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An in-session exploration of ruptures in working alliance and their associations with clients’ core conflictual relationship themes, alliance-related discourse, and clients’ postsession evaluations

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Abstract
This exploratory study examined (a) the relationship among the occurrence of ruptures in the working alliance, the emergence of client’s core conflictual relationship themes (CCRT), and focus of discourse within therapeutic sessions and (b) the relationship between ruptures in the working alliance and client’s postsession evaluations of session’s smoothness and depth. The authors included 151 sessions from five therapies conducted in a student counseling center. Sessions were content analyzed by independent raters, and a self-report questionnaire was given to clients after each session. Ruptures were positively related to the emergence of clients’ CCRT during the session, but only when the therapist was addressed as the “other.” Sessions with ruptures were characterized by heightened discussion of working alliance components and were evaluated as less smooth than sessions without ruptures. Findings are discussed, and the importance of ruptures in working alliance for therapeutic change is emphasized.

Keywords: alliance; ruptures in the working alliance

It is widely acknowledged that the formation of a solid and stable working alliance is related to positive therapeutic outcomes (Horvath & Symonds, 1991). Although most of the research has focused on the global contribution of the formation of a solid working alliance to therapeutic outcomes, there is also accumulating evidence on the therapeutic relevance of fluctuations in this alliance throughout the treatment. Those fluctuations were conceptualized in various terms: strains in the alliance (Bordin, 1994), weakenings and repairs of the alliance (Lansford, 1986), impass in the therapeutic relationship (Elkind, 1992), and the term that is most accepted and most frequently used: ruptures in the working (or therapeutic) alliance (Safran, 1993a, 1993b; Safran, McMain, Crocker, & Murray, 1990; Safran & Muran, 1996, 2000; Safran & Segal, 1990).

Ruptures in working alliance are defined as “deteriorations in the relationship between therapist and patient” (Safran & Muran, 1996, p. 447). These deteriorations may appear in clients’ behavior during a session in two alternative ways: (a) confrontational ruptures, in which clients directly reveal their dissatisfaction with the therapist or with some aspect of the therapy, and (b) withdrawal ruptures, in which clients emotionally or cognitively withdraw from the therapeutic relationship (Harper, 1989a, 1989b; Safran, 1993a, 1993b). There is now evidence that therapeutic outcomes depend not only on clients’ and therapists’ abilities to form an initial therapeutic alliance but also on their abilities to deal with and resolve ruptures in this alliance (Safran & Muran, 1996).

Previous studies have explored the basic components and steps that constitute the process of resolution of ruptures in working alliance. According to Safran (1993a, 1993b), these ruptures result from clients’ unique and subjective interpretation of a therapist’s interventions, which is derived from their dysfunctional interpersonal schemes. As such, ruptures in working alliance may be a good opportunity for the therapist to learn more about the dysfunctional patterns that bias clients’ cognitions, feelings, and behavior in their interpersonal life. Safran (1993a, 1993b) also argued that specific therapeutic interventions in response to the emergence of these
ruptures could advance clients’ exploration of their dysfunctional interpersonal schemes and promote change by providing corrective emotional experiences.

Following this reasoning, we conducted an exploratory study to examine three main research issues: (a) the association between the presence of clients’ dysfunctional interpersonal schemes (what Luborsky & Crits-Christoph, 1998, called core conflictual relational themes [CCRT]) in a given therapeutic session and the emergence of ruptures in working alliance within that session; (b) the association between the emergence of ruptures in working alliance in a given session and changes in the focus of clients’ and therapists’ attention during that session; and (c) the association between the emergence of ruptures in working alliance in a given session and clients’ postsession evaluations of their experience during that session (session smoothness and depth).

It is important to note that ruptures in the working alliance, as with many other aspects of the psychotherapeutic process, can be measured from three different perspectives: that of the client, the therapist, and a “third-party observer” (Safran, 1993b, p. 37). With regard to the measurement of the working alliance, studies have frequently shown that these perspectives (clients and observers or clients and therapists) do not necessarily coincide (e.g., Halstead, Brooks, Goldberg, & Fish, 1990; Horvath & Marx, 1990). To test our main hypotheses, we found it more relevant to use mainly the observer’s perspective in assessing in-session occurrence of ruptures in working alliance, the in-session emergence of clients’ CCRTs, and focus of attention during the session. Nevertheless, we also measured clients’ perspective about occurrence of problems in the therapeutic relationship during a session as well as their evaluation of the session’s smoothness and depth.

Our main assumption was that ruptures in working alliance within a given therapeutic session would be positively associated with the emergence of some core components of clients’ dysfunctional interpersonal schemes during that session. According to psychodynamic theorists (e.g., Gelso & Carter, 1985, 1994; Greenson, 1967; Sterba, 1934; Zetzel, 1956), the therapeutic relationship is driven by two antagonistic forces: (a) forces derived from clients’ rational capabilities (conflict free, autonomic ego functions) that set the basis for the formation of a solid and stable working alliance with the therapist and (b) forces derived from instinctual nongratified conflictual needs that emerge and are expressed through transference to the therapist. In these terms, the working alliance is based on clients’ ego-related forces, which allow them to deliberately set adequate goals for therapy, collaborate with their therapist’s interventions, and actively engage in therapeutic tasks. However, at the same time, clients’ thoughts and behaviors within the therapeutic setting are also guided by less conscious and more conflictual forces that are organized around their dysfunctional interpersonal schemes.

