INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

ProQuest Information and Learning
300 North Zeib Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®
NOTE TO USERS

This reproduction is the best copy available.

UMI
THERAPEUTIC ALLIANCE RUPTURE TYPES IN TIME-LIMITED PSYCHOTHERAPY WITH A FOCUS ON THE DISCREPANCY BETWEEN PATIENTS' AND THERAPISTS' PERCEPTION OF THE RUPTURES

by

Gitte Bowman Bak

May 2003

Submitted to the Graduate Faculty of Political and Social Science of the New School University in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Dissertation Committee:
Dr. Jeremy D. Safran (Chair)
Dr. J. Christopher Muran
Dr. David Shapiro
Dr. Elizabeth Ross
Abstract

The aim of this dissertation was to explore the therapeutic alliance, focusing especially on discrepancies between patients' and therapists' perspective, with a goal of building a taxonomy of alliance rupture types. Preliminary analysis of archival data at The Brief Psychotherapy Research Project at Beth Israel in New York found that only in a third of the cases did patients and therapists agree on the occurrence of a rupture in a particular session, and this researcher speculated that this discrepancy might imply that different rupture types exist, with patients and therapists more likely to be aware of each their different subset of ruptures.

46 rupture segments, from 23 dyads, were selected, with one patient-reported and one therapist reported rupture from each, from three different time-limited treatment modalities (BAP, BRT and CBT). These were coded on the process measure SASB, a tool for capturing the moment-to-moment therapy process on two dimensions, affiliation and dependence.

Statistical analyses of patient and therapist behavior across rupture segments did not find significant differences between the two perspectives.

However, statistical analyses on the same variables picked up significant differences between treatment modalities, particularly for therapist behavior. It was found that BRT therapists were exhibiting more autonomy-encouraging behavior and were generally seen as less hostile than therapists in BAP and CBT.

Analysis of most prevalent patient behavior in rupture segments found
interesting tendencies, with patients reporting ruptures with relatively more submissive patient behavior and therapists reporting ruptures with relatively more independent patient behavior. This was further explored, and a taxonomy of ruptures was made, categorized by reporter and the combined patient/therapist behavior captured on the two SASB dimensions. Subgroups resembling rupture categories identified by other researchers, e.g. Safran et al (1990), were established. In addition, a finding was made of a subtle type of therapist-reported ruptures lacking distinct characteristics of “typical” patient rupture markers. In these situations, the therapists experience tension or sense potential alliance problems, but any defensiveness, avoidance or hostility is only picked up by a more global evaluation of the underlying sense of the segments.
ACKNOWLEDGEMENTS

The inspiration and impetus for the research in this dissertation came from my involvement in the Brief Psychotherapy Research Project at Beth Israel Medical Center, where I started working as a research assistant in 1996 and I owe a lot to everybody in the Research Project.

In particular, I would like to express my gratitude to Dr. Jeremy D. Safran, who inspired me to join the Research Project in the first place and whose writings and research has been a tremendous influence on my own thinking since I came to the New School University.

I would also like to thank Dr. J. Christopher Muran for allowing me to be a member of the Research Project at BIMC and using their data and resources for completing this research; his clear-sightedness was a big help towards the end of my dissertation.

This research required a lot of coding and rating by independent people and I am grateful that a number of other graduate students were willing to help me with this. Especially, do I owe a lot to Liz Bowman, MA, Dalia Spector, MA, and Zack Miller, MA, who undertook and successfully completed an enormous job with the SASB coding.

Over the years, a number of other people have been a great inspiration for me in my studies at the New School University. In particular, do I think of myself as being fortunate to have had the chance to learn from Dr. David Shapiro. His thinking has been, and will continue to be, a guiding force for me in my clinical work and research.
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

Chapter I.
INTRODUCTION

Chapter II.
REVIEW OF THE LITERATURE

1. Research on the therapeutic alliance
2. Rater perspective
3. Ruptures

Chapter III.
THE IMPORTANCE OF STUDYING RUPTURE TYPES AND THE AIM OF THIS DISSERTATION
Chapter IV.
RESEARCH APPROACH 24

Chapter V.
RESEARCH METHOD 25

1. Subjects 25
2. Rupture events 28
3. Event measures 30
4. Procedure 31
   Verification of events 31
   Rating of events 37
   Analyses 39

Chapter VI.
RESULTS 41

1. Introduction 41
2. Data analysis 46
3. Taxonomy of ruptures 55

Chapter VII.
DISCUSSION 80

1. Limitations of study 80
2. Summary 82
3. Suggestions for future research 89

Chapter VIII.
REFERENCES 91

Chapter IV
APPENDICES 98
LIST OF TABLES

TABLE
1. Interrater reliability on SASB measures 39
5. Comparison of Structural Analysis of Social Behavior (SASB) Cluster Means for Therapist Behavior – by Modality 54
6. Taxonomy of rupture types 61
LIST OF FIGURES

