapy research, investigators have been able to develop more specific understandings of the ways in which clinical phenomena occur. Researchers have since furthered the use of task analysis in the field (e.g., Greenberg, 2007; Pascual-Leone et al., 2009).

A number of studies have been conducted in which task analysis is used to understand aspects of psychotherapy process and outcome. For instance, Greenberg and Foerster (1996) used task analysis to explore the process of resolving “unfinished business” in psychotherapy. Bennet and colleagues (2006) used task analysis to explore
the rupture resolution process in cognitive analytic therapy for individuals diagnosed with Borderline Personality Disorder, comparing good and poor outcome cases in order to address whether or not the rupture resolution process differed by condition. Aspland and colleagues (2008) applied task analysis to explore the rupture resolution process in CBT. These studies all demonstrate the iterative process by which task analysis moves between theory and clinical data in order to gradually develop models of task completion, as well as the utility of task analysis in working with complex clinical phenomena.

**e. Qualitative Methods**

In addition to the task analytic framework, the research strategies used in thematic analysis (e.g., Boyatzis, 1998) and Consensual Qualitative Research (CQR; e.g., Hill, 2012; Hill et al., 1997) have strongly impacted the methodology used in the present study. In task analytic terms, this study should be understood as an effort toward refinement of the SPM of rupture resolution (Safran & Muran, 1996, 2000), through the use of detailed descriptive analyses and close observation of psychotherapy sessions in high and low outcome cases. The analysis of patient and therapist narratives to identify themes present across cases draws from thematic analysis (e.g., Boyatzis, 1998). Finally, CQR’s (e.g., Hill, C., 2012, Hill et al., 1997) development of terminology to describe the frequency of relevant themes has also influenced the methodology of the present study.

**II. Hypotheses**

Given the combination of exploratory methods and hypothesis-testing methods used in this dissertation, hypotheses will be presented for a subset of the analyses conducted.
For the qualitative data analysis which drew upon the task analytic framework as well as thematic analysis and CQR, instead of entering into the data analysis process with predetermined hypotheses, an exploratory stance was taken, with an interest in refining the SPM of rupture resolution through close observation, and in so doing, to address whether or not aspects of the SPM (Safran & Muran, 1996, 2000), or other relevant markers, would emerge in the data, and in whether or not these markers would be able to differentiate between high and low outcome BRT cases.

In the exploratory analysis of narrative themes portion of this study, there were no predetermined hypotheses being tested, but rather, the researchers were interested in themes that may emerge in patient and therapist narratives across the dataset (see the methods section of this dissertation for a full discussion of the data analysis process in these portion of the study). The discussion of narrative themes is presented in Appendix B as it was conducted outside of the task analytic framework but may be useful in conceptualizing future research.

For the quantitative analyses of patient and therapist ratings of the Working Alliance Inventory (WAI), the Session Evaluation Questionnaire (SEQ) and the single item resolution question, a series of hypotheses were tested. It was hypothesized that in rupture sessions, patients and therapists from high outcome dyads would exhibit WAI scores as well as SEQ depth subscale scores that exceed the control limit more often than in low outcome cases. It was also hypothesized that patients and therapists from the high outcome group would have higher modal scores on the WAI, the SEQ depth subscale score, and the single item rupture question than the low outcome group, which would
indicate a stronger alliance, greater session impact, and a stronger sense of rupture resolution in the high outcome cases. As this study focused primarily on qualitative analyses, these statistical analyses are presented in Appendix C. They are included with the hope that they will be useful in designing future studies.

It was also hypothesized that on average, patients and therapists from the high outcome group would have higher mean ratings on the WAI, the SEQ depth subscale score and the single item rupture resolution question. This would indicate that in high outcome cases, the dyad would experience a stronger working alliance as well as greater depth of experience and a stronger sense of rupture resolution. While multilevel modeling should be used to address these questions as multiple data points over time were used from the same participants, independent samples t-tests were used to conduct preliminary analyses. Due to this statistical limitation, as well as the small sample size, results and discussion associated with these hypotheses are presented in Appendix D.

III. Method

a. Data Collection

Solely archival data was used in this study, from the Brief Psychotherapy Research Program, located at Beth Israel Medical Center in New York City. The Brief Psychotherapy Research Program is one of the premier psychotherapy research programs in the country, offering outpatient psychotherapy for individuals and training for psychology interns and externs as well as psychiatry residents. The program has been funded by a series of grants, including from the National Institute of Mental Health.

b. Participants
Participants included in this study consisted of 18 patient-therapist dyads from the Brief Psychotherapy Research Program.

c. Patients

Patients included in this study consisted of 18 individuals who received psychotherapy at the Brief Psychotherapy Research Program. 44% of the patients included were male while 66% were female. Their ages ranged from 24 to 69 years old (M = 45.2, SD = 11.4). 83% identified as White, not of Hispanic origin. 6% identified as Hispanic, and 11% identified as Asian or Pacific Islander. 89% of patients included in this study were employed and 11% were unemployed. 44% were married or remarried, while 39% were single and had never been married, and 17% were divorced or separated. 28% of these individuals had a graduate degree, 44% had a college degree, 11% had completed some graduate coursework, and 17% had completed some college coursework.

Patient diagnoses were determined based on the Structured Clinical Interview for the DSM-IV (SCID; First, Spitzer, Gibbon & Williams, 1995). 78% of patients included in this study met DSM-IV criteria for a depressive disorder and 33% met DSM-IV criteria for an anxiety disorder. 11% met criteria for an adjustment disorder. 78% of patients included in this study met criteria for an Axis I as well as an Axis II diagnosis. 28% of patients met DSM-IV criteria for Avoidant Personality Disorder, 11% met criteria for Obsessive Compulsive Personality Disorder, 5% met criteria for Histrionic Personality Disorder, and 5% for Self-Defeating Personality Disorder. 39% met criteria for Personality Disorder Not otherwise Specified. This diagnosis was provided when patients were sub-threshold for two or more personality disorders when assessed using
the SCID for DSM-IV. 17% of patients included in this study were given a V-code, indicating that they were experiencing a stressor that was not captured by a medical or psychiatric diagnosis but which could impact their treatment (Glick, 2010).

In order to best assess the effect of the psychotherapy provided in the study, and because the therapist participants were mainly in training, potential participants were excluded if there were indications of psychosis, current substance abuse, suicidality, mania, impulsivity, mental retardation, brain disease, or if individuals were on psychiatric medications that had not yet been stabilized for a minimum of three months (Banthin, 2011; Glick, 2010).

d. Therapists

Therapists included in this study consisted of 16 individuals who were therapists at the Brief Psychotherapy Research Program. 14 therapists included in this study worked with one patient included in the study, while two therapists treated two patients included in the study. Therapists were in the process of completing their PhD or PsyD in clinical psychology or had already done so. 40% of the therapists included in this study were male, while 60% were female. 80% of the therapists identified themselves as White, not of Hispanic origin, 7% identified as Black, not of Hispanic origin, 7% identified as other, and 6% did not respond to this question. Their ages ranged from 27 to 41 years old (M = 32.7, SD = 3.75). 73% had obtained an MA or MS and were working toward a PhD or PsyD while 27% had already obtained a PhD or PsyD. 60% of therapists endorsed currently being in a relationship, 33% described themselves as single, and 7% did not respond to this question.
e. Treatment Modality

All patients included in this study were provided with BRT. BRT focuses on understanding and addressing ruptures in the therapeutic alliance and draws from psychoanalytic theory as well as mindfulness-based practices. In particular, BRT employs an intensive focus on the here and now within sessions and encourages therapeutic metacommunication in order to understand ruptures in the alliance (Safran & Muran, 2000). In this study, BRT was used as a primary treatment modality. Patient-therapist dyads met once per week for 30 weeks, with the exception of one dyad that met for 39 sessions and one dyad that met for 32 sessions, for clinical reasons.

f. Therapist Training Procedure

Therapists met with licensed clinical psychologists who are experts in BRT for weekly training and supervision. Training and supervision took place in a group format and each meeting was 90 minutes long. In addition to reviewing their cases, therapists participated in experiential training activities and mindfulness exercises in order to develop their capacity to administer BRT. Therapists participated in these meetings for the duration of the time that they worked with their patient(s).

g. Outcome Measures

The Symptom Checklist – 90 - Revised (SCL-90R; Derogatis, 1983) is a 90 item self-report measure that asks individuals to rate the extent to which they experience a range of symptoms on a Likert scale, from 0, indicating “not at all” to 4, indicating “extremely.” It assesses a range of psychiatric symptoms, for example, “crying easily” and “worrying too much about things” (Derogatis, 1983). Patients were asked to
complete the SCL-90 prior to the beginning of treatment as well as at the end of treatment, in order to assess changes in symptomatology over the course of treatment.

The Inventory of Interpersonal Problems (IIP; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 64 item self-report measure that assesses interpersonal functioning by asking individuals to rate the extent to which they find specific interpersonal tasks difficult and the extent to which they engage in various interpersonal behaviors too much. It includes 32 items that form eight subscales, assessing interpersonal styles such as “nonassertiveness” and being “domineering/controlling” (Horowitz et al., 2000). Patients were asked to complete the IIP prior to the beginning of treatment as well as when treatment was completed in order to assess changes in interpersonal functioning over the course of treatment.

The Target Complaints questionnaire (TC; Battle et al., 1966) is a self-report measure that asks individuals to list three items that they would like to work on in treatment. Individuals are also asked to rate the extent to which a given problem bothers them on a Likert scale, from 1 to 13. Patients were asked to complete this questionnaire prior to the beginning of treatment. At the end of treatment, they were provided with the three complaints that they had initially listed and were asked to rate the extent to which they felt bothered by them, in order to assess for changes in patients’ experience of their primary concerns over the course of treatment.

The Wisconsin Personality Disorders Inventory (WISPI; Klein, Benjamin, Trece, Rosenfeld & Greist, 1993) is a 240 item self-report measure that assesses the presence of symptoms of personality disorders based on a range of statements (e.g.,
“Driving while drunk or high does not worry me; I figure whatever happens, happens”).

Individuals are asked to rate their experience on a Likert scale ranging from 1 to 10, with a score of 1 indicating “Never/Not At All” and a score of 10 indicating “Always/Extremely” (Klein et al., 1993). Patients were asked to complete the WISPI at the beginning and end of treatment in order to assess changes in symptoms of personality disorders over the course of treatment.