One of the most accepted approaches for conceptualizing and assessing clients’ dysfunctional interpersonal schemes is Luborsky and Crits-Christoph’s (1998) CCRT method. According to CCRT, dysfunctional interpersonal schemes have three basic elements: (a) a person’s wishes, needs, or intentions during an interpersonal interaction with a specific other; (b) actual or expected responses of the other; and (c) expressed or unexpressed responses of the self during the interaction. From a psychodynamic perspective, these themes are carried from a client’s history of painful interpersonal relationships, and as such, they set up unrealistic expectations from others, including the therapist, and tend to be self-confirmatory and a source of relational tensions, misunderstandings, conflicts, and maladjustment (Luborsky & Crits-Christoph, 1998).

In fact, clients tend to describe their problems in terms of interpersonal difficulties (Horowitz & Vitkus, 1986). Because conflictual relational themes are a major concern of clients in the course of their therapy (Luborsky, Barber, & Diguer, 1992), these conflictual themes may motivate them to work in the direction of changing them. However, these dysfunctional interpersonal schemes are based on rigid principles of interpretation of the interpersonal reality, and as such, they may tend to be resistant to accommodation through experience and may interfere with a client’s ability to cooperate with therapeutic tasks that can promote intrapsychic change (Luborsky & Crits-Christoph, 1998). Therefore, whereas ego-related motivational forces that support the formation of a working alliance with the therapist seem to promote change, CCRT-related forces that seek self-confirmation within therapeutic sessions are likely to create a more complex and conflictual attitude toward therapeutic work and change.

We assume that both forces are present in a dialectical way in clients’ state of mind while working with a therapist, and that their relative dominance in a given session can determine the emergence of ruptures in working alliance within that session. When conflict-free, ego-related forces are dominant in a given session, the client may be occupied with the therapeutic work itself and no rupture would be observed. However, when CCRTs resurge in clients’ state of mind within a session or are directly or indirectly enacted toward the therapist, these cogni-
Ruptures in the working alliance

Ruptures and enactments may interfere with clients’ capacity to cooperate in the therapeutic work, thereby fostering the emergence of ruptures in working alliance. In support of this view, Safran, Muran, and Samstag (1994) found that an important component in the resolution process of these ruptures is the inquiry of clients’ interpersonal schemes that may have caused them to withdraw from the therapeutic relationship.

Our second research issue concerns the effects of ruptures in working alliance on the therapeutic discourse in a given session. When working alliance is not disturbed, clients’ attention and discourse tend to be focused on issues that bother them in life and they probably would use the session to talk about these problematic issues. However, with the emergence of ruptures in working alliance, a shift in clients’ attention and experience would occur. In these cases, clients’ attention would be probably directed toward the tension and problems they are experiencing in the relationship with the therapist. In other words, the working alliance would move forward and occupy more segments of the session’s discourse. Because the basic elements of the working alliance are the emotional bond between client and therapist as well as their agreement on the goals and the tasks of the therapy (Bordin, 1979), it is logical to assume that clients experiencing in-session ruptures in working alliance would be more concerned with their emotional bond with the therapist and the therapy’s goals and tasks rather than with their actual life problems. Their attention would be directed to the current therapeutic setting, and they would start asking questions about the different working alliance components. On this basis, we hypothesized that the emergence of ruptures in working alliance would move clients from being in therapy and in the therapeutic relationship to the adoption of an external observer attitude toward therapy and the therapeutic relationship. This external observer attitude would be then manifested in heightened discussion, exploration, and clarification of the various working alliance components.

Our third research issue concerns clients’ evaluation of the therapeutic session in terms of their emotional experience during that session and the session’s efficacy. These two aspects of evaluation are frequently related as smoothness and depth of therapeutic sessions (Stiles, 1980; Stiles et al., 1994). Regarding clients’ emotional experience during therapeutic sessions, it was logical to expect that the emergence of ruptures in working alliance within a given session would disturb clients’ emotional equanimity within that session and then would lead them to evaluate the session as a source of tension and discomfort. With regard to clients’ evaluations of session efficacy or depth, it was more difficult to make a prior prediction. Some researchers have formulated the idea that ruptures and repairs of the working alliance may have a curative value in the therapeutic process (Bordin, 1994; Luborsky, 1994; Safran et al., 1994), but we were not sure that clients would think the same way. In the current study, we attempted to explore this issue.