FIGURE
1. SASB codes for the patient behavior in all 50 rupture segments (unweighted) 44
2. SASB codes for the therapist behavior in all 50 rupture segments (unweighted) 45
3. Majority occurrence of SASB codes for the patient behavior in 42 rupture segments 57
4. Majority occurrence of SASB codes for the patient behavior in 20 rupture segments reported by patients. Type 1 and 4 58
5. Majority occurrence of SASB codes for the patient behavior in 22 rupture segments reported by therapists. Type 2 and 3 59
# LIST OF APPENDICES

**APPENDIX**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Subject and Therapist Demographics</td>
</tr>
<tr>
<td>B</td>
<td>Informed Consent Form</td>
</tr>
<tr>
<td>C</td>
<td>Post-Session Questionnaire (Patient version)</td>
</tr>
<tr>
<td>D</td>
<td>Instruction to independent judges on rating alliance rupture events</td>
</tr>
<tr>
<td>E</td>
<td>Cluster Version of Structural Analysis of Social Behavior (SASB):</td>
</tr>
<tr>
<td></td>
<td>Surface 1</td>
</tr>
<tr>
<td></td>
<td>Surface 2</td>
</tr>
<tr>
<td>F</td>
<td>Tally of SASB scores –unweighted</td>
</tr>
<tr>
<td>G</td>
<td>Tally of SASB scores – weighted</td>
</tr>
<tr>
<td>H</td>
<td>SASB codes for patient and therapist behavior in individual rupture segments (unweighted)</td>
</tr>
</tbody>
</table>
Chapter I.

INTRODUCTION

The relevance of looking at rupture types should be seen in light of the increasing importance placed upon the therapeutic working alliance as a concept underlying all forms of therapy, which followed Bordin's reformulation of the construct into more broad, pantheoretical terms (Bordin, 1979; Horvath, 1994). This working alliance construct stresses the collaborative element of the client-therapist relationship (Bordin, 1979). However, before going into details about Bordin’s construct, it may be informative to look at some of the earlier ideas on the client-therapist relationship leading up to Bordin’s notion of the therapeutic working alliance.

The necessity of establishing an effective client-therapist relationship from the beginning of treatment was already discussed by Freud in 1913, when he talked about the "effective transference" and "rapport": "It remains the first aim of the treatment to attach him (the patient) to it and to the person of the doctor. To ensure it, nothing need be done, but
to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment (...)" (Freud, 1913, p. 139). For Freud however, in contrast to Bordin’s later ideas, the effective client-therapist relationship was something separate from the analytic situation, something outside the neurotic process or transference. In the classical psychoanalytic model, the therapist is considered external to the process, as someone taking a neutral position. Greenberg and Mitchell describe it this way, “The analyst’s position vis-à-vis the patient is similar to the position, within the drive-model, of an individual’s objects. As the object is external to drive-derived aims, so the analyst is external to the neurotic process” (1983, p. 388).

In 1956, Zetzel introduced the term "therapeutic alliance", when she outlined how the ego-psychological approach made a distinction between transference as therapeutic alliance and the transference neurosis, where the former is considered a prerequisite for an effective analysis and the latter is the manifestation of resistance that needs to be analyzed. The therapeutic alliance is here defined as the patient’s identification with the therapist, and essential for its development is the maturity of the patient's ego characteristics and the therapist's ability to engage in behaviors that facilitate the alliance (in contrast to therapist
behaviors that solely deal with transference interpretations). Zetzel’s construct is clearly connected to models that stress early parental failure and developmental arrest. With an emphasis on the patient’s ego capacities the patient increasingly becomes an ally in the therapist’s attempts to get at an underlying conflict and the analytic relationship is seen as a form of partnership (Mitchell and Black, 1995). The patient in therapy gradually develops better skills for self-observation, and the partnership seems to “reactivate, between patient and analyst, some form of the early developmental reciprocity that existed between mother and infant” (Ibid. p. 59)

Building on Zetzel, Greenson (1965), in his work with patients who seemed unanalyzable or interminable, similarly found that it was important to look at two distinct categories of patients’ reactions to the analyst: the transference neurosis and the working alliance. Greenson defined the "working alliance" as "the relatively nonneurotic, rational rapport which the patient has with his analyst" and found that the alliance is formed "between the patient's reasonable ego and the analyst's analyzing ego" (Greenson, 1965, p. 157).

In order for this formation to take place, first, the patient must be able to split off a reasonable, observing ego from his or her irrational, experiencing ego (Ibid.). The analyst’s attitude in his or her work with
the patient is also important: "His (the analyst's) consistent and unwavering pursuit of insight in dealing with any and all of the patients' material and behavior is the crucial factor" (Ibid. p. 177). Finally, the treatment situation in itself with its constant emphasis on the joint effort of the therapist and the patient in the therapeutic work aids the development of the alliance.