**The Global Assessment Scale** (GAS; Endicott, Spitzer, Fleiss & Cohen, 1976) asks clinicians to provide a single rating to describe a patient’s overall functioning. The lowest score on the scale indicates that an individual “needs constant supervision for several days to prevent hurting self or others” and the highest score on the scale indicates “superior functioning on a wide range of activities, life’s problems never seem to get out of hand…” (Endicott et al., 1976). Clinicians were asked to provide a GAS rating on their patient after their second psychotherapy session in order to assess functioning early in the treatment process, and were asked to provide a second GAS rating at the end of treatment, in order to assess for changes in each patient’s global functioning.

**h. Process Measures**

**The Post-Session Questionnaire** (PSQ; Muran, Safran, Samstag, & Winston, 2002) is a self-report measure that is filled out by both patients and therapists after each psychotherapy session. There are two versions of the form: a questionnaire for patients and a questionnaire for therapists. Each form asks individuals to reflect on their experience during a given psychotherapy session as well as their understanding of the impact of treatment overall. Further, patients and therapists are asked to rate the extent to
which they experienced ruptures in the therapeutic alliance, and if so, to describe them.
The measures from the PSQ that were used in the present study are the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984), the single item resolution question and the patient and therapist rupture narratives (see Appendix A).

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a self-report measure in which patients and therapist are asked to rate statements on a Likert scale from one to seven. Items assess patient and therapist agreement on the tasks and goals of treatment as well as their bond at a particular point in time. Examples of items include “My therapist and I agree about the things I need to do in therapy to help improve my situation” on the patient form and “I appreciate my patient as a person” on the patient form (Horvath & Greenberg, 1989).

The Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) is a self-report measure consisting of pairs of words that convey opposite experiences (e.g., “Full” and “Weak”). Patients and therapists rate their experience of the session with regard to these terms on a scale from one to seven. This measure assesses the degree of smoothness and depth that patients and therapists experience in a given session. For the purposes of this study, only the depth subscale of the SEQ was used. This scale assesses patient and therapist experiences of profound meaning having occurred in session, with word pairs including “Shallow” and “Deep” as well as “Valuable” and “Worthless.” Higher scores are associated with greater experiences of depth (Stiles & Snow, 1984).
**General Rupture Questionnaire:** As part of the PSQ, patients and therapists are also asked to respond to six questions regarding the occurrence of ruptures. In addition to rating the extent to which they experienced a rupture, they are asked to describe the problem as well as the extent to which the problem was addressed and resolved. Patient and therapist ratings and narratives of ruptures were used to determine whether or not ruptures had occurred in each session and whether or not they experienced the rupture as resolved (the single item resolution question asks patients and therapists to answer the question “To what extent was the problem resolved by the end of the session?”). Responses are on a Likert scale ranging from one to five. A response of one indicates “not at all” and a response of five indicates “very much” (Muran, Safran, Samstag, & Winston, 2002, see Appendix A).

**i. Data selection**

In keeping with the aims of this study, which included an effort to understand whether or not ruptures are resolved differently in high and low outcome psychotherapy cases, 50% of the cases included in this study are considered high outcome and 50% are considered low outcome, n=18 therapeutic dyads (n=18 patients, n=16 therapists). In order to select cases for this study as well as previous studies using similar datasets (e.g. Banthin, 2011; Elvy, 2010; Glick, 2010), treatment outcome for 73 BRT cases was assessed. Using ratings of the SCL-90, the IIP, the GAS, the TC and the WISPI, residual gains scores were calculated for the 73 BRT cases, which were then submit to a principal component analysis with a varimax rotation. There was a large first factor (composed of the outcome measures described above) and the scores on this factor were rank ordered.
With an effort to select cases among the highest and lowest in rank order, cases were examined for the presence or absence of ruptures reported on the PSQ, based on numerical ratings of ruptures as well as patient narratives of rupture experiences. Research team members reviewed rupture narratives in order to ensure that cases with ruptures in the alliance were selected. Cases were then matched in order to capture ruptures as equally as possible over the course of treatment in high and low ranking cases (Banthin, 2011; Elvy, 2010; Glick, 2010; J.C. Muran, personal communication, October 3, 2014). The ranks of the high outcome cases included in this study are: 4, 5, 7, 8, 9, 14, 17, 23, and 24 and the ranks of the low outcome cases included in this study are: 52, 53, 55, 59, 61, 63, 65, 66, and 67. Thus, the highest ranking case in the dataset is 4 out of 73 and the lowest is 67 out of 73, and the high and low outcome cases demonstrate substantial differences in the degree and direction of change experienced.

Ultimately, two to three sessions per case were selected for inclusion in the dataset, such that a total of 44 sessions were included in the present study. 50% or 22 of the sessions in the dataset are from high outcome cases and 22 are from low outcome cases. Again, all sessions included were deemed sessions in which a rupture in the therapeutic alliance occurred, on the basis of patient report and expert review of the PSQs. The sessions included range from early to late in the course of treatment, with the earliest session included being session four and the latest being session 28.

j. Qualitative Data Analysis Using Task Analytic Framework

The qualitative data analysis based on a task analytic framework formed the primary analyses conducted in this study. Video recordings and transcripts of each
psychotherapy session included in the dataset were used in order to perform the qualitative analysis of the data. Transcripts were used in conjunction with video recordings except when video data was not available, in which case transcripts were used alone. Transcripts were highly detailed, including all audible utterances by both patient and therapist. As previously discussed, qualitative data analytic strategies drawing from task analysis, thematic analysis and CQR were used in order to conduct a detailed examination of the rupture and resolution process that occurred in each of the sessions and cases included in the dataset. The analysis was divided into five phases, each of which aimed to complete an aspect of the analytic process and/or to answer a set of questions. It is important to note that with the exception of a small number of quantitative analyses (described below), all findings are based on qualitative analyses conducted by the author with the supervision of the research team at the Brief Psychotherapy Research Program. Thus, while percentages and frequency counts are used to describe patterns in the data, they are used as a heuristic to discuss themes that emerged and are not to be understood as hard and fast numerical data. In order to address questions that emerged in the data analysis process, the research team discussed the sessions included in this dataset during each phase of the analyses presented.

In phase one, the author conducted a detailed descriptive analysis of each session included in the dataset. This descriptive analysis identified the presence or absence of components of the SPM (Safran & Muran, 1996, 2000). Also, in phase one, the author utilized non-SPM descriptors to capture aspects of the rupture and resolution process not described by the SPM. Thus, in addition to identifying instances in which each of the
four stages of the SPM occurred in the sessions, the author identified nine additional descriptors that occurred across a range of the sessions, based on recurrent themes in patient and therapist narratives. For example, instances in which therapists disclosed their own experience of a rupture in the here and now were tracked, as well as instances in which patients expressed confusion and/or frustration about the treatment modality or treatment in general (see Table 1 for a full list of descriptors). Each SPM descriptor and non-SPM descriptor was labeled on detailed notes of a given psychotherapy session, in order to allow for an exploration of the frequency and sequence in which these markers occurred.

In phase two, consecutive rupture sessions within cases were examined in order to explore whether or not the rupture resolution process occurred over the course of more than one session. Additionally, transcripts and patient and therapist narratives of all rupture sessions included in the dataset were examined by the author to identify recurrent rupture themes within individual cases across multiple rupture sessions. Note that an additional exploratory analysis of rupture themes in patient and therapist rupture narratives across all 30 sessions for each case in the dataset was also conducted, and was generally consistent with the themes that emerged in phase two. See Appendix B for a discussion of the exploratory analysis of rupture themes.

In phase three, high outcome cases were compared to one another in order to address the question of whether or not certain aspects of the SPM or non-SPM descriptors were common or uncommon among high outcome cases. This phase aimed to identify any consistencies that may exist amongst high outcome cases.
In phase four, as with the high outcome cases in phase 3, low outcome cases were compared to one another in order to identify any consistencies that may exist across low outcome cases, in terms of both the elements of the SPM and non-SPM descriptors.

In phases three and four, two lenses were used to explore the nature of the rupture resolution process across the cases: by the presence of each descriptor and by the frequency of each descriptor. A descriptor was considered to be present within a case if it occurred one or more times in at least one of the sessions included in the dataset within the case. A descriptor was considered to be frequent within a case if it occurred one or more times in every session included in the dataset for a given case. Note that as the qualitative analyses conducted in this phase were conducted by the author based on a detailed descriptive analysis and close observation, without the use of a validated measure or reliability checks, the percentages listed below are to be understood as heuristics for capturing differences between the high and low outcome cases (see Table 3).

In phase five, findings from the high and the low outcome cases were contrasted with one another, in order to determine whether or not the occurrence of aspects of the SPM or non-SPM descriptors would differentiate between high and low outcome cases.

In addition to the qualitative data analysis using a task analytic framework, a series of other analyses were conducted in order to understand the data from a variety of perspectives. Methods for these exploratory analyses are presented below and results as well as discussion of them are available in the appendices of this dissertation.

**k. Exploratory Analysis of Themes in Rupture Sessions**
Following the detailed analysis of video recordings as well as transcripts of the rupture sessions included in this study as described above, a qualitative, exploratory analysis of themes that emerged in patient and therapist rupture narratives (as provided on the PSQ) was performed, drawing from thematic analysis (Boyatzis, 1998; Mcleod, 2011). In an effort to understand the ruptures that occurred across the entirety of each case within the dataset, all available PSQs for both patients and therapists for each case in the dataset were reviewed. The author identified themes within patient and therapist rupture narratives across the course of treatment, adhering closely to patient and therapist language. Themes discussed are those that occurred in the narratives for a minimum of five sessions. The author also identified themes that emerged in both patient and therapist rupture narratives solely within the final five sessions of treatment, in order to gain a greater understanding of the nature of the therapeutic process at termination. Themes discussed are those that occurred in the narratives for a minimum of two sessions, in order to focus on prevalent themes instead of those that were idiosyncratic. As the exploratory analysis of rupture narratives was a secondary analysis conducted in order to provide additional information about the rupture resolution process and to inform future studies, results and discussion are presented in Appendix B.

1. Quantitative Analyses of Patient and Therapist Ratings of the WAI

In order to assess patient and therapist agreement on the tasks and goals of treatment as well as shifts in their bond over the course of therapy, modal WAI scores were examined over the course of treatment. Also, control charting was used to provide another lens through which these scores may be understood. Control charting methods
were first used by Shewhart (1931) in the field of engineering. Control charting offers a way to see change on a given measure, while viewing scores with respect to typical ratings (e.g., Berk, 2013). Control charting demonstrates the discrepancy of particularly high or low ratings from an individual or system’s typical responses. For the purposes of this study, WAI scores were considered outside of the control limit if they deviated from an individual’s mean rating (by exceeding or falling below the mean) by at least one standard deviation (see Eubanks-Carter, Gorman and Muran, 2012 for a detailed discussion of control charting methodology in psychotherapy research).