In this study, we used a process-research, in-session methodology for examining this study’s three main hypotheses at the level of individual therapeutic sessions. Specifically, we approached five clients before beginning a psychodynamic-oriented treatment, asked them to provide narratives of interpersonal interactions, and content analyzed their narratives to identify their main CCRTs. Then approximately all the therapeutic sessions of these five clients were audiotaped, transcribed, and content analyzed by independent raters, who looked for (a) particular markers within the session of ruptures in working alliance, (b) the emergence of at least two components (wish and response of self, wish and response of others, or response of self and response of others) of the clients’ CCRTs (as identified before treatment) during the session, and (c) the focus of clients’ and therapists’ attention in the session. In addition, after each session, clients provided their own perspective on the occurrence of ruptures in working alliance within the given session and evaluated the session in terms of their emotional experience during that session and the session’s depth. Our predictions were as follows:

Ruptures in working alliance within a given therapeutic session would be positively associated with the emergence of a client’s CCRT during that session.

Ruptures in working alliance within a given therapeutic session would be positively associated with the extent of discussion, exploration, and clarification of the various working alliance components during that session.

Ruptures in working alliance would be inversely associated with a client’s evaluation of the session’s smoothness.

**Method**

**Participants**

Five clients were sampled at the Student Counseling Center at Bar-Ilan University. The clients were selected after the intake phase according to the intaker’s evaluation about their suitability for
short-term treatment (i.e., high motivation to begin treatment, absence of suicidal tendencies and psychotic symptoms). Following this procedure, the center’s director (Shraga Zim) met personally with seven clients who fulfilled these criteria, provided them information about the research process, and gave them an informed consent form. Five clients (two women and three men; age range: 22–28 years, \( Mdn = 24 \)) agreed to participate without receiving any monetary benefit. Their main complaints at the time of referral involved issues that are typical for their developmental stage (young adulthood), such as conflicts regarding dependence, autonomy, personal identity, and close relationships.

**Therapists**

Each client was treated by a different therapist. All five therapists (four women, one man) were senior clinical psychologists with more than 8 years of clinical practice who reported having a psychodynamic orientation. Therapists, who were not aware of the research hypotheses, consented to cooperate with the research procedure and to audiotape each session.

**Sessions**

All the treatments were conducted on a weekly-session basis. Four treatments continued throughout 12 months and one treatment ended after 6 months. The number of sessions for each client ranged between 16 and 40 (\( M = 31.8 \)) with a total of 159 sessions for the five clients. Only eight sessions were not audiotaped as a result of technical problems. The audiotape protocols of the remaining 151 sessions were transcribed and content analyzed. Eliane Sommerfeld read each session protocol and divided it into units of analysis, which contained uninterrupted segments of the client’s discourse and were delimited by the therapist’s interventions. If the client’s discourse was too long (more than five lines in the transcript), the unit was further divided according to theme shifts or silence breaks.

**Pretreatment Assessment: Determining Clients’ CCRT**

Before beginning treatment, Eliane Sommerfeld approached clients and interviewed them using the Relationship Anecdote Paradigms (RAP; Luborsky & Crits-Christoph, 1998) in order to collect narratives for the CCRT formulation. In this interview, clients were asked to recall 10 concrete episodes in which they had a meaningful interaction with any other person (clients were free to choose the “other person” in the episode). Then they were asked to describe what happened in each episode, what was said, how they and the other person reacted, and how the relational episode ended.

The RAP interviews were audiotaped and transcribed, and Eliane Sommerfeld and a clinical psychology graduate student (who was unaware of the research hypotheses) independently analyzed and scored the 10 narratives of each client according to the rating scoring sheet formulated by Barber (1991). This rating form included a list of 33 categories of wishes, needs, or intentions (Ws); 24 categories of actual or expected responses from others (ROs); and 23 categories of responses of the self (RSs). The two judges read each narrative and rated the extent to which each of the Ws, ROs, and RSs categories were present in the recalled episode. Ratings were made on a 7-point scale, ranging from 1 (not at all present) to 7 (very much present).

For each client, we defined the most dominant Ws, ROs, and RSs as those categories that both judges rated higher than 5 and that occurred in two or more episodes (these chosen categories appeared in an average of four episodes; no category occurred in more than six episodes). This liberal criterion was chosen to avoid omission errors (failure to identify Ws, ROs, and RSs that may appear during therapeutic sessions) in this early, explorative stage of our research. For each client, these recurrent Ws, ROs, and RSs served as the basis for content analyzing his or her sessions’ transcripts. In the current sample, for each client, the number of most dominant Ws ranged between 5 and 10 (\( Mdn = 7 \)); the number of most dominant ROs, between 4 and 10 (\( Mdn = 8 \)); and the number of most dominant RSs, between 3 and 7 (\( Mdn = 6 \)).