In both Zetzel’s and Greenson’s models, within the ego-psychological model, the real relationship with the therapist seems to play an important role, but as a prerequisite rather than as a curative agent itself. The shift to seeing the therapeutic relationship, and not the therapist’s interpretations, as the primary agent of change happens however with the object relations theory, self psychology, and relational theory, although in slightly different ways. These models see the therapist as an inherent part of the dyadic therapy situation. The therapist is now a co-creator of the transference (Greenberg and Mitchell, 1983).

Balint says about this, "(...) in certain periods of the treatment, creating and maintaining a workable relationship, particularly with a patient in regression, is perhaps a more important therapeutic task than giving correct interpretations” (Balint, 1992, p. 160). Therapy’s goal is to offer the patient a “new beginning” by allowing the patient to
establish the compulsively desired primitive relationship with the analyst, i.e. the world of ocnophilia, philobatism, or primary love, and maintain this in peace until the patient is ready to discover other ways of relating (Ibid.).

Winnicott sees the therapist’s role to be comparable to that of the good-enough mother as someone that can create a holding function for the regressed patient, and by this enable the patient to correct the original parental failure and continue his or her development of a true self. Winnicott states that the analyst’s failures are an important element in treatment, because these make it possible for the patient to deal with the original failures in a safe environment. (Winnicott, 1963).

Kohut stresses the importance of the therapist being emphatically attuned to the patient, modeled after the original, healthy parent-infant relationship, whereby a self-object transference gets established that will allow reactivation of the structure-building or development of a “nuclear self”, a process thwarted in childhood; “the self-object transferences during analysis are in essence a new edition of the relation between the self and its self-objects in early life” (Kohut, 1977, p. 173 n). Kohut states about the therapy and the therapeutic relationship, “Every interpretation, in other words, and every reconstruction, consists of two phases; first the analysand must realize that he has been understood;
only then, as a second step, will the analyst demonstrate to the analysand the specific dynamic and genetic factors that explain the psychological content he had first emphatically grasped" (Ibid. p. 88).

With the therapist as a co-creator of the transference, the therapist’s counter-transference reactions become important tools for the therapist in his or her work, helping inform him or her of the patient’s relational patterns (Greenberg & Mitchell, 1983). Relational theory sees the "(...) analyst as discovering himself within the structures and strictures of the repetitive configurations of the analysand’s relational matrix. The struggle to find his way out, the collaborative effort of analyst and analysand to observe and understand these configurations and to discover other channels through which to engage each other, is the crucible of analytic change" (Mitchell, 1988, p. 292). Mitchell sees the therapeutic relationship as a new encounter between two people, where both of them are trying to find and connect with the other person. This process may ultimately help broaden the patient’s way of relating.

In his 1979-paper Bordin, starting with the early contributions of particularly Zetzel (1956) and Greenson (1965), developed the idea of the working alliance as an integral part of all types of psychotherapy. By his insistence on the collaborative aspects between client and therapist he seems to be influenced by models that see the therapist as a co-
creator of the transference. Although Bordin does not directly state this, in his views, the technical and the relational elements of the therapeutic situation are intertwined. Bordin thus proposed that all genres of psychotherapy have embedded working alliances, and that the effectiveness of a therapy is a function (at least in part) of the strength of the working alliance rather than of the kind (Bordin, 1979).

According to Bordin, the working alliance is seen as having three distinct, but interrelated features: "An agreement on goals, an assignment of tasks or a series of tasks, and the development of bond" (Ibid. p. 253). The strength of the alliance is a result of the mutual understanding and agreement between the therapist and the patient about the goals and tasks, which are both influenced by and at the same time influence the experience of association (bonding) between the two parties. The working alliance thus emphasizes the collaborative element of the therapist-patient relationship.

Goals are directly related to the changes that the patient and the therapist aim for in therapy. Depending upon the modality, therapy may be more or less narrow in its goal-direction; e.g. Bordin sees goals in behavior therapy as directed towards changing specific acts of the individual, whereas psycho-dynamic goals tend to encompass all thinking, acting, and feeling and be directed toward a central core of the
patient (Ibid.)

Tasks involve the assignments and requirements that therapy put upon the patient and the therapist. Again, these tasks vary from one therapeutic method to another, e.g. in behavior therapy "the patient (...) may be assigned the task of observing and tabulating the frequency and circumstances surrounding a particular action, e.g. assertive behavior" (Ibid. p. 254). For the therapist's part tasks may involve e.g. interpreting or empathic understanding.