In the context of the present study, increases and decreases in patient and therapist WAI ratings over the course of treatment were of interest in understanding the impact of ruptures and rupture resolution on the therapeutic alliance. Patient and therapist WAI scores were collected from the PSQs and were charted separately. Analyses compared the high and low outcome groups based on instances in which patient and therapist WAI scores exceeded or fell below the control limit. Analyses also compared the high and low outcome groups on the basis of patient and therapist modal WAI scores across the course of treatment. As these analyses were secondary to the qualitative analyses previously discussed and were done in order to provide additional information about the rupture resolution process and to inform future studies, results and discussion are presented in Appendix C.

Four additional questions were addressed regarding possible differences between mean WAI scores in the high and low outcome groups. However, as independent
samples t-tests were used instead of multilevel modeling despite the presence of nested data, these questions, results and discussion are presented in Appendix D.

m. Quantitative Analysis of Patient and Therapist Ratings of the SEQ

The depth subscale of the SEQ was examined in order to assess patients and therapists having experienced a given session as profound or superficial. In addition to assessing patient and therapist depth subscale scores across the course of treatment, control charting was used to provide another lens through which to view these scores. As with patient and therapist ratings of the WAI, patient and therapist SEQ depth subscale scores were collected from the PSQs and were charted separately. SEQ depth subscale scores were considered outside of the control limit if they deviated from the mean by at least one standard deviation. Analyses compared the high and low outcome groups based on instances in which patient and therapist SEQ depth subscale scores exceeded or fell below the control limit. Analyses also compared the high and low outcome groups on the basis of patient and therapist modal SEQ depth subscale scores across the course of treatment. As these analyses were secondary to the qualitative analyses previously discussed and were done in order to provide additional information about the rupture resolution process and to inform future studies, results and discussion are presented in Appendix C.

Four additional questions were addressed regarding possible differences between mean SEQ depth subscale scores in the high and low outcome groups. However, as independent samples t-tests were used instead of multilevel modeling despite the
presence of nested data, these questions, results and discussion are presented in Appendix D.

n. Quantitative Analysis of Patient and Therapist Ratings of the Single Item Resolution Question

The single item resolution question (“To what extent was the problem resolved by the end of the session?”) on the patient and therapist PSQ was examined in order to assess differences in perceptions of the extent to which ruptures were resolved between the high and low outcome groups. Analyses compared the high and low outcome groups on the basis of patient and therapist modal single item resolution question ratings across the course of treatment. As these analyses were secondary to the qualitative analyses previously discussed and were done in order to provide additional information about the rupture resolution process and to inform future studies, results and discussion are presented in Appendix C.

Four additional questions were addressed regarding possible differences between mean responses to the single item rupture resolution question in the high and low outcome groups. However, as independent samples t-tests were used instead of multilevel modeling despite the presence of nested data, these questions, results and discussion are presented in Appendix D.

IV. Results

Results for the qualitative data analysis using a task analytic framework will be presented phase by phase, as the analyses were conducted. Drawing from the task analytic framework, analyses aimed to refine the stage process model by conducting a detailed descriptive analysis based on close observation of rupture sessions in high and
low outcome cases. Also drawing from thematic analysis and from CQR, descriptors that marked salient themes were generated and then assessed for presence and frequency in the data analysis process.

In phase one, in the process of conducting a detailed descriptive analysis of each session included in the study, SPM stages were noted in the course of each session when applicable, and non-SPM descriptors were used to describe the ways in which ruptures occurred and were addressed when the SPM did not fully capture what transpired between patient and therapist, in order to work toward refining the SPM. See Table 1 for a full list of the descriptors utilized for this study. Note that all SPM descriptors are from Safran and Muran’s (1996, 2000) descriptions of the stage process model.

Table 1

Descriptors used in qualitative data analysis using task analytic framework

| Stage Process Model Stage 1: Attending to rupture marker |
| Stage Process Model Stage 2: Exploring the rupture experience |
| Stage Process Model Stage 3: Exploration of avoidance |
| Stage Process Model Stage 4: Emergence of wish/need and/or exploration of interpersonal schema |
| Patient avoids exploration of rupture (using strategies such as avoidance, minimizing, topic changing) |
| Therapist discloses own experience with regard to the rupture resolution process in the here and now |
| Therapist encourages patient to explore his or her own experience in the here and now, outside of Stage Process Model Stage 1 |
| Patient expresses confusion and/or frustration about treatment modality or treatment in general |
| Patient contributes to resolution process by making links to outside experience |
| Therapist offers patient an interpretation in the context of the rupture process |
| Patient rejects therapist’s interpretation |
| Therapist persistently adheres to discussing the here and now |
| Patient and therapist discuss hierarchy in therapeutic relationship or patient complains about therapist neutrality or therapist occupying a professional role |
In phase two, each of the cases included in the study were examined to assess for the presence of patterns in the rupture resolution process across multiple rupture sessions. Recall that for each of the 18 cases in the study, either two or three rupture sessions were used. Both consecutive and non-consecutive rupture themes were included in the dataset. The investigator was interested in whether or not the same rupture or rupture theme was discussed over the course of multiple sessions, both in cases in which consecutive sessions were included in the analyses and in cases in which non-consecutive cases were included in the analyses. Themes were considered recurrent when they emerged in more than one of the rupture sessions for a given case. Rupture themes that were considered recurrent for a given case were thus evident in either two or three rupture sessions.

Among high outcome cases, five of the nine cases in the analyses included consecutive rupture sessions. Within these five cases, four included discussion of the same rupture or rupture theme across consecutive sessions. Among low outcome cases, four of the nine cases in the analyses included consecutive rupture sessions. Within these four cases, all included discussion of the same rupture or rupture theme across consecutive sessions.

Transcripts for all rupture sessions included in the dataset (that is, not only those sessions that were consecutive) were then reviewed to identify recurrent rupture themes within individual cases across multiple rupture sessions. Findings are presented below in Table 2, and include recurrent rupture themes in consecutive and non-consecutive rupture sessions. Note that while a number of the categories below could be construed as forms of expression of treatment dissatisfaction (e.g., a patient expressing feeling overwhelmed
in a session could potentially be understood as an expression of dissatisfaction with aspects of treatment), the theme “treatment dissatisfaction” refers to instances in which there was more explicit conversation about a patient’s questions or concerns about the utility or efficacy of the sessions.

Table 2

Recurrent rupture topics and themes

<table>
<thead>
<tr>
<th>Case #</th>
<th>Recurrent topic/theme</th>
<th>Case #</th>
<th>Recurrent topic/theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discussion of patient having felt vulnerable and overwhelmed in previous session</td>
<td>10</td>
<td>Theme of treatment dissatisfaction</td>
</tr>
<tr>
<td>3</td>
<td>Theme of treatment dissatisfaction</td>
<td>11</td>
<td>Feelings of being disconnected and stuck</td>
</tr>
<tr>
<td>7</td>
<td>Discussion of patient having felt criticized in previous session</td>
<td>13</td>
<td>Theme of treatment dissatisfaction</td>
</tr>
<tr>
<td>9</td>
<td>In two consecutive sessions, discussion regarding patient’s difficulty beginning sessions due to feelings of vulnerability and concerns about being judged by therapist and others</td>
<td>14</td>
<td>Confusion between patient and therapist about the topic of conversation</td>
</tr>
<tr>
<td>15</td>
<td>Patient refers to having felt rejected in previous session</td>
<td>16</td>
<td>Theme of boundary crossing on part of patient</td>
</tr>
<tr>
<td>17</td>
<td>Theme of treatment dissatisfaction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An additional exploratory analysis of rupture themes in patient and therapist rupture narratives across all 30 sessions of treatment was also conducted, and was generally
consistent with the themes presented here. See Appendix B for a discussion of the exploratory analysis of rupture themes.

In phases 3 and 4, the rupture resolution process in high and low outcome cases was explored by examining the occurrence of stage process model and non-stage process model descriptors across cases. Recall that two lenses were used to explore the nature of the rupture resolution process across these cases: the presence of each descriptor and the frequency of each descriptor. A descriptor was considered to be present within a case if it occurred one or more times in at least one of the sessions included in the dataset within the case. A descriptor was considered to be frequent within a case if it occurred one or more times in every session included in the dataset for a given case.

It is important to note that as the analyses conducted in this phase were conducted by the author without the use of a validated measure or reliability checks, the percentages listed below and throughout phases three, four and five of this study are to be understood as heuristics for capturing differences between the high and low outcome cases, rather than to be read as hard and fast numerical data. Percentages by case are out of nine high outcome and nine low outcome cases included in the analyses, while percentages by session are out of the 22 corresponding sessions for each outcome group (see Table 3).

Table 3

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Presence by Case (%)</th>
<th>Frequency by Case (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>SPM Stage 1: Attending to rupture marker</td>
<td>100% (9)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>SPM Stage 2: Exploring rupture experience</td>
<td>89% (8)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>Descriptor</td>
<td>Presence by Case (%)</td>
<td>Frequency by Case (%)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>SPM Stage 3: Exploration of avoidance</td>
<td>67% (6)</td>
<td>55% (5)</td>
</tr>
<tr>
<td>SPM Stage 4: Emergence of patient’s wish/need and/or exploration of interpersonal schema</td>
<td>89% (8)</td>
<td>67% (6)</td>
</tr>
<tr>
<td>Patient avoids exploration of rupture</td>
<td>78% (7)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>Therapist discloses own experience regarding rupture in here and now</td>
<td>89% (8)</td>
<td>89% (8)</td>
</tr>
<tr>
<td>Therapist encourages patient to explore his/her experience in present</td>
<td>100% (9)</td>
<td>78% (7)</td>
</tr>
<tr>
<td>Patient expresses confusion/frustration about treatment</td>
<td>78% (7)</td>
<td>78% (7)</td>
</tr>
<tr>
<td>Patient contributes to resolution process by making links to outside experience</td>
<td>44% (4)</td>
<td>89% (9)</td>
</tr>
<tr>
<td>Therapist offers interpretation in the context of rupture</td>
<td>89% (8)</td>
<td>100% (9)</td>
</tr>
<tr>
<td>Patient rejects interpretation</td>
<td>44% (4)</td>
<td>33% (3)</td>
</tr>
<tr>
<td>Therapist persistently adheres to discussing the here and now</td>
<td>22% (2)</td>
<td>0</td>
</tr>
<tr>
<td>Patient and therapist discuss hierarchy in therapeutic relationship / therapist's professional role</td>
<td>22% (2)</td>
<td>33% (3)</td>
</tr>
</tbody>
</table>
In phase five, high and low outcome cases were compared to one another on the basis of analyses conducted in phases three and four. In order to focus the analyses on descriptors that were particularly distinct when comparing the high and low outcome groups, results will be discussed for the descriptors in which there was a difference of at least 20 percentage points between the high and low outcome cases, for presence and/or frequency of the descriptors. 20 percentage points was used as a guideline after reviewing the data to identify more substantial differences between groups. That is, in establishing a cut off point of 20 percentage points, an effort was made to focus further analyses and discussion on markers that could indicate substantial differences between the high and low outcome groups. Brief examples will be provided alongside the high and low outcome group comparisons, followed by more extensive examples in the discussion section of this dissertation.