**Analysis of the Sessions**

Each speech unit in a session served as the data set for the independent analysis of three main sets of variables: (a) the emergence of rupture markers in the working alliance; (b) the occurrence of a client’s CCRT components; and (c) clients’ or therapist’s explicit references to the various dimensions of the working alliance (bond, goals, tasks). Each set of variables was analyzed by two independent judges, who were clinical psychology graduate students unaware of the research hypotheses (different pairs of judges were used for analyzing each of the three main variables). These judges were trained for the analyses of sessions, independently read all clients’ speech units, and marked units that fit the various criteria described shortly. Training involved independent analysis of five session protocols and joint meetings for discussion and clarification. After training, each judge rated independently 10% to
12% of all the sessions, and a kappa coefficient 
(Cohen, 1960) was computed to estimate interrater agreement. We used kappa coefficients because each judge marked whether or not a specific category (e.g., confrontational rupture marker, client’s CCRT component) appeared in each of a session’s speech units. This procedure revealed adequate reliability indexes for all the variables, ranging from .45 to .65 (.65 for in-session emergence of CCRT; .45 for confrontational rupture markers, .59 for withdrawal rupture markers, and .56-.64 for remarks about working alliance).²

The emergence of ruptures in working alliance within a therapeutic session was analyzed based on Harper’s (1989a, 1989b) manual of rupture markers. In this manual, Harper defined 10 different markers of confrontational ruptures (e.g., negative emotions about the therapist as a person, difficulty related to being in therapy, difficulty about the progress being made in therapy, dissatisfaction with the schedule of therapy) and eight different markers of withdrawal ruptures (e.g., denial of emotional experience, minimal reaction to the therapist’s intervention, intellectualization). Judges read each speech unit and decided whether there was a rupture marker in it and, if so, which type of marker was present (confrontational, withdrawal). On this basis, for each therapeutic session, we computed two variables: (a) the occurrence of at least one confrontational rupture (0 = no, 1 = yes) and (b) the occurrence of at least one withdrawal rupture (0 = no, 1 = yes). Markers of confrontational ruptures appeared in 104 sessions and markers of withdrawal ruptures in 75 sessions. In 63 sessions, there were markers of both confrontational and withdrawal ruptures.³

The analysis of the emergence of a client’s CCRT within a therapeutic session was made for each speech unit separately. Judges read the list of most dominant components of a client’s CCRT (as scored in the pretreatment RAP) and marked whether one or more of these components appeared in a speech unit. A speech unit was defined as a CCRT speech unit (a unit in which a client’s CCRT emerged) only when at least two elements of a client’s CCRT (i.e., W + RO, W + RS, or RO + RS) were present in that unit. After marking CCRT speech units, judges specified who was the “other” included in the CCRT: client’s therapist, parents, romantic partners, family members, other people, or client’s own self. On this basis, we computed the percentage of CCRT speech units in which a specific other appeared (client’s therapist, parents, romantic partners, family members, other people, client’s own self) in a given session from the total number of speech units in that session.

To compute scores reflecting the amount of remarks concerning the working alliance appearing in the client–therapist dialogue during a session, we analyzed both clients’ and therapist’s explicit references to the various dimensions of the working alliance. For this purpose, we developed a manual according to Bordin’s (1979) definitions of the bond, goals, and tasks components of working alliance. In this manual, we defined nine types of remarks to each of these three components and provided examples of clients’ and therapists’ remarks that guided judges in the analysis of speech units. The nine types of remark included (a) positive remarks (e.g., “Last time I felt that you understood me”; “You feel that speaking about it helps you feel better”); (b) negative remarks (e.g., “I’m not feeling good about coming here”; “You are afraid that you’ll be too dependent on me”); (c) agreement remarks (e.g., “I agree that it is good to come twice a week”); “We both think that this is one of the goals of your therapy”); (d) disagreement remarks (e.g., “I don’t think that speaking about things is going to resolve them”; “I don’t agree with you that the frequency of sessions is unimportant”); (e) ambivalent remarks (e.g., “Sometimes I feel that it helps to talk about this stuff but sometimes I feel that it only makes things harder”; “You are not sure if it is okay or not to be so attached to a therapist”); (f) neutral remarks (e.g., “I found a way to fund the treatment”; “That’s one of your goals in therapy”); (g) questions and attempts to explore a working alliance component (e.g., “Do you think that it is a good idea to write down my dreams in the morning?”; “How do you feel about being in therapy?”); (h) attempts to clarify a working alliance component (e.g., “I know that if I’ll understand this pattern, it will enable me to choose better next time”; “So you say that your goal here is to be more comfortable about dating?”); and (i) expression of wishes or needs regarding a working alliance component (e.g., “I wish I was more mean-
percentages of the different types of remarks about the various working alliance components from the total number of speech units in that session.

**Postsession Evaluations**

Immediately after each session, clients completed a brief version of the Post-Session-Questionnaire (Samstag, Batchelder, Muran, Safran, & Winston, 1998). In our study, this self-report questionnaire was designed (a) to obtain clients’ own perspective about the experience of ruptures in working alliance during the session and (b) to obtain clients’ evaluation of the session as a whole. The first part of the questionnaire included 10 Osgood-type items taken from the Session Evaluation Questionnaire (Stiles, 1980), six of which tapped the depth of the session (e.g., bad-good, ordinary-special, valuable-worthless, shallow-deep, empty-full, weak-powerful) and four that tapped the smoothness of the session (e.g., uncomfortable-comfortable, rough-smooth, unpleasant-pleasant, tense-relaxed). Ratings were made on a 10-point scale. Cronbach alphas revealed acceptable reliability coefficients for the two categories of items (.90, .86). On this basis, we computed two total scores for each client in each session by averaging the relevant items. Higher scores reflected the appraisal of a deeper and smoother session.