Bonds are related to trust and attachment between patient and therapist and seem to be influenced, among others, by differences in emphasis on therapist's versus patient's responsibilities in the various therapies, e.g. the behavior therapist being in a major executive role vs. client-centered therapy's emphasis on the responsibilities of the patient (Ibid.).

The above formulation offered by Bordin sparked a lot of interest in research on the alliance, both in terms of developing measures of the alliance, and in terms of investigating the relationship between alliance and outcome.
Chapter II.

REVIEW OF THE LITERATURE

1. Research on the therapeutic alliance

During the past 15 years, following among others Bordin's conceptualization, a lot of psychotherapy research into the working alliance has been undertaken and evidence has emerged that seems to support the fact that the working alliance is predictive of therapy outcome; (e.g., Horvath & Symonds, 1991; Luborsky, 1994).

However, already before Bordin's concept of the working alliance had been clearly formulated, some researchers had found indications of a connection between the therapeutic relationship and outcome. E.g. in their review of comparative studies of different psychotherapies, Luborsky, Singer, & Luborsky (1975) found only insignificant differences in outcome between various forms of psychotherapy. Smith and Glass (1977) reported similar findings in their meta-analysis of 375 controlled evaluations of psychotherapy and counseling, where they found only negligible differences in the effects of the different therapy
types. Although Luborsky, Singer, and Luborsky warn against over-interpreting this result - due to the fact that all patients in their study seemed to achieve some gain, why a significant difference may be hard to find - the results seem to point to some common elements in the different therapies. The researchers suggested that, "The most potent explanatory factor is that the different forms of psychotherapy have major common elements - a helping relationship with a therapist is present in all of them (...)" (Luborsky, Singer, & Luborsky, 1975, p.1006).

In 1977, Gurman looked at patients' perceptions of the quality of the therapeutic relationship and found that they were closely linked with treatment outcome. However, in Gurman's study the concept of the therapeutic relationship was based upon a measure of "therapeutic conditions", which does not capture the collaborative aspect of the alliance, but rather what is "offered" by the therapist to the patient (Gurman, 1977). Frank formulated the connection between the working alliance and outcome this way: "(...) more of the determinants of therapeutic success lie in the personal qualities of and the interaction between patient and therapist than in the particular therapeutic method used" (Frank, 1982).

Luborsky's later review of 24 samples of patients within 18 different
studies (all studies done after 1976) also found the therapeutic alliance to have significant predictive power over outcome, with correlations ranging between .20 and .45 (Luborsky, 1994). Similar results were obtained by Horvath and Symonds (1991) in their meta-analysis of 24 studies published between 1975 and 1991: they found an average effect size of \( r = .26 \) for the relation between working alliance and outcome.

2. Rater perspective

Gurman's 1977-research on the relationship between patient's perception of the therapeutic relationship and outcome included 26 studies, and in 23 of these Gurman found that a positive relationship existed (Gurman, 1977). In addition to yielding information about the predictive power of the alliance, this research highlighted an interesting aspect of the measurement variables for the alliance, namely the perspective of the rater. Gurman concludes, "Across studies using a variety of instruments to assess patients' and therapists' perception of the therapeutic relationship, there is with the possible exception of therapist empathy, little convincing evidence of agreement between these parties. Even studies using the same relationship measures do not show confirmatory results" (Ibid. p. 517). Comparing patients' and trained judges' ratings of the therapeutic relationship, Gurman finds a similar

11
disagreement. According to Gurman, "The major methodological implication of these findings for future research on the therapeutic relationship is that these evaluative perspectives (patients', therapists', and judges') represent substantially different sources of assessment, each of which may supply relatively unique information about the quality of the interaction between patients and therapists. Therefore, researchers are cautioned against assuming that evaluation of therapy relationships from any one perspective may speak, by implication, for the persons who may be occupying other phenomenological positions" (Ibid. p.518, my parenthesis)

Later research by Horvath & Symonds (1991) focused specifically on this variable. In their meta-analysis on the relation between the working alliance and outcome Horvath and Symonds included results of 24 studies according to certain criteria, which among others involved these two: 1) the relationship construct measured had to be identified by the authors as either "working", "helping" or "therapeutic" alliance, and 2) the studies should report a quantifiable relationship between alliance and subsequent measures of outcome. The meta-analysis looked at assessments of the working alliance and the outcome from the perspective of the patient, the therapist, and observers, and found that patients' and observers' ratings of the working alliance were better
predictors of outcome than were therapists' ratings, irrespective of rater of outcome. Calculated effect sizes (ES), based upon the product-moment correlation coefficient \( r \), showed an ES of .27, .23, and -.03 for clients, observers, and therapists respectively.