Presence by case

Recall that descriptors were considered to be present within a case if they occurred one or more times in at least one of the sessions included in the dataset within the case. Five descriptors were identified as sufficiently distinct for further discussion when comparing high and low outcome cases on the basis of presence of the descriptor by case.

- Stage Process Model – stage four occurred in more of the high outcome cases than low outcome cases. Stage four of the SPM consists of instances in which in the context of the addressing a rupture in the therapeutic alliance, patients are able to express an underlying wish or need to their therapist, often contacting some
vulnerability or assertiveness (e.g., a patient was able to express his wish to be cared for to his therapist for the first time). In some instances, patients were also able to explore the interpersonal schema that had been evoked in the rupture process.

• Patients avoided exploration of the rupture process in more of the low outcome cases than high outcome cases (e.g., patients used storytelling or humor to avoid exploration of a rupture).

• Therapists encouraged patients to explore their experience in the here and now in more of the high outcome cases than low outcome cases (e.g., a therapist repeatedly encouraged their patient to discuss their affective experience in the moment and the patient was able to explore feeling uncomfortable discussing the therapeutic relationship).

• Patients contributed to the resolution process by making links to outside experience in more of the low outcome cases than high outcome cases (e.g., a patient was able to connect the rupture experience to feelings of neediness that occurred with her boyfriend).

• Finally, therapists persistently adhered to discussing the here and now in two high outcome cases, whereas this was not observed in any of the low outcome cases (e.g., therapists repeatedly returned to exploration of patient affect in the here and now despite patients’ expression of confusion and frustration).

*Frequency by case*
Recall that descriptors were considered to be *frequent within a case* if they occurred one or more times in every session included in the dataset for a given case. Three descriptors were identified as sufficiently distinct for further discussion when comparing high and low outcome cases on the basis of frequency by case.

- The descriptor “therapists disclosed their own experience in the here and now” was more frequent in low outcome cases than high outcome cases (e.g., therapists expressed feelings of being stuck in the context of a rupture or disconnected from their patients).
- The descriptor “therapists encouraged patients to explore their experience in the here and now” was more frequent in high outcome cases than low outcome cases.
- Finally, the descriptor “therapist offers interpretation of the rupture process” was more frequent in low outcome cases than high outcome cases (e.g., a therapist pointed out their patient’s fear of his own destructiveness).

*Quantitative analyses*

A brief summary of quantitative analyses conducted is presented below. For a detailed discussion of the following quantitative analyses, see Appendix D.

- Therapist mean ratings of the WAI were significantly higher in the high outcome group than in the low outcome group, both across the course of treatment and in rupture sessions only. Patient mean ratings of the SEQ depth subscale score were significantly higher in the high outcome group than in the low outcome group, when looking at ratings across the course of the entire case.
• There were no significant differences in patient mean WAI ratings across the course of treatment or in rupture sessions only when comparing the high and low outcome groups. There were no significant differences in patient mean ratings of the SEQ depth subscale score in high and low outcome groups when looking at rupture sessions only. There were also no significant differences in therapist mean ratings of the SEQ depth subscale score in high and low outcome cases when looking across the course of treatment or in rupture sessions only. There were no significant differences in patient or therapist mean ratings of the single item rupture question, when looking across the course of treatment or in rupture sessions only.

V. Discussion

One of the principal aims of this study was to contribute to the refinement of the SPM of rupture resolution through the use of close observation and an intensive descriptive analysis. In the qualitative data analysis process, a series of descriptors were used to describe and assess the presence and frequency of themes in the data. Each of the descriptors that met previously described criteria in presenting a difference between the high and low outcome groups are discussed below.

• One of the most prominent findings from the present study is that therapists encouraged patients to explore their experience in the here and now more often in high outcome cases than in low outcome cases. This was the case when viewed through the lens of presence by case and frequency by case.
In reviewing these instances, it often appeared that this technique helped patients to develop greater awareness of negative affect in the moment and to verbally express aspects of their experience for the first time. For example, in a high outcome case, the dyad discussed the patient’s anger and frustration with her therapist, and her wish to be more fully understood. As the conversation unfolded, the therapist asked the patient to explore her experience in the here and now and the patient described feeling like “a sad, hollow, deprived version of herself.” By exploring the patient’s affect in the moment, the patient was able to develop a more nuanced understanding of her own experience. This finding is in keeping with BRT’s advocacy of close attention to the here-and-now process within sessions. It is also in keeping with Glick’s (2010) finding of higher levels of patient Experiencing in high outcome cases than in low outcome cases, indicating that patients and therapists in high outcome cases may have been better able to process the rupture experience and the associated affect within sessions than those in low outcome cases (Glick, 2010).

- It was also notable that based on the qualitative data analysis, through the lens of presence by case, SPM – stage four occurred in more of the high outcome cases than low outcome cases.

This included instances in which in the context of the addressing a rupture in the therapeutic alliance, patients were able to express an underlying wish or need to their therapist, and/or to explore an interpersonal schema. This observation supports research suggesting that the rupture resolution process may impact overall treatment outcome. For instance, in a high outcome case, in the context of a rupture in which the dyad discussed
the patient’s concerns about treatment and his difficulties expressing anger and accepting help from others, the patient was eventually able to talk about his feelings of weakness and vulnerability and discussed his fear of being vulnerable. When his therapist asked him about how it was to be vulnerable within the session, the patient was able to express his longing to be vulnerable and to be “…enveloped, supported, understood and cared for.” This expression of underlying vulnerability and a wish to be cared for fostered a greater sense of understanding of the patient and therapist’s experience with one another. That there were more instances of SPM - stage 4 based on presence by case but not frequency by case is not surprising, as it may be that one instance (rather than repeated instances) in which an individual is able to express an underlying wish or need and/or is able to explore an interpersonal schema is sufficient to positively impact treatment outcome. To complicate matters, it is interesting that modal scores on the single item rupture resolution question, which asks about the extent to which the rupture was resolved within the session, were the same or similar in the high and low outcome groups, on the basis of patient and therapist ratings (see Appendix C). That the modal scores do not indicate a greater experience of rupture resolution in the high outcome cases than in the low outcome cases highlights the importance of future research in which a systematic observer based method such as the 3RS (Eubanks-Carter et al., 2009) or the SWAI-O (Berk et al., 2010) may be used to reliably identify ruptures and their resolution through the use of a group of coders.
• Another prominent finding, based on frequency by case analyses, was that therapists more often offered interpretations of the rupture process to patients in low outcome cases than in high outcome cases.

Review of these instances suggests that the interpretations offered in both high and low outcome cases appear to have had the potential to be helpful to patients. For instance, in a high outcome case, in the context of a rupture, the therapist pointed out to the patient his tendency to give up his own sense of what would and wouldn’t work for him, thereby quickly giving up his sense of authority about himself. In a low outcome case, the patient questioned the value of thinking about her feelings in treatment. The therapist suggested to the patient that she was fighting herself in trying to avoid any exploration of her negative feelings, and that this was likely the source of an internal conflict. Based on these examples and others, the interpretations offered in low outcome cases did not appear to be particularly detrimental to the treatment process and there were no striking differences in the nature of the interpretations offered in high and low outcome cases. It remains unclear why this occurred more often in low outcome cases than in high outcome cases.

• Based on presence by case qualitative analyses, patients more often contributed to the resolution process by making links to outside experience in low outcome cases than in high outcome cases.

It is difficult to explain this difference between groups as review of these instances does not indicate that this action on the part of patients was detrimental or problematic in the low outcome group. For instance, in a high outcome case, in the context of a rupture, the
patient explained to the therapist that she had realized in the last third of treatment that she didn’t need to protect her therapist from her experience (including feelings of anger) and connected this to having tried to protect important others in her life from her experience as well. In a low outcome case, in a rupture in which the patient questioned the value of treatment and wondered whether being in touch with her feelings would lead her to feel better, the dyad discussed the patient’s tendency to carry her burdens in life alone. Eventually, the patient was able to verbalize her feeling that she couldn’t unburden herself because others would be unable to handle her “stuff,” and went on to express her fear of being weak like her mother. Across the high and low outcome groups, it typically appeared that patients were genuinely trying to understand the relationship between their experience in session and elsewhere, and were recognizing patterns in their interpersonal experiences with the help of their therapists.

• On the basis of presence by case qualitative analyses, patients more often avoided exploration of the rupture process in low outcome cases than in high outcome cases.

This is unsurprising as it led to instances in which ruptures were not fully processed. For instance, in a low outcome case, in the context of a rupture in which the patient indirectly expressed dissatisfaction with treatment and discussed her sadness that her marital conflict had not been resolved, the therapist observed that the patient appeared “emotional.” The patient responded “...not because I’m really thinking about it...” and the therapist attempted to bring the patient’s attention to her experience in the moment. The patient soon shifted the topic and told a story about an incident at work and her
husband’s reaction to it. The therapist noted how defeated the patient seemed to feel, and also said that she wanted feedback from the patient about what the patient would find helpful in treatment. The patient said “ok” but then began to talk about having stomach pain. In moments such as this, patients often appeared uncomfortable and nervous and despite therapists’ attempts to explore their experience, the conversation moved away from the issue at hand.

• Also based on presence by case qualitative analyses, therapists were more persistent in adhering to discussing the dyads’ experience in the here and now, as is prescribed by the BRT model, in high outcome cases than in low outcome cases. This occurred in two of the high outcome cases while it did not occur in any of the low outcome cases.