In the second part of the questionnaire, clients were asked to indicate whether or not there was a problematic event in their relationship with the therapist during the session. If they identified such a problem, they were asked to indicate whether the problem arose at the beginning, middle, or end of the session and to rate the tension this problem caused on a 5-point scale, ranging from very low (1) to very high (5).

**Results**

**The Within-Session Occurrence of Ruptures in Working Alliance**

A simple but important finding relates to the frequency of ruptures in working alliance within the sessions’ transcripts (see Table I for each client’s frequencies). Overall, in 77% of the sessions (N = 116), there was at least one rupture marker (the

<table>
<thead>
<tr>
<th>Table I. Descriptive Statistics of In-Session Ruptures Occurrence for Each Client</th>
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<tbody>
<tr>
<td><strong>Variable</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Confrontational rupture markers</td>
</tr>
<tr>
<td>Sessions with at least 1 marker</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>Markers from total speech units within session (%)a</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>No. markers in therapy</td>
</tr>
<tr>
<td>Markers per session</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Withdrawal rupture markers</td>
</tr>
<tr>
<td>Sessions with at least 1 marker</td>
</tr>
<tr>
<td>Markers from total speech units within session (%)b</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>No. markers in therapy</td>
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<tr>
<td>Markers per session</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Client’s reports about problem</td>
</tr>
<tr>
<td>Sessions with problem</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

*aNon-significant differences were found between clients in confrontational markers.  
bDifferences between clients in withdrawal rupture markers were significant, F(4, 146) = 21.1, p < .01. Sheffe post hoc tests indicated that Client D revealed a higher frequency of this kind of ruptures than the other clients.
number of markers ranged from 1 to 45 markers per session, $M = 5.4$, $SD = 6.8$). There was no evidence for such rupture markers in only 23% of the sessions. Regarding clients’ postsession evaluations, clients identified a problematic event in their relationship with the therapist in 42% of the sessions ($N = 64$). A chi-square test revealed that both perspectives (i.e., judges’ content analysis and clients’ postsession evaluations) were not associated, $\chi^2 = 0.11$, $df = 1$, $p > .05$, $N = 151$.

**Ruptures in Working Alliance and the Within-Session Emergence of Clients’ CCRT**

In this section, we examined our main hypothesis concerning the association between the emergence of a client’s CCRT during a given therapeutic session and the occurrence of confrontational and withdrawal ruptures in working alliance within that session. The data were analyzed using multilevel methods (hierarchical linear modeling [HLM] procedure; Bryk & Raudenbush, 1992) because they represented a two-level model. The lower level represented the therapeutic sessions ($N = 151$) that were nested within five clients. At this level, we assessed the emergence of a client’s CCRT during a given therapeutic session and the occurrence of confrontational and withdrawal ruptures. The upper level represented the five clients from whom these sessions were sampled. In HLM, the two levels of analyses are simultaneously addressed in a hierarchically nested data set, which, in our case, was the session nested within a client. This statistical procedure provided independent coefficients of the associations among constructs at the lower level (in-session associations between CCRT markers and ruptures) and modeled them at the upper level (between-clients effects) using maximum likelihood estimation and giving unequal weight to each client (because of differing number of sessions). In this way, we controlled for the dependency of the data (i.e., the fact that the 151 sessions were derived from only five clients) and the fact that clients differed in the number of sessions.

On this basis, we conducted a series of HLM analyses examining the lower level (in-session) association between the emergence of a client’s CCRT during a given therapeutic session and the occurrence of confrontational and withdrawal ruptures within that session. Specifically, we conducted 12 HLM analyses examining these lower level associations. In each analysis, we included one of the six in-session CCRT scores (frequencies of CCRT speech units that referred to therapist, parents, romantic partners, family members, other people, or client’s self) as a predictor of the in-session occurrence of either confrontational or withdrawal ruptures. We performed separated HLM analyses for each type of rupture. Table II presents the relevant HLM coefficients, standard errors, and significance tests for the analyses. 4

As can be seen in Table II, the HLM revealed significant in-session associations between the percentage of CCRT speech units involving clients’ therapist or romantic partners that appeared in a given session and the occurrence of confrontational markers in that session. However, no significant in-session association was found with regard to the occurrence of withdrawal rupture markers in a session (see Table II). An examination of the HLM coefficients revealed different patterns of associations for CCRT speech units in which therapists or romantic partners were involved. Fitting our hypothesis, higher percentages of CCRT speech units involving clients’ therapist within a given session were associated with the occurrence of confrontational ruptures within that session (see Table II). However, the occurrence of confrontational ruptures within a given session was also associated with lower percentages of CCRT speech units involving clients’ romantic partners within that session (see Table II).