Bachelor's study of 47 clients seen in short-term therapy (6-38 sessions) similarly found that clients' perceptions of the alliance were superior to therapists' in the prediction of outcome (Bachelor, 1991). Bachelor's results showed that client ratings of the Penn Helping Alliance Ratings Method, Helping Alliance type 1 (perceived warmth, helpfulness, and support of the therapist) accounted for 40% and 44% of positive change in psychological functioning and target complaints (two outcome measures) respectively. When using therapist ratings of alliance, the strongest predictor found was the patient participation dimension on the Vanderbilt Psychotherapy Process Scale, which accounted for 13% and up to 21% of the variance in target complaints and psychological functioning, respectively.

3. Ruptures

Most of the studies of the predictive power of the working alliance are based upon measures of the therapeutic alliance early in treatment or using an average across sessions (e.g. Gomes-Schwartz, 1978, Hartley
& Strupp, 1983, and Luborsky, 1976). This research does not tell us anything about variations in the alliance over time. A number of researchers have in this connection pointed to the dynamics of the alliance; the alliance is not to be seen in a static way, but is fluctuating over time and is characterized by so-called "ruptures" (Safran et al., 1990; Safran & Muran, 1996), "breaches" (Safran, 1993), "strains" (Bordin, 1994), or "impasses" (Elkind, 1992, Weiner, 1982).

A rupture can be defined as "(...) an impairment or fluctuation in the quality of the alliance between the therapist and client" (Safran et al., 1990 p. 154) and when it is very severe as a "(...) deadlock or stalemate that causes therapy to become so difficult or complicated that progress is no longer possible and termination occurs" (Hill et al., 1996, p. 207). It can occur in situations where a therapist's actions confirm a client's dysfunctional interpersonal schemata (Safran et al., 1990). Other researchers have particularly stressed ruptures that arise when a client in therapy experiences his or her own behavior as problematic in ways related to those described as the goals of the therapy (Bordin, 1994). These two cases might be seen as complementary, tapping into different nuances of ruptures. In both cases the rupture constitutes a critical change event, which can present the therapist with an opportunity to explore central themes of the patient's, and, if resolved, can lead to
therapeutic change (Safran et al., 1990; Safran & Muran, 1996).

Foreman and Marmor (1985) in their study of six patients with initially poor alliances, found that three of these patients developed improved alliances following certain therapist actions mainly addressing problems related to the alliance, with successful outcome as a result. Although this study is based upon a very limited sample size and its results therefore hardly are generalizable, it lends some support to the view of the alliance as dynamic as opposed to the notion of the alliance as static and fixed from early on in treatment.

Greenson did already stress the dynamic nature of the alliance in 1965, pointing out that the patient in a successful analysis oscillates between the transference neurosis and working alliance, and that the working alliance as a consequence of this may suffer impairment and temporarily be lost (Greenson, 1965).

Where prior research had been using ratings of the working alliance based upon entire sessions of therapy, Lansford concentrated on studying the process aspect of the working alliance, emphasizing the central role of the building and repair of the working alliance in the therapeutic work (Lansford, 1986). In her preliminary studies of six short-term time-limited therapies, she investigated “weakens” and repairs of the working alliance and their relation to change in therapy.
"Weakenings were operationally defined as a negative response to therapy, fear of the therapist's critical judgement or disapproval, problems with coming to or talking in therapy, or problems with termination, such that difficulties were caused in the ongoing flow of the relationship or the therapy. Repairs were a measurement of the extent to which the identified weakenings in the alliance seemed to be addressed or resolved by patient and therapist, such that the more ongoing, harmonious flow of the therapy could again continue" (Ibid. p. 364).

Using unitized process ratings, in which patient and therapist interaction were rated on an ongoing basis, segmenting weakenings and repairs in the alliance, Lansford found among others correlations of .96 between discussion of the focus in the weakening and repair sequences and outcome. Lansford states in her article that the data must be considered preliminary, and only a few of the results are reported. However, with this limitation in mind, her study seems to show that the alliance is affected by therapist repair actions, especially with good-outcome patients, and Lansford concludes that "(t)he most successful outcomes were associated with patient's and therapist's actively dealing with weakenings in the therapeutic alliance" (Ibid., p. 366).

Research by Safran and colleagues (e.g. Safran et al., 1990; Safran and Muran, 1996; Safran et al., 1994) has also aimed at analyzing the
therapy process by focusing specifically on alliance rupture events, their resolution and relationship to outcome. Using a task analytic approach (Rice & Greenberg, 1984) they are currently working on verifying a model that describes the sequential process involved in the resolution of a rupture. Their preliminary model now consists of four stages:

1) Attending to the Rupture Marker, which involves a) the indication of the presence of a rupture based upon patient behavior/verbalizations signaling either confrontation with or withdrawal from the therapist, and b) the therapist focusing the patient on the immediate experience.

2) Exploration of the Rupture Experience, which consists of a) patient expresses negative feelings, and b) therapist facilitates self-assertion

3) Exploration of Avoidance. a) Patient discloses block, b) therapist probes block, and c) patient explores block.