In these instances, the therapists were sometimes insistent in focusing on the patient’s experience in the here and now even when it appeared that patients would prefer to focus on other topics. For instance, in a high outcome case, in the context of a rupture in which the patient expressed feelings of embarrassment about discussing aspects of her life in the presence of her therapist, the patient connected her desire for a therapist who would be a “guiding force” to experiences she had had in other relationships in her life. The therapist repeatedly encouraged the patient to explore her experience in the here and now and then asked the patient if she was feeling uncomfortable. The patient acknowledged that she was uncomfortable, and made another connection to a related outside experience. The therapist became frustrated, asking the patient again to explore her experience in the here and now, and appeared annoyed, saying “what is going on?” This was followed by
further discussion about the tension in the session, and the patient continued to express a sense of confusion about the treatment process. That this insistence was observed in two of the high outcome cases and not in any of the low outcome cases was contrary to expectations. While therapist flexibility is generally encouraged in order to meet patients’ needs, based on observation, this persistence occurred in cases in which it appeared that there was a particularly high level of therapist adherence to the BRT model as a whole. In discussions with the research team about this observation, investigators who had supervised BRT cases at the time that this data was collected remarked that there had been a greater emphasis on the exploration of the here and now as well as metacommunication, and that there have been shifts in the supervisory approach since. Thus, it seems that while aspects of therapists’ technique may have been heavy handed, these therapists demonstrated a notable commitment to the model, which may have had a beneficial effect on the treatment process overall.

- Based on frequency by case qualitative analyses, therapists more often disclosed their own experience in the here and now in low outcome cases than in high outcome cases.

For instance, in a low outcome case, in the context of a rupture, the therapist explained to the patient that he was struggling with how to be helpful and “good enough” for the patient, and was feeling that whatever she offered did not feel right to the patient. While there are ways in which therapist metacommunication can be used to help to facilitate the rupture resolution process, in some rupture narratives, patients referred to feeling blamed and responsible for therapists’ difficulties when faced with this type of therapist
disclosure. It appears that the way in which the intervention was conducted limited its utility in some cases, instead of providing an opening through which to explore the rupture experience.

- Findings from the present study indicate that the rupture resolution process may be best understood when taking into account resolutions that occur over multiple sessions, and when addressing the ways in which rupture themes recur across multiple sessions for a given patient.

There is a great deal of clinical utility in working with therapists to cultivate their awareness of ruptures that may linger beyond the session in which they emerge. In keeping with the BRT model and with other forms of psychotherapy, this study also supports the notion that it is useful for therapists to be attuned to the nature and themes of the ruptures that recur for each of their patients, as a window into their experience outside of treatment.

**VI. Limitations and future research**

A number of limitations impacted the present study and are informative in conceptualizing future research on the rupture resolution process. First, the qualitative analyses presented were conducted by the author, instead of with a group of coders, and the findings presented here are inherently impacted by the author’s biases as a clinician and researcher in training. In an effort to address this concern, the author met with the research team regularly to discuss the data analysis and findings. As team leaders also reviewed a subset of the psychotherapy sessions used in this study, there were opportunities to discuss conceptual and theoretical questions throughout the process.
Nonetheless, further analyses will benefit from using a group of coders to examine the data. One method in particular that may be useful in exploring this dataset is the 3RS (Eubanks-Carter et al., 2009), as it offers a systematic, observer–based method in which coders establish reliability to assess ruptures and rupture resolution strategies in psychotherapy sessions.

Of particular importance in future studies is the question of how best to determine the outcome of psychotherapy. While this study used a composite score made up of a number of standard outcome measures to place cases in the high and low outcome groups, it may also be fruitful to consider addressing outcome based on change on specific measures, such as the SCL-90 or the IIP alone. As outcome measures assess different kinds of change, by creating composite outcome scores, the differences in, for instance, changes in interpersonal functioning and changes in general symptom intensity may not have been accounted for to the fullest extent possible. This may have had a negative impact on the accuracy of the division of cases into high and low outcome groups.

As all of the cases included in the present study completed the full course of treatment, cases in which ruptures occurred that were significant enough to prompt patient drop out were not analyzed. Exploration of the rupture and resolution process in cases that end prematurely could contribute a great deal to the field’s understanding of problems in forming and maintaining a therapeutic alliance as well as difficulties that emerge between patients and therapists in addressing problems in their working relationship. Thus, future studies should include not only cases that are considered high
or low outcome at the end of the treatment protocol, but also, those in which patients drop out of treatment early.

The findings in the present study suggest that rupture themes recur multiple times over the course of treatment, and research also suggests that ruptures may be resolved over multiple sessions. With this in mind, future research should include intensive case studies that would allow researchers to examine the rupture and resolution process in detail over time, instead of sampling a small number of rupture sessions from a case.

While this study utilized a small sample size of 18 cases in order to conduct in-depth qualitative analyses, the small sample size limited the nature of the quantitative methods available to explore differences between the high and low outcome groups. In the future, it may be informative to examine a larger sample in order to explore whether or not similar phenomena emerge in the rupture resolution process. Further, despite the presence of nested data, independent samples t-tests were used for some preliminary statistical tests (see Appendix D) that should be further pursued using multilevel modeling.

In summary, through the use of close observation and an intensive descriptive analysis, the present study demonstrates differences as well as similarities in the ways that ruptures are resolved in high and low outcome BRT cases, and emphasizes the importance of understanding the rupture resolution process over time. This study has aimed to be one step in the process of the refinement of the SPM of rupture resolution, and to contribute to the field’s understanding of the rupture resolution process, in an effort to provide information that will be useful to clinicians and researchers alike.
References


APPENDIX A

Figure 1. Post Session Questionnaire: Patient Version

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, ROOM 5F-04
NEW YORK, NY 10003

PATIENT POST-SESSION QUESTIONNAIRE
V2001

Complete immediately after session. Please answer all questions.

Your number ___________________ Session number ___________________
Your therapist's initials ___________________ Date of session ___________________

PART A

1. Please rate how helpful or hindering to you this session was overall by circling the appropriate number below.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely hindering</td>
<td>Neutral</td>
<td>Extremely helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

2. Please rate to what extent you feel that the problems you had at the beginning of therapy are resolved.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

PART B

1. Did you experience any problem or tension in your relationship with your therapist during the session?

Yes____ No____

2. If so, about where in the session did this problem begin?

Beginning____ Middle____ End____

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

<table>
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<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td></td>
<td></td>
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</table>

4. Please describe the problem:

5. To what extent was this problem addressed in this session?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Very much</td>
<td></td>
<td></td>
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</table>

6. To what degree do you feel this problem was resolved by the end of the session?

<table>
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<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Please rate the extent to which each of the following statements reflects your experience during this session.

...
a. I felt a closer connection with my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

b. I discovered feelings toward my therapist that I had not been fully aware of.

Not at all  2  3  4  5
Somewhat  Definitely

c. My therapist and I were able to work through a conflict and connect in a stronger way.

Not at all  2  3  4  5
Somewhat  Definitely

d. I saw how I was contributing to the difficulties my therapist and I were having.

Not at all  2  3  4  5
Somewhat  Definitely

e. I acted in a way which felt more authentic or genuine for me.

Not at all  2  3  4  5
Somewhat  Definitely

f. I recognized and accepted my therapist’s limitations.

Not at all  2  3  4  5
Somewhat  Definitely

g. I felt freer to make mistakes with my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

i. I saw that I can expose risky feelings and not be rejected/criticized by my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

j. I began to get the sense that I don’t have to protect my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

k. I felt more comfortable with expressing vulnerability or anger towards my therapist.

Not at all  2  3  4  5
Somewhat  Definitely

l. I told my therapist something I had been hesitant to say.

Not at all  2  3  4  5
Somewhat  Definitely

m. I felt able to disagree with my therapist.
n. I began to accept a part of myself which I had not fully acknowledged before.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Definitely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

o. I said something to my therapist which I had felt for a while and it left me with a sense of relief.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Definitely</td>
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</tbody>
</table>

p. I saw that I was doing something to distance myself from my therapist or push him/her away.

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<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Definitely</td>
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</table>

q. I felt more trusting of my therapist.

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<tr>
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r. I was afraid something I said would upset or hurt my therapist but I found out that it did not.

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<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Definitely</td>
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</table>

**PART C**

Please circle the appropriate number to show how you feel about this session.

**This session was:**

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<td>Uncomfortable</td>
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</table>

**PART D**
The following items reflect your working relationship with your therapist based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. My therapist and I agreed about the things I need to do in therapy to help improve my situation.

   1  2  3  4  5  6  7
Never Sometimes Always

2. What we are doing in therapy gave me new ways of looking at my problem.

   1  2  3  4  5  6  7
Never Sometimes Always

3. I believed that my therapist likes me.

   1  2  3  4  5  6  7
Never Sometimes Always

4. My therapist did not understand what I am trying to accomplish in therapy.

   1  2  3  4  5  6  7
Never Sometimes Always

5. I was confident in my therapist's ability to help me.

   1  2  3  4  5  6  7
Never Sometimes Always

6. My therapist and I worked towards mutually agreed upon goals.

   1  2  3  4  5  6  7
Never Sometimes Always

7. I felt that my therapist appreciates me.

   1  2  3  4  5  6  7
Never Sometimes Always

8. We agreed on what is important for me to work on.

   1  2  3  4  5  6  7
Never Sometimes Always

9. My therapist and I seemed to trust one another.

   1  2  3  4  5  6  7
Never Sometimes Always

10. My therapist and I seemed to have different ideas on what my problems are.

    1  2  3  4  5  6  7
Never Sometimes Always

11. We had a good understanding of the kind of changes that would be good for me.

    1  2  3  4  5  6  7
Never Sometimes Always

12. I believed the way we were working with my problem was correct.

    1  2  3  4  5  6  7
Never Sometimes Always

PART E
Please rate how well each of the following sets of four adjectives, taken all together, describes YOUR THERAPIST in the session just completed.

<table>
<thead>
<tr>
<th>Set</th>
<th>Adjectives</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>2</td>
<td>TRICKY-BOASTFUL-CONCEITED-CRAFTY</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>3</td>
<td>UNSOCIAL-INTROVERTED-DISTANT-SHY</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>4</td>
<td>MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>5</td>
<td>UNDECEPTIVE-UNARGUMENTATIVE-NONegotistical-UNDEVOUS</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>6</td>
<td>KIND-TENDER-FORGIVING-COOPERATIVE</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>7</td>
<td>COLDHEARTED-IMPOLITE-UNSYPATHETIC-UNCORDIAL</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>8</td>
<td>FRIENDLY-OUTGOING-CHEERFUL-APPROACHABLE</td>
<td>1 2 3 4 5 6 7</td>
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</table>

**PART F**

Please check any of the following adjectives to describe how you felt in this session with your therapist. A check beside the word means "Yes." You may check as many or as few adjectives as you would like.