To illustrate a client’s CCRT and how it was manifested in a session with rupture markers, we provide here a vignette extracted from the clinical

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**Table II. HLM Coefficients and Statistics for the Contribution of In-Session Frequencies of CCRT Speech Units to In-Session Markers of Confrontational and Withdrawal Ruptures**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Confrontational ruptures</th>
<th>Withdrawal ruptures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\gamma$</td>
<td>$SE$</td>
</tr>
<tr>
<td>Therapist</td>
<td>0.14</td>
<td>0.05</td>
</tr>
<tr>
<td>Parents</td>
<td>-0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Romantic partners</td>
<td>-0.08</td>
<td>0.04</td>
</tr>
<tr>
<td>Family members</td>
<td>0.06</td>
<td>0.08</td>
</tr>
<tr>
<td>Other people</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td>Client’s self</td>
<td>0.03</td>
<td>0.03</td>
</tr>
</tbody>
</table>

*Note. HLM = hierarchical linear modeling; CCRT = core conflictual relationship theme.

*p < .05. **p < .01.
material of Client A (Session 13). This 24-year-old woman was suffering from relational problems with her husband and parents as well as low self-esteem. On the RAP interview, before therapy, it was found that her CCRT included Ws “to respect others,” “to be accepted, understood,” and “to be assertive and independent, to stand for my own rights”; ROs dealing with “the other sets limits” and “the other controls”; and RSs reflecting “feelings of helplessness” and “feelings of guilt and anxiety.” The following are some segments extracted from that session:

C (entering the therapist’s office): I am late.
T: The time of the session is yours.
C: It’s mine, but you are the one that has to wait for me.
T: Do you understand what you are apologizing for?
C: I don’t know. It doesn’t seem to me right that you have to wait for me. It’s just annoying to wait. It is wrong to be late. It is not exactly my fault; I did not have much to do about the traffic. I shouted at the driver to hurry up, but it didn’t work. But in the meantime, you might have called me and thought that I would not come today.

Some minutes later:

T: What do you think about your apologies? What are your thoughts about being wrong?
C: If I’m late, that’s wrong. In any case that’s wrong if someone is late.
T: Yes, but it isn’t just that. You are always trying to be okay, you try to control your thoughts, the traffic, and all the things that are out of your control . . . but what are you apologizing for? It seems that you feel not okay on many occasions.
C: We know that I always feel guilty. But on this occasion, I am not sure that these feelings have anything to do with my apologies.
T: There are many options on how to react on this type of occasion. You could ask, for example, if I waited too long. But you chose to take all the responsibility on yourself and to apologize. And it has costs: You feel guilty and the person who is in front of you can never complain about you because you are always so right.
C: The truth is that I am being criticized a lot by close friends or acquaintances. For example, my boss had a lot of complaints about me, although I have tried very hard to be okay in my job.

This example illustrates an enactment of some of the client’s CCRT components in her relationship with the therapist (e.g., wishes of “to respect others” and “to be accepted or understood,” RS of “guilt feelings”). Following this episode, a confrontational rupture occurred:

C: I want to ask you something. I feel that I am jumping from one topic to another, and I’m not sure if it is okay to work like this on therapeutic session . . . I would think that therapeutic sessions would be more focused on a specific problem, but I usually feel very confused when I’m with you.

Then the therapist asked her to elaborate about how she felt about the therapeutic relationship and tasks. The therapist also provided legitimacy to feel that there are a lot of subjects to work during treatment. But the client expressed another rupture marker and said:

C: You are giving me a justification to jump from one story to another, but I feel that I’m losing the sequence of things. We talk about a lot of stuff, but it doesn’t help me to create a coherent line of thinking.

From this point, the therapist and the client were engaged in talking about the working alliance, and many speech units contained different types of remarks about the bond and the task components. This vignette illustrates how the client’s appraisals of the therapeutic relationship and therapeutic work are colored by her conflictual relationship themes.
them. In this way, the HLM coefficient for a specific rupture type represents its unique contribution to components and markers of working alliance beyond the contribution of the other type of rupture. Specifically, we conducted 12 HLM analyses. In each analysis, we entered the two types of ruptures as the predictors and one of the three working alliance components or one of nine working alliance markers as the predicted variable. Table III presents the relevant HLM coefficients, standard errors, and significance tests for the analyses.5

The HLM analyses revealed significant in-session associations between occurrence of confrontational ruptures on a given session and the percentage of bond remarks and tasks remarks that appeared in that session (see Table III). However, no significant association was found between the occurrence of confrontational rupture and the percentage of goals remarks. As can be seen in Table III, higher percentages of bond remarks or tasks remarks were found in sessions with confrontational ruptures than in sessions without this kind of rupture. No significant in-session association was found between occurrence of withdrawal ruptures and each of the three working alliance components. That is, the occurrence of confrontational ruptures within a therapeutic session was significantly associated with a higher level of references to the bond and task components of the working alliance.