4) Self-assertion, which marks the beginning of the resolution process and involves a) patient self-assertion and b) therapist validating this assertion.

(Safran & Muran, 1996)

The researchers hope that their model will function as "(...)"
"roadmap" that will sensitize clinicians to sequential patterns that are likely to occur" (Ibid. p. 448). Safran & Muran (1996) further hypothesize that patients having specific problems establishing an alliance with their therapist will benefit from therapy that utilizes the task-facilitative interventions that have emerged as part of their process research.

Henry and Strupp (1994), based upon the work with their colleagues in the Vanderbilt II study and their research focusing especially on observable interpersonal transactional behaviors and the effects of these on patients' introjects, have "(...) come to conceptualize the therapeutic alliance as isomorphic with these interpersonal transactions" (Henry & Strupp, 1994, p. 64). In their study of a good-outcome and a poor-outcome case, each seen by four therapists, they worked with very small units of interpersonal process (15 minutes of the third session), in which therapist and patient behaviors were coded for their level of affiliation and interdependence as well as their focus on other, self, or introject. Henry & Strupp found that therapy cases in which therapists and patients engaged in certain interpersonal processes were more likely to have a good outcome. The good-outcome group had more examples of therapists engaging in affiliative control and affiliative autonomy-granting behavior and of patients showing more friendly autonomy and
less hostile separation than the poor-outcome group. The good-outcome cases also had more incidences of positive complementarity (affiliative behavior by both parties), and the interpersonal process was less complex (contradictory) in this group.

The work by Henry & Strupp (1994) and Safran and colleagues (e.g. Safran & Muran, 1996) is trying to operationalize the working alliance concept by elucidating the ways in which the alliance is related to change or outcome. This research thus moves beyond earlier research's focus on correlational data showing that the alliance is predictive of outcome to a focus on how the alliance may be affecting outcome.
Chapter III.

THE IMPORTANCE OF STUDYING RUPTURE TYPES AND THE AIM OF THIS DISSERTATION

As mentioned in the prior sections, a good working alliance seems to be predictive of a good outcome of psychotherapy. However, research on the working alliance has shown that the correlation of therapists' alliance scores with patients' (clients') is quite low (e.g., Horvath & Greenberg, 1994; Tichenor and Hill, 1989), and that the patient-reported alliance scores predicted outcome best (Horvath & Symonds, 1991). Related to this, a high correlation between therapists' and patients' experience of and report of the presence of a rupture in the alliance cannot be expected either; and one can ask the question whether this prospective discrepancy implies that different types of ruptures exist, with patients and therapists more likely to be aware of each their different subset of these.

A preliminary analysis performed by this researcher, using a large subset of data from a pool maintained by the Brief Psychotherapy Research Project at Beth Israel Medical Center in New York, indicated
that patients and therapists only agree on the occurrence of a rupture in a session in approximately one third of the instances when a rupture is reported by either participant. In two thirds of the cases, only one of the parties reports the occurrence of a rupture in a specific session. These are very interesting data that seem to support the necessity of investigating this area further. However, the preliminary analysis can only be used as a hint, since no stringent criteria were applied concerning inclusion or exclusion of cases.

This points to the importance of investigating the nuances of the ruptures further with a special focus on the perspective (patient versus therapist). Hill et al. (1996) pointed out in their study the relevance of looking at both perspectives, since they saw indications that therapists and clients may view impasses differently. They found among others that therapists were often unaware of clients’ dissatisfaction with therapy and were often taken aback by clients' termination, and it was only later when reconstructing the events leading up to the termination that the therapists were able to realize that something in the therapy process had somehow also frustrated them.

Considering the dynamic nature of the alliance, an understanding of alliance ruptures and their resolution is essential. This seems to necessitate an analysis of the subtleties of the psychotherapy process in a
very fine-grained way (e.g. Safran & Muran, 1996). This need is clearly stated by Henry and Strupp: "It is our experience that although most therapists understand the importance of a good therapeutic alliance, many cannot adequately perceive the nuances of interpersonal process as it unfolds" (Henry & Strupp, 1994, pp. 66-67). For a therapist to fully utilize the change opportunity presented by the rupture, he or she must necessarily perceive the rupture when it occurs. The study of rupture types might be an important step in gathering information about the interpersonal process at very critical points in therapy when the quality of the therapeutic alliance may be deteriorating, and, in the most severe cases, when clients may be about to terminate therapy.

The specific aim of this dissertation is to explore the therapeutic alliance, focusing especially on discrepancies between patients' and therapists' perception of the occurrence of ruptures, with a goal of building a taxonomy of alliance rupture types.