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<thead>
<tr>
<th>Number</th>
<th>Adjective</th>
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<tbody>
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<tr>
<td>3</td>
<td>ENTHUSIASTIC</td>
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<td>4</td>
<td>OBJECTIVE</td>
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<td>5</td>
<td>MANIPULATED</td>
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<tr>
<td>6</td>
<td>MOTHERLY</td>
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<tr>
<td>7</td>
<td>DISAPPOINTED</td>
</tr>
<tr>
<td>8</td>
<td>INTERESTED</td>
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<tr>
<td>9</td>
<td>SUSPICIOUS</td>
</tr>
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<td>10</td>
<td>INADEQUATE</td>
</tr>
<tr>
<td>11</td>
<td>SURPRISED</td>
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<tr>
<td>12</td>
<td>ANGRY</td>
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<td>13</td>
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<td>STRONG</td>
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<td>15</td>
<td>BORED</td>
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<td>16</td>
<td>CAUTIOUS</td>
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<td>17</td>
<td>EMBARRASSED</td>
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<td>18</td>
<td>AFFECTIONATE</td>
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<td>19</td>
<td>SAD</td>
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<td>DISLIKED</td>
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<td>26</td>
<td>CONFUSED</td>
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<td>27</td>
<td>INDIFFERENT</td>
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<td>28</td>
<td>ALOOF</td>
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<tr>
<td>29</td>
<td>SYMPATHETIC</td>
</tr>
</tbody>
</table>
Figure 2. Post Session Questionnaire: Therapist Version

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, ROOM 5F-04
NEW YORK, NY 10003

THERAPIST POST-SESSION QUESTIONNAIRE
V2001

Complete immediately after session. Please answer all questions.
Your patient’s initials _______ Session number _______
Your initials _______ Date of session _______

PART A
1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

1 2 3 4 5 6 7 8 9
Extremely
hinderin
Neutral
Gelpful

2. Please rate to what extent your patient’s problems are resolved.

1 2 3 4 5 6 7 8 9
Not at all
Moderately
Completely

PART B
1. Did you experience any problem or tension in your relationship with your patient during the session?

Yes______ No______

2. If so, about where in the session did this problem begin?

Beginning______ Middle______ End______

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

1 2 3 4 5
Low
Medium
High

4. To what extent was this problem addressed in this session?

1 2 3 4 5
Not at all
Somewhat
Very much

5. To what degree do you feel this problem was resolved by the end of the session?

1 2 3 4 5
Not at all
Somewhat
Very much

6. Please describe the problem briefly:
7. Please rate the extent to which each of the following statements reflects your experience during this session.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>a. I felt a closer connection with my patient.</td>
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<tr>
<td>b. I found myself talking about feelings I didn’t know I had.</td>
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<tr>
<td>c. My patient and I were able to work through a conflict and connect in a stronger way.</td>
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<tr>
<td>d. I saw how I was contributing to the difficulties my patient and I were having.</td>
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<tr>
<td>e. I acted in a way which felt more authentic or genuine for me.</td>
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<tr>
<td>f. I recognized and accepted my patient’s limitations.</td>
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<tr>
<td>g. I felt freer to make mistakes with my patient.</td>
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<tr>
<td>h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my patient.</td>
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<tr>
<td>i. I saw that I can expose risky feelings and not be rejected/criticized by my patient.</td>
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<tr>
<td>j. I began to get the sense that I don’t have to protect my patient.</td>
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<tr>
<td>k. I felt more comfortable with expressing vulnerability or anger towards my patient.</td>
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<tr>
<td>l. I told my patient something I had been hesitant to say.</td>
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</table>
m. I felt able to disagree with my patient.

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<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Definitely</td>
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n. I began to accept a part of myself which I had not fully acknowledged before.

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</table>

o. I said something to my patient which I had felt for a while and it left me with a sense of relief.

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p. I saw that I was doing something to distance myself from my patient or push him/her away.

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q. I felt more trusting of my patient.

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r. I was afraid something I said would upset or hurt my patient but I found out that it did not.

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PART C

Please circle the appropriate number to show how you feel about this session.

This session was:

<table>
<thead>
<tr>
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<th>1</th>
<th>2</th>
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<td>4</td>
<td>5</td>
<td>6</td>
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<td>Uncomfortable</td>
</tr>
</tbody>
</table>
PART D
The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. My patient and I agreed about the things he/she needs to do in therapy to help improve his/her situation.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

3. My patient believed that I like him/her.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

4. My patient believed that I did not understand what he/she is trying to accomplish in therapy.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

5. My patient was confident in my ability to help him/her.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

6. My patient and I worked toward mutually agreed-upon goals.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

7. My patient felt appreciated by me.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

8. We agreed on what is important for him/her to work on.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

9. My patient and I seemed to trust one another.

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Sometimes | Always |

10. My patient and I seemed to have different ideas on what his/her problems are.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Sometimes | Always |

11. We have established a good understanding of the kind of changes that would be good for him/her.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Sometimes | Always |

12. My patient believed the way we were working with his/her problem was correct.

    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Sometimes | Always |
PART E

Please rate how well each of the following sets of four adjectives, taken all together, describes your patient in the session just completed.

1. ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS  least          most
   1 2 3 4 5 6 7
2. TRICKY-BOASTFUL-CONCEITED-CRAFTY
   1 2 3 4 5 6 7
3. UNSOCIAL-INTROVERTED-DISTANT-SHY
   1 2 3 4 5 6 7
4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE
   1 2 3 4 5 6 7
5. UNDECEPTIVE-UNARGUMENTATIVE-NONEGOTIATIONAL-UNDEVIOUS
   1 2 3 4 5 6 7
6. KIND-TENDER-FORGIVING-COOPERATIVE
   1 2 3 4 5 6 7
7. COLDHEARTED-IMPOLITE-UNSYMPATHETIC-UNCordial
   1 2 3 4 5 6 7
8. FRIENDLY-OUTGOING-CHEERFUL-APPROACHABLE
   1 2 3 4 5 6 7

PART F

Please check any of the following adjectives to describe how you felt in this session with your patient. A check beside the word means “Yes.” You may check as many or as few adjectives as you would like.

1__HELPFUL          11__SURPRISED          21__HAPPY
2__TIRED             12__ANGRY            22__THREATENED
3__ENTHUSIASTIC      13__RECEPTIVE         23__ANXIOUS
4__OBJECTIVE         14__STRONG           24__OVERWHELMED
5__MANIPULATED       15__BORED            25__RELAXED
6__MOTHERLY          16__CAUTIOUS          26__CONFUSED
7__DISAPPOINTED      17__EMBARRASED        27__INDIFFERENT
8__INTERESTED        18__AFFECTIONATE     28__ALOOF
9__SUSPICIOUS        19__SAD              29__SYMPATHETIC
10__INADEQUATE       20__DISLIKED         30__FRUSTRATED

31. To what extent do you feel uncomfortable or badly about having any of these feelings in the session?
   1 2 3 4 5 6 7
   Not at all        Somewhat        Completely

32. To what extent did any of these feelings emerge as new or different for you in this session?
   1 2 3 4 5 6 7
   Not at all        Somewhat        Completely
PART G

The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. I liked my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

2. I struggled to understand my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

3. I felt appreciated by my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

4. I felt uncomfortable with my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

5. I felt confident in my ability to help my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

6. I felt that I am not totally honest about my feelings toward my patient.

   1 2 3 4 5 6 7
   Never Sometimes Always

Progress Note: Please write a few sentences about the session.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature:_________________________________________________________________
APPENDIX B

Exploratory Analysis of Narrative Themes in Rupture Sessions

Themes that emerged in a qualitative analysis of patient and therapist rupture narratives, as written on their PSQs, will be discussed from two perspectives. First, themes that emerged in the rupture narratives that were written regarding the last five sessions of treatment will be discussed. Of interest in these analyses was whether there were differences between high and low outcome cases in the nature of the final portion of therapy. Finally, themes that emerged across the course of treatment will be discussed, in an effort to identify any similarities or differences between high and low outcome cases in terms of the nature of the ruptures that emerged over the 30 sessions.

In high outcome cases, patient narratives of ruptures that occurred during the final five sessions of treatment most often discussed three themes (themes discussed occurred in a minimum of two sessions). Patients discussed feelings of dissatisfaction with treatment, concerns about termination, and feeling distant from their therapist. The same three themes were evident in therapist narratives, in keeping with the fact that they were describing similar incidents in their post-session questionnaires.

In low outcome cases, patient narratives of ruptures that occurred during the final five sessions of treatment most often discussed five themes (again, themes discussed below occurred in a minimum of two sessions). Patients discussed feelings of concern regarding termination and feelings of dissatisfaction with treatment. Patients also discussed feeling that a miscommunication had occurred between themselves and their therapists, which included instances in which patients felt they had not fully expressed
themselves in session. Patient narratives also included patient experiences in which they had a negative reaction to an aspect of their therapist’s behavior during or immediately before their session began, and instances in which patients felt overwhelmed by affect during the session. Three themes emerged from therapist narratives in low outcome cases. Therapists described concerns regarding the impending termination, patient disappointment with the treatment, and a feeling of tension during the session.

In high outcome cases, patient narratives of ruptures that occurred over the course of treatment (themes discussed occurred in a minimum of five narratives) most often included discussion of patient dissatisfaction with or doubts about treatment, as well as instances in which patients felt misunderstood or struggled to express themselves in session. In high outcome cases, therapist narratives of ruptures that occurred over the course of treatment most often included discussion of patient dissatisfaction with or doubts about treatment, instances of misunderstanding that occurred between patient and therapist, and therapist feelings of frustration, irritation or boredom during session.

In low outcome cases, patient narratives of ruptures that occurred over the course of treatment (again, themes discussed occurred in a minimum of five narratives) most often included dissatisfaction with treatment. Patients also wrote about struggling to disclose aspects of their experience to their therapist and feeling uncomfortable during the session. Patient narratives also included discussion of feeling attracted to their therapist and/or a desire to share a more intimate relationship with their therapist, as well as concerns about termination. Finally, patient narratives depicted instances in which patients felt criticized or rejected by their therapist or felt ignored or unheard by their
therapist. In low outcome cases, therapist narratives of ruptures that occurred over the course of treatment (again, themes discussed occurred in a minimum of five narratives) most often included patients’ dissatisfaction with treatment. Rupture narratives also discussed instances in which patients desired greater intimacy with their therapist and instances in which patients struggled to share aspects of their experience with their therapist. Therapists wrote about their own concerns about their capacity to effectively deliver the treatment. Therapists also wrote about instances in which patients felt criticized in session and instances in which it was difficult for patients to focus on or explore their affect during the session.