The HLM analyses also revealed significant in-session associations between occurrence of confrontational ruptures and each of the nine types of working alliance remarks. As can be seen in Table III, higher percentages of all of these working alliance remarks were found in sessions with confrontational ruptures than in sessions without this kind of rupture. No significant in-session association was found between occurrence of withdrawal ruptures and each of the nine types of working alliance remarks. Thus, it seems that in sessions with confrontational ruptures in working alliance, there was a higher level of exploratory and inquisitive remarks about the working alliance and not only negative remarks about its components.

### Ruptures in Working Alliance and Clients’ Postsession Evaluations

To examine our third hypothesis, HLM analyses were conducted examining the association between occurrence of ruptures in working alliance within a given session and clients’ appraisal of the depth and smoothness of that session. Specifically, we conducted two HLM analyses. In each analysis, we entered the two types of ruptures as the predictors and one of the two client postsession appraisals (session depth, session smoothness) as the predicted variable. Table IV presents the relevant HLM coefficients, standard errors, and significance tests for the analyses. The HLM analyses revealed only a significant in-session association between occurrence of withdrawal ruptures and clients’ appraisal of session smoothness. No significant in-session association was found with regard to the occurrence of confrontational ruptures (see Table IV). As can be seen in Table IV, sessions with withdrawal ruptures

<table>
<thead>
<tr>
<th>Variable</th>
<th>Confrontational ruptures</th>
<th>Withdrawal ruptures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>γ</td>
<td>SE</td>
</tr>
<tr>
<td>WA components</td>
<td></td>
<td></td>
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<tr>
<td>Bond</td>
<td>4.95</td>
<td>1.54</td>
</tr>
<tr>
<td>Goals</td>
<td>0.35</td>
<td>0.31</td>
</tr>
<tr>
<td>Tasks</td>
<td>5.34</td>
<td>1.14</td>
</tr>
<tr>
<td>Type of remark</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
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<td>0.34</td>
</tr>
<tr>
<td>Negative</td>
<td>0.49</td>
<td>0.15</td>
</tr>
<tr>
<td>Agreement</td>
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<td>0.13</td>
</tr>
<tr>
<td>Disagreement</td>
<td>1.32</td>
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<tr>
<td>Ambivalent</td>
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<td>0.34</td>
</tr>
<tr>
<td>Neutral</td>
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<td>0.56</td>
</tr>
<tr>
<td>Attempt to explore</td>
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<td>0.67</td>
</tr>
<tr>
<td>Attempt to clarify</td>
<td>1.70</td>
<td>0.60</td>
</tr>
<tr>
<td>Wish expression</td>
<td>0.16</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Note. HLM = hierarchical linear modeling; WA = working alliance.
*p < .05. **p < .01.
were experienced as less smooth than sessions without this kind of rupture.

Because we found earlier that there was a discrepancy between clients' perspective of ruptures in working alliance and the content analysis of occurrence of these ruptures, we thought it would be interesting to explore whether and how these two perspectives can jointly contribute to understand clients' appraisal of session depth. In other words, we asked whether clients' evaluation of session depth differed between sessions in which clients reported a rupture in working alliance and raters identified such a rupture and sessions in which only clients or the rater identified a rupture in working alliance. Then we conducted an HLM analysis predicting clients' appraisal of session depth with the clients' identification of a working alliance rupture (yes, no), raters' identification of such a rupture (yes, no), and the interaction between these two factors as the predictors. This analysis revealed a significant interaction effect, $\gamma = 1.17$, $SE = 0.52$, $t(145) = 2.25$, $p < .05$. As can be seen in Figure 1, clients' identification of a rupture in working alliance was associated with higher appraisals of session depth (compared with a session in which they did not identify such a rupture) only when this rupture was also identified by independent raters but not when these raters did not identify any rupture. That is, heightened client evaluation of the depth of a given session was mainly found when both the client and independent raters identified ruptures in working alliance.  

**Discussion**

In this study, we explored the associations between in-session occurrence of ruptures in the working alliance, clients' CCRTs, alliance-related discourse, and clients' postsession evaluations of the session's smoothness and depth. Findings indicated that the occurrence of these ruptures, mainly of a confrontational nature, was associated with the emergence of clients' CCRT in their discourse during a therapeutic session, but only when the conflictual themes (wishes, mental representations of self and others) were directed toward the therapist. In addition, during therapeutic sessions with confrontational ruptures in working alliance (compared with other sessions), the focus of clients' and therapists' discourse shifted toward the bond and task components of the working alliance and reflected heightened attempts to explore and clarify the therapeutic relationship. Findings also indicated that the occurrence of ruptures in working alliance, mainly of a withdrawal nature, within a given therapeutic session was associated with clients' postsession reports of less emotional comfort during that session. Thus, it seems that ruptures in working alliance within a therapeutic session can be viewed as a juncture of clients' intrapsychic domain, as reflected in the emergence of their CCRTs in that session, and the interpersonal field of psychotherapy, as reflected in within-session direction of attention toward the therapeutic relationship and disruption of clients' emotional equanimity.