Selected therapy situations, in which patient and therapist are not in agreement identifying a rupture, are used as the basis for analyses and for developing the taxonomy. The taxonomy can be seen as a way of presenting commonalities between events and hopefully will be a useful tool for generating models of therapeutic change that can ultimately help informing therapists in their work with patients.
The study will also include a comparison of ruptures across different treatment modalities in order to investigate any effect of treatment modality on ruptures identified from patient's versus therapist's perspective.
Chapter IV.

RESEARCH APPROACH

The research is based upon a discovery-oriented approach, in which the moment-to-moment process in a selection of rupture events is described and analyzed in a fine-grained manner (Elliott, 1984; Rice & Greenberg, 1984). According to Elliott (1984) "(...) the discovery-oriented approach to studying change episodes in psychotherapy rests on phenomenological observation linked to specific therapy events, focused on significant moments of change, and analyzed in as comprehensive a fashion as possible" (pp. 251-252). This qualitative method of study seems particularly promising for the understanding of the dynamics of therapeutic process rather than using traditional aggregate designs (Rice & Greenberg, 1984). Other researchers have similarly stressed the importance of studying patient-therapist interaction episodes rather than isolated process variables (McCullough et al., 1991; Henry et al., 1986).
Chapter V.

RESEARCH METHOD

1. Subjects

The subjects used in this research were selected from a data pool maintained by the Brief Psychotherapy Research Project at Beth Israel Medical Center, New York. Patients in this project are treated according to a 30 or 40 session protocol in one of five possible treatment modalities that all follow a technical manual.

A sample of 26 patients was used, with 10 patients each selected from the treatment modalities of Brief Adaptive Psychotherapy (BAP) and Brief Relational Therapy (BRT), and 6 patients from Cognitive Behavioral (CBT). The lower number of CBT patients were due to an inability to find more cases in this treatment modality that were adhering to the pre-established selection criteria for this study.

The mean age of patients was 39 years (range 24 – 55 years), 62% were female, 96% had completed at least some college work, and 84%
of the patients were white (see Appendix A). Patients were assigned to a particular treatment protocol on a random basis. 81% of the 26 patients completed their treatment protocol and 5 dropped out before finishing all sessions.

Diagnostic status according to DSM-III-R (American Psychiatric Association, 1987) included: 1) on Axis I: Agoraphobia, Anxiety Disorder NOS, Depressive Disorder NOS, Dysthymic Disorder, Generalized Anxiety Disorder, Hypochondriasis, Major Depressive Disorder, Obsessive-Compulsive Disorder, Panic Disorder without Agoraphobia, Past Substance Abuse, Relational Problems (V-codes), and Social Phobia; and on Axis II: Avoidant Personality Disorder, Borderline Personality Disorder (mild), Depressive Personality Disorder, Negativistic Personality Disorder, Obsessive-Compulsive Personality Disorder, Personality Disorder NOS, and Paranoid Personality Disorder. At the Brief Psychotherapy Research Project all diagnostic evaluations are performed by trained research assistants that evidence adequate reliability on ongoing reliability checks. Each patient signed an informed consent form at intake, in which permission is given to use his or her assessment as well as treatment data for research purposes including videotaped material (see appendix B).

At the Brief Psychotherapy Research Project, general inclusion
criteria for acceptance consisted of the following: patients should be between 18-60 years old, have DSM-III-R Axis I diagnosis of a Mood or Anxiety Disorder or an DSM-III-R Axis II disorder of Cluster C Personality Disorder or Personality Disorder NOS; patients should agree to not participate in other psychotherapy or take psychopharmacological medication while in program; patients should be willing to complete treatment protocol, complete evaluation interviews and agree to complete post-session questionnaires after each session as well as various assessment forms at intake, midphase, termination and at a 6-months follow-up; and patients should agree to have evaluation and treatment sessions videotaped.

Exclusion criteria included evidence of either of the following: psychosis; an active DSM-III-R Axis III diagnosis; organic brain syndrome or mental retardation; current substance abuse; risk for suicide history of violence or impulse control problems; current psychopharmacological treatment.

Patients were assigned on a random basis to a particular therapist in one of three treatment modalities BAP, BRT or CBT. For this study, there were 23 therapists, of which 48% were female, the mean age was 37 years (range 27 – 60; see appendix A). 21 therapists each treated one patient in this study, 2 treated more than one. Each therapist
participated in ongoing weekly group and individual supervision. Therapists' education included: MA, MSW, MD and Ph.D, the mean for their clinical experience was 7 years (post degree/internship).

2. Rupture events

For each of the 26 dyads, two rupture events were chosen: 1) patient is sole identifier of rupture and 2) therapist is sole identifier of rupture, adding up to a total of 52 rupture events.