There were a number of themes in common in patient and therapist narratives of ruptures in the final five sessions of high and low outcome cases, including concerns about termination and dissatisfaction with aspects of the treatment. It is difficult to identify systematic differences between the groups, and notable that in both outcome groups, patients and therapists reported concerns about termination as well as dissatisfaction with aspects of the treatment. When considering themes that emerged in rupture narratives over the course of treatment, patients and therapists described similar experiences. However, it is notable that when looking at rupture narratives over the course of treatment, in the low outcome group, patients and therapists more often made reference to difficulty with bond aspects of the therapeutic relationship. In some cases, patients described struggling to disclose aspects of their experience to their therapists. There were also two low outcome cases in which patients expressed feelings of attraction to their therapists and discussed their desire to share a more intimate relationship with
their therapist. Also, both patient and therapist narratives depicted instances in which patients felt criticized or rejected by their therapist.

The difficulty of finding a comfortable level of connection in the treatment relationship, or, the difficulty of establishing a bond that was satisfactory to both patient and therapist, may have been an impediment in the therapeutic process throughout the treatment, and may have impacted the dyad’s ability to process ruptures, potentially impacting treatment outcome. This could be more fully explored through the use of intensive analysis of all of the sessions in these cases. Finally, it is to be expected that instances of patients feeling criticized or rejected by their therapist would have a limiting, negative impact on the dyad’s processing of ruptures in the alliance.
APPENDIX C

Patient and Therapist WAI and SEQ Depth Subscale Score Ratings: Control Charting and Modal scores

The following questions were addressed with regard to patient and therapist WAI scores:

1) In how many high outcome rupture sessions and in how many low outcome rupture sessions did patient and/or therapist WAI scores exceed the control limit?

2) In how many high outcome rupture sessions and in how many low outcome rupture sessions did patient and/or therapist WAI scores fall below the control limit?

3) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist WAI scores exceed the control limit when looking across the course of treatment?

4) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist WAI scores fall below the control limit when looking across the course of treatment?

5) Comparing the high and low outcome groups, are there differences between patient and/or therapist modal WAI scores across the course of treatment?

The questions below were addressed with regard to patient and therapist SEQ depth subscale scores:
1) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist SEQ depth subscale scores exceed the control limit?

2) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist SEQ depth subscale scores fall below the control limit?

3) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist SEQ depth subscale scores exceed the control limit when looking across the course of treatment?

4) In how many high outcome sessions and in how many low outcome sessions did patient and/or therapist SEQ depth subscale scores fall below the control limit when looking across the course of treatment?

5) Comparing the high and low outcome groups, are there differences between patient and/or therapist modal SEQ depth subscale scores across the course of treatment?

Additionally, the following questions were addressed with regard to patient and therapist single item resolution question ratings:

1) Comparing the high and low outcome groups, are there differences between patient and/or therapist modal scores on the single item rupture question across the course of treatment?

A series of questions were addressed with regard to patient and therapist WAI scores, both in rupture sessions and across the course of treatment. WAI scores were
assessed based on control charting procedures that indicate instances in which a score is markedly higher or lower than is typical for a given participant on a given measure. This analysis was conducted looking at the rupture sessions included in the dataset as well as looking at all sessions available across the course of treatment. When looking at rupture sessions included in the dataset only, based on patient ratings of the WAI, WAI mean scores that exceeded the control limit occurred more often with respect to sessions that occurred in low outcome cases, whereas based on therapist ratings, WAI mean scores that exceeded the control limit occurred more often with respect to sessions that occurred in high outcome cases (see Table 4).

WAI scores for rupture sessions included in the dataset were also assessed using control charting in order to address patient and therapist WAI ratings that fell below the control limit. Based on patient ratings of the WAI, WAI mean scores that fell below the control limit occurred more often in rupture sessions that occurred within the context of high outcome cases than in rupture sessions that occurred within the context of low outcome cases (see Table 4). This was also the case when considering therapist WAI ratings, however the difference between high and low outcome cases was one case only (see Table 4). Note that there were missing WAI scores for some rupture sessions. Thus, while all 9 high outcome and 9 low outcome cases were included and patient WAI scores were available for all sessions, therapist WAI ratings were available for 20 out of 22 rupture sessions from high outcome cases and 19 out of 22 sessions from low outcome cases.
Control charts were also used to examine WAI scores across the course of treatment. Based on patient and therapist ratings, there were minimal differences in the frequency of WAI scores that exceeded or fell below the control limit when comparing the high outcome and low outcome groups (see Table 4). Note that as there were missing WAI scores for some sessions, percentages provided in Table 4 are based on available WAI ratings.

Table 4

Comparisons of Patient and Therapist WAI Ratings in High and Low Outcome Cases Using Control Charting

<table>
<thead>
<tr>
<th></th>
<th>Patient rating</th>
<th>Therapist rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High outcome</td>
<td>Low outcome</td>
</tr>
<tr>
<td>Rupture sessions with WAI mean above control limit</td>
<td>2 (9%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>Rupture sessions with WAI mean below control limit</td>
<td>9 (41%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>Sessions with WAI mean above control limit across course of treatment</td>
<td>48 (20%)</td>
<td>44 (17%)</td>
</tr>
<tr>
<td>Sessions with WAI mean below control limit across course of treatment</td>
<td>46 (19%)</td>
<td>56 (22%)</td>
</tr>
</tbody>
</table>

*Notes: % listed above is % of sessions with available data*
SEQ depth subscale scores were also assessed based on control charting procedures that indicate instances in which a score is markedly higher or lower than is typical for a given participant on a given measure. Rupture sessions included in the dataset as well as SEQ depth subscale ratings across the course of treatment were used in this analysis. When looking at rupture sessions included in the dataset, based on patient ratings of the SEQ depth subscale, scores that exceeded the control limit occurred more often with respect to sessions that occurred in low outcome cases, whereas based on therapist ratings, SEQ depth subscale scores that exceeded the control limit occurred with the same frequency in high and low outcome cases (see Table 5). Based on patient and therapist ratings, scores that fell below the control limit occurred more in rupture sessions that occurred within the context of low outcome cases than in rupture sessions that occurred within the context of high outcome cases. However, the differences in frequency between high and low outcome cases were small (see Table 5). Note that there were missing SEQ depth subscale scores for some rupture sessions. Thus, while all 9 high outcome and 9 low outcome cases were included and patient SEQ depth subscale scores were available for all sessions, therapist ratings were available for 20 out of 22 rupture sessions from high outcome cases and 19 out of 22 sessions from low outcome cases.

Control charts were also used to examine SEQ depth subscale scores across the course of treatment. Based on patient and therapist ratings, there were minimal differences in the frequency of SEQ depth subscale scores that exceeded or fell below the control limit when comparing the high outcome and low outcome groups (see Table 5).
Note that as there were missing SEQ depth subscale scores for some sessions, percentages provided in Table 5 are based on available SEQ depth subscale score ratings.

Table 5

*Comparison of Patient and Therapist SEQ Depth Subscale Scores in High and Low Outcome Cases Using Control Charting*

<table>
<thead>
<tr>
<th></th>
<th>Pt rating</th>
<th>Th rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High outcome</td>
<td>Low outcome</td>
</tr>
<tr>
<td>Rupture sessions with depth subscale scores above control limit</td>
<td>2 (9%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>Rupture sessions with depth subscale scores below control limit</td>
<td>3 (14%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>Sessions with depth subscale scores above control limit across course of treatment</td>
<td>31 (13%)</td>
<td>50 (19%)</td>
</tr>
<tr>
<td>Sessions with depth subscale scores below control limit across course of treatment</td>
<td>41 (17%)</td>
<td>48 (19%)</td>
</tr>
</tbody>
</table>

*Notes: % listed above is % of sessions with available data.*

Patient and therapist modal WAI scores were also examined in order to assess whether or not patients and/or therapists typically provided higher WAI ratings in the high outcome group than in the low outcome group. Modal WAI scores were reviewed by looking at all WAI scores across each of the cases included in the dataset. Modal
WAI scores were the same or similar between high and low outcome groups, on the basis of both patient and therapist ratings (see Table 6).

Table 6

*Modal Responses to the WAI*

<table>
<thead>
<tr>
<th></th>
<th>Patient rating</th>
<th>Therapist rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High outcome</td>
<td>Low outcome</td>
</tr>
<tr>
<td>Modal response to the WAI across case</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Patient and therapist modal SEQ depth subscale scores were also examined in order to assess whether or not patients and/or therapists typically provided higher SEQ depth subscale ratings in the high outcome group than in the low outcome group. Modal SEQ depth subscale scores were reviewed by looking at all SEQ depth subscale scores across each of the cases included in the dataset. Modal SEQ depth subscale scores were the same or similar between high and low outcome groups, on the basis of both patient and therapist ratings (see Table 7).

Table 7

*Modal Responses to SEQ Depth Subscale*

<table>
<thead>
<tr>
<th></th>
<th>Patient rating</th>
<th>Therapist rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High outcome</td>
<td>Low outcome</td>
</tr>
<tr>
<td>Modal response to the SEQ depth subscale across cases</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

The single item resolution question (“To what extent was the problem resolved by the end of the session?”) on the patient and therapist PSQ was examined in order to
assess differences in perceptions of the extent to which ruptures were resolved between the high and low outcome groups. Modal scores on the single item resolution question were the same or similar between high and low outcome groups, on the basis of both patient and therapist ratings (see Table 8).

Table 8

<table>
<thead>
<tr>
<th>Modal Responses to Single Item Rupture Resolution Question</th>
<th>Patient rating</th>
<th>Therapist rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>High outcome</td>
<td>Low outcome</td>
<td>High outcome</td>
</tr>
<tr>
<td>Modal response to rupture resolution question across case</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Instances in which patient and therapist ratings of the WAI exceeded or fell below the control limit were similar in high and low outcome cases. However, one notable difference did emerge. Based on patient ratings, in the high outcome group, there were substantially more instances of WAI scores below the control limit than in the low outcome group. This could be due to a greater profundity of experience of ruptures and processing of ruptures in the high outcome cases, leading patients to provide lower WAI ratings at a given time of measurement. That is, it may point to a lack of avoidance of difficult conversations in these sessions, which could lead patients to feel particularly negative about their relationship with their therapist at one point in time but which may have been followed by successful resolution in subsequent sessions.

Contrary to expectations, instances in which patient and therapist ratings of the SEQ depth subscale score exceeded or fell below the control limit were similar in the
high and low outcome groups, and both occurred relatively infrequently. While it may be that looking for instances of exceeding or falling below the control limit by at least one standard deviation was too blunt a measure to find differences in this sample, it is unclear why differences did not occur.