Because the findings are correlational, we cannot determine what the causal direction is between ruptures in working alliance and the emergence of CCRT within a given therapeutic session. Nevertheless, it seems fairly safe to say that these findings are in line with the dialectical interplay of the two forces clients bring to therapy: (a) the rational and ego-related forces that account for clients' ability to create a working alliance and stay in therapy and (b) the conflictual forces that reflect their typical and
dysfunctional way of interpersonal relatedness. Although these two forces are both present in clients’ mind, there are times in a session when one is more dominant than the other, and this relative dominance seems to affect the current client–therapist relationship, the issues discussed during the session, and clients’ experience of the session. When conflictual forces begin to dominate clients’ experience and their dysfunctional interpersonal schemes emerge in their within-session discourse toward the therapist, our findings indicate that the working alliance is more likely to be disrupted. Moreover, this rupture in working alliance seems to direct clients’ and therapists’ attention and discourse toward the exploration and clarification of their own relationship and to disrupt clients’ emotional discomfort during the session.

These ideas fit with the assumption that ruptures in working alliance are important events in the therapeutic work (e.g., Safran, 1993a, 1993b). When these ruptures occur, our findings indicate that dysfunctional interpersonal schemes are likely to be active and available in clients’ here-and-now state of mind. Therefore, ruptures in working alliance offer a good opportunity for processing information about clients’ maladaptive patterns of relatedness and altering dysfunctional representations. In other words, therapists can refer to rupture markers as signs for critical points of intervention during therapy.

An important finding relates to the incompatibility between clients’ reports about the occurrence of a problem in the therapeutic relationship within a session and the appearance of rupture markers in their within-session discourse. This finding can be explained in methodological terms, because the cognitive processes and techniques involved in reading the sessions’ transcripts and spotting rupture markers by independent raters are very different from those involved in the global evaluation that clients were asked to perform after a session. Nevertheless, it is important to note the finding regarding the evaluation of session depth: Clients were more likely to evaluate a session as more valuable when both they and independent raters identified a rupture in working alliance. Thus, it seems that the more a client’s dissatisfaction with the working alliance becomes explicitly conscious and openly expressed during a session, the more likely he or she tends to experience a session as helpful. This finding may have practical implications. It may be important for therapists to detect subtle signs of ruptures in working alliance and to invite clients to look at and explore these ruptures during the therapeutic session.

Interestingly, CCRTs concerning clients’ romantic partners were less likely to emerge during sessions in which ruptures in working alliance were present. This finding may be a product of some sort of displacement: When clients are engaged in information processing and verbal expression of various aspects of the therapeutic relationship, they may be less occupied with their relations with romantic partners. However, this is only a post hoc speculation, and future research should examine this unexpected finding further.

A note of caution is warranted because of the small sample size and the reactivity of the postsession questionnaire. Although small samples are common in process research studies, one should be aware about potential biases that such small samples can create in variables’ distribution and research findings. In our case, this limitation is especially relevant because of the high number of computations involved in the HLM procedure. Additionally, the fact that clients completed a brief questionnaire after each session might have interacted with the therapeutic process, thereby limiting the generalizability of the findings to natural therapeutic settings. Future studies are needed not only to replicate the current findings but to extend the scope of exploration of ruptures in the working alliance and their contribution to intrapsychic and behavioral changes during therapy. Specifically, it would be important to investigate how the relationship among ruptures, clients’ CCRTs, therapeutic discourse, and session smoothness and depth is modified in different contexts of rupture resolution, meta-alliance ratings, and global therapeutic outcomes. Nevertheless, the findings of the current study provide important and novel information about the psychological correlates of in-session ruptures in working alliance between clients and therapists.

Acknowledgements

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Notes

1 The specific contents of each client’s Ws, ROs, and RSs are available upon request from Eliane Sommerfeld.
2 The various manuals used for the analyses of a client’s speech units are available upon request from Eliane Sommerfeld.
3 We also computed the percentage of speech units in which appeared either a confrontational or withdrawal rupture marker from the total number of speech units in a given session. Statistical analyses performed on these percentages revealed effects identical to those reported in the Results section.
4 HLM analyses, including the six CCRT scores as simultaneous predictors of the occurrence of confrontational or withdrawal ruptures in a given session, revealed in-session effects identical to those reported in Table I.

5 We also conducted HLM analyses in which the interaction between confrontational ruptures and withdrawal ruptures was included as an additional predictor. However, this interactive effect made no significant contribution to any of the working alliance components and markers as well as client’s appraisal of the session.

6 We also conducted similar HLM analyses predicting percentages of the three working alliance components, percentages of the nine working alliance markers, and clients’ appraisal of session smoothness. However, these analyses revealed no significant interaction effect between clients’ identification of a working alliance rupture and raters’ identification of such a rupture.

References