Also contrary to expectations, the analyses conducted in which modal scores for the WAI, SEQ depth subscale score and the single item resolution question in the high and low outcome groups were compared indicate similar modal ratings in the two outcome groups. It is unclear why this occurred. In order to better understand any statistically significant differences between the high and low outcome groups on these process measures, it is recommended that future studies employ multilevel modeling.
APPENDIX D

Additional questions addresses regarding WAI scores using independent samples t-tests

1) Are patient WAI scores in rupture sessions significantly different between high and low outcome cases?
2) Are therapist WAI scores in rupture sessions significantly different between high and low outcome cases?
3) Are patient WAI score averages across the entirety of the cases included in the dataset significantly different between high and low outcome cases?
4) Are therapist WAI averages across the entirety of the cases included in the dataset significantly different between high and low outcome cases?

Independent samples t-tests were used to assess differences between high and low outcome cases. These results are considered preliminary and future studies should address them further using multilevel modeling.

WAI scores in rupture sessions in the high and low outcome cases included in this study were compared in order to assess whether or not patient and/or therapist perceptions of the working alliance in the context of ruptures differed by outcome group. Independent samples t-tests were used to assess differences between the high and low outcome groups. On average, patient ratings of the WAI in rupture sessions were higher (higher scores on the WAI indicate a stronger therapeutic alliance) in the high outcome group (M = 5.20, SE = 0.21) than in the low outcome group (M = 4.83, SE = 0.24). However, there was no significant difference between the high and low outcome groups, $t(16) = 1.18$, $p > .05$. There was a small to medium – sized effect, $r = 0.27$. On average,
therapist ratings of the WAI in rupture sessions were higher in the high outcome group (M = 5.30, SE = 0.28) than in the low outcome group (M = 4.35, SE = 0.30). There was a significant difference between the high and low outcome groups, $t(16) = 2.29, p < .05$. There was a medium to large – sized effect, $r = 0.48$.

WAI scores across all sessions in high and low outcome cases were also compared using independent samples $t$-tests, in order to assess whether or not patient and/or therapist perceptions of the working alliance across the course of treatment differed by outcome. On average, patient average ratings of the WAI across the course of treatment were higher in the high outcome group (M = 5.64, SE = 0.20) than in the low outcome group (M = 5.22, SE = 0.26). However, there was not a significant difference between the high and low outcome groups $t(16) = 1.29, p > .05$. There was a small to medium – sized effect, $r = 0.29$. On average, therapist average ratings of the WAI across the course of treatment were higher in the high outcome group (M = 5.31, SE = 0.16) than in the low outcome group (M = 4.59, SE = 0.21). There was a significant difference between the high and low outcome groups $t(16) = 2.77, p < .05$. There was a large – sized effect, $r = 0.55$.

As was expected, therapist ratings of the WAI in rupture sessions as well as across the course of treatment were significantly higher in the high outcome group than in the low outcome group, with large and medium to large-sized effects, respectively. Given the fact that the mode of treatment employed in this study, BRT, emphasizes the importance of addressing alliance ruptures, which is in turn crucial in maintaining and repairing the working alliance, it is not surprising that higher ratings on the WAI were
associated with the high outcome group. Contrary to expectations, patient ratings of the
WAI in rupture sessions and across the course of treatment were not significantly
different in the high and low outcome groups. However, both were in the expected
direction, with medium sized effects. This, as well as encouraging findings based on
therapist WAI ratings, suggests that significantly higher patient WAI scores in high
outcome cases may be evident if a larger sample were to be explored. Multilevel
modeling should be used to explore these preliminary findings further.

**Additional questions addressed using the SEQ depth subscale score**

1) Are patient SEQ depth subscale scores in rupture sessions significantly
different between high and low outcome cases?

2) Are therapist SEQ depth subscale scores in rupture sessions significantly
different between high and low outcome cases?

3) Are patient SEQ depth subscale score averages across the entirety of the cases
included in the dataset significantly different between high and low outcome
cases?

4) Are therapist SEQ depth subscale score averages across the entirety of the
cases included in the dataset significantly different between high and low
outcome cases?

Independent samples t-tests were used to assess differences between high and low
outcome cases. These results are considered preliminary and future studies should
address them further using multilevel modeling.
SEQ depth subscale scores in rupture sessions in the high and low outcome cases included in this study were compared in order to assess whether or not patient and/or therapist perceptions of the depth of sessions in the context of ruptures differed by outcome. Independent samples t-tests were used to assess differences between the high and low outcome groups. On average, patient ratings of the SEQ depth subscale score in rupture sessions were higher (higher scores on the SEQ depth subscale score indicate greater perception of depth in a session) in the high outcome group (M = 5.57, SE = 0.20) than in the low outcome group (M = 5.09, SE = 0.19). However, there was no significant difference between the high and low outcome groups, \( t \) (16) = 1.67, \( p > .05 \). There was a medium – sized effect, \( r = 0.37 \). On average, therapist ratings of the SEQ depth subscale score in rupture sessions were higher in the high outcome group (M = 5.52, SE = 0.26) than in the low outcome group (M = 4.97, SE = 0.35). However, there was no significant difference between the high and low outcome groups \( t \) (16) = 1.26, \( p > .05 \). There was a small to medium – sized effect, \( r = 0.28 \).

SEQ depth subscale scores across all sessions in high and low outcome cases were also compared using independent samples t-tests, in order to assess whether or not patient and/or therapist perceptions of the depth of sessions across the course of treatment differed by outcome. On average, patient ratings of the SEQ depth subscale score across the course of treatment were higher in the high outcome group (M = 5.73, SE = 0.18) than in the low outcome group (M = 5.15, SE = 0.15). There was a significant difference between the high and low outcome groups, \( t \) (16) = 2.44, \( p < .05 \). There was a large – sized effect, \( r = 0.49 \). On average, therapist ratings of the SEQ depth subscale score
across the course of treatment were higher in the high outcome group ($M = 5.07$, $SE = 0.18$) than in the low outcome group ($M = 4.97$, $SE = 0.13$). However, there was no significant difference between the high and low outcome groups, $t(16) = 0.44$, $p > .05$. There was a small – sized effect, 0.10.

Based on an independent samples t-test, patient ratings of the SEQ depth subscale score across the course of treatment were significantly higher in the high outcome group than in the low outcome group, with a large-sized effect. This indicates that for patients, there may have been a greater experience of session impact in the high outcome group than in the low outcome group. This finding is in keeping with more frequent instances of therapist encouragement of processing affect in the here and now in high outcome cases as well as the presence of more instances of SPM-stage four in the high outcome group than in the low outcome group. Both processing affect in the here and now and resolving ruptures in the alliance can reasonably be expected to require thoughtful and at times difficult conversations between patient and therapist, which could contribute to a greater experience of session depth.

Although contrary to expectations there were no significant differences in patient or therapist ratings of the SEQ depth subscale score between the high and low outcome groups when looking at rupture sessions only, in both cases, there was a medium-sized effect. Given that findings were in the expected direction and that medium sized effects were found, as well as the fact that findings based on patient SEQ scores across the course of treatment indicate significantly greater experience of depth in high outcome cases than low outcome cases, it may be that additional differences would be evident with
a larger sample. The comparison between therapist SEQ depth subscale scores across the course of treatment in high and low outcome groups yielded non-significant results along with a small effect size. While it remains unclear why, unlike patient ratings, therapists ratings indicate no differences between groups, given that outcome was determined mainly based on patient self-report, patient experiences of depth may have more utility in understanding the treatment process in keeping with the design of this study. These preliminary findings should be explored further using multilevel modeling.

**Additional questions addressed using the single item rupture question**

1) Are there significant differences between the high and low outcome groups in patient perception of rupture resolution (based on the single item resolution question) in rupture sessions included in the dataset?

2) Are there significant differences between the high and low outcome groups in therapist perception of rupture resolution (based on the single item resolution question) in rupture sessions included in the dataset?

3) Are there significant differences between the high and low outcome groups in patient perception of rupture resolution (based on the single item resolution question) in ruptures across the course of treatment?

4) Are there significant differences between the high and low outcome groups in therapist perception of rupture resolution (based on the single item resolution question) in ruptures across the course of treatment?
Independent samples t-tests were used to assess differences between high and low outcome cases. These results are considered preliminary and future studies should address them further using multilevel modeling.

The single item resolution question ("To what extent was the problem resolved by the end of the session?") on the patient and therapist PSQ was examined in order to assess differences in perceptions of the extent to which ruptures were resolved between the high and low outcome groups. On average, patient ratings of the resolution item in rupture sessions were lower (lower ratings indicate a weaker sense of rupture resolution in a session) in the high outcome group (M = 3.56, SE = 0.22) than in the low outcome group (M = 3.74, SE = 0.18). However, there was no significant difference between the high and low outcome groups, t (15) = -0.63, p > .05 and there was a small – sized effect, r = -0.15. On average, therapist ratings of the resolution item in rupture sessions were higher in the high outcome group (M = 3.02, SE = 0.18) than in the low outcome group (M = 2.85, SE = 0.29). However, there was no significant difference between the high and low outcome groups, t (14) = 0.47, p > .05 and there was a small – sized effect, r = 0.12.

On average, patient ratings of the resolution item in all patient – identified rupture sessions across the course of treatment were lower in the high outcome group (M = 3.36, SE = 0.12) than in the low outcome group (M = 3.44, SE = 0.72). However, there was not a significant difference between the high and low outcome groups, t (15) = -0.29, p > .05 and there was a small – sized effect, r = -0.07. On average, therapist ratings of the resolution item in all therapist – identified rupture sessions across the course of treatment
were lower in the high outcome group (M = 2.69, SE = 0.17) than in the low outcome group (M = 2.87, SE = 0.18). However, there was no significant difference between the high and low outcome groups $t (16) = -0.71, p > .05$ and there was a small – sized effect, $r = -0.17$.

The analyses conducted on the single item resolution question indicate no significant differences between the high and low outcome groups. Further, effect sizes were small across the analyses. It may be that the single item measures is too broad a tool to identify differences between high and low outcome cases, and more detailed measures may be more useful in elucidating differences in the experience of resolution and its role in treatment outcome. Additionally, as the single item resolution question refers specifically to the goings on in a given session, its utility in addressing ruptures that occur over the course of treatment is limited. It is also possible that the notion of complete resolution of a rupture (the item states “To what extent was the problem resolved by the end of the session?”) is not the sine qua non of good treatment outcome, but rather, that it is the process of working toward resolution that is meaningful in cultivating and maintaining a working alliance. If this is the case, we may not expect an item measuring the extent of resolution of a rupture to be an appropriate tool to separate high and low outcome cases, and may look instead to measures such as the WAI, that assess patient and therapist experiences of working with one another with more nuance, to do so. These preliminary findings should be addressed further using multilevel modeling.