The rupture events were selected based upon post-session questionnaires (PSQ) that were administered to both patient and therapist by the Brief Psychotherapy Research Project (see appendix C). A section in the PSQ addresses any possible tension felt by the patient in his or her relationship with the therapist during the session (the patient-PSQ) or by the therapist in his or her relationship with the patient during the session (the therapist-PSQ). The highest degree of tension is to be rated by the patient or therapist on a 5-digit scale (from 1 to 5, with 1 as lowest degree), and a short description of the problem is asked for. The present study only selected events with an intensity level of 2 or higher.

Primarily events occurring in the middle 20 sessions of treatment were selected (or middle 30, if 40 session protocol) in order to exclude any ruptures solely related to beginning/ending issues in the therapeutic
alliance.

Videotapes of sessions were then used to locate the rupture events. This process was aided by an indication on the PSQ stating whether the tension occurred at the beginning, in the middle, or at the end of the session. A 3-4 minutes segment containing the rupture event was extracted on a separate tape and transcribed.

The presence of the rupture event was verified by two sets of two independent judges that looked at a composite tape containing a mix of the selected rupture events and other segments from the same patient-therapist dyads from sessions where no ruptures were reported. The segments were shown in a random order. Each judge was asked to identify the presence or absence of a rupture for each segment, and for ruptures identified rate the intensity of the rupture on a scale from 1 to 5, with 1 representing a vague and hardly noticeable rupture, 3 the presence of a definite rupture of medium intensity, and 5 the presence of a severe rupture.

To assist the judges in their decision and to ensure a somewhat uniform standard for determining the presence of a rupture, the judges received an instruction which included a short description of the categorization of rupture markers proposed by Safran et al. (1994). This instruction is marked as Appendix D.
No further training was provided as this research was aimed at exploring the rupture construct developed by Safran and his colleagues (Safran et al, 1994). However, the verification process served as a safeguard that observers could validly identify the patient- and therapist-reported ruptures.

3. Event measures

The rupture events, after having been reliably identified by the judges, were coded by three independent coders according to the Structural Analysis of Social Behavior (SASB) (Benjamin, 1974; Grawe-Gerber & Benjamin, 1989). SASB is a circumplex model of interpersonal behavior involving two basic dimensions: affiliation and interdependence, and three surfaces: transitive (focus on other), intransitive (focus on self, reaction to other person), and introjects (inward focus). The present study will use only the two first surfaces. The condensed cluster version using eight clusters to capture patient and therapist behavior was used (Benjamin et. al., 1981). See Appendix E for more details of the SASB measure.

SASB seems to be very well suited for describing interpersonal process in a moment-to-moment fashion and for mapping the resolution/non-resolution process (e.g. Alpher, 1991, Wiggins, 1982).
Henry, Schacht, & Strupp point out that SASB is "the most detailed, conceptually rigorous, and empirically validated of current (circumplex) models" (Henry et al., 1986, p. 27)

The following examples of coding of two categories of rupture "markers" (Safran et al., 1990) are meant to illustrate the use of SASB for coding: 1) a withdrawal rupture, which can be characterized by the patient distancing him- or herself from the therapist, the task, or his or her own experience, will typically involve SASB codings of patient's behavior of "Deferring and Submitting" (code 2-5), Sulking and Appeasing (code 2-6), or "Walling Off and Avoiding" (2-8), whereas 2) a confrontational rupture, where the patient expresses e.g. an accusatory statement regarding the therapist, might involve SASB codings of patient's behavior of "Belittling and Blaming" (code 1-6) (Safran et al., 1994).

4. Procedure

Verification of events

Selection and verification of rupture events was done in two separate studies. My master's thesis was planned as the first verification
study and involved a sample of 28 rupture events from 14 patients, with 7 patients selected from each of these treatment modalities: Brief Adaptive Psychotherapy (BAP) and Brief Relational Therapy (BRT).

The result of this verification study yielded an intraclass reliability of .7930 between the two raters and the original report on the PSQ by either patient and therapist. This clearly showed that independent judges could reliably identify the presence and intensity of ruptures, originally reported by one of the participants in the rupture, in videotaped therapy sessions using the description of rupture markers proposed by Safran and his colleagues (Safran et al. 1994).

However, in two instances did neither of the judges pick up the presence of a patient-reported rupture, and in 7 situations did both the judges identify a rupture in sessions that was originally reported as free of ruptures by the participants.

The first study was evidence that observers are able to identify reliably rupture situations from non-rupture situations. The relatively high occurrence of incidents of both judges identifying a rupture in a situation where neither participants originally reported one (“false positives”), which happened in 25% of the selected non-rupture segments, may be partly explained by the manner in which the non-rupture segments were extracted. As a starting point, random non-
rupture sessions were used. However, in order not to bias the verification process by making the non-rupture segments very easily distinguishable by an arbitrary beginning, ending, and content, an effort was made to locate a segment within the session where the participants were involved in dialogue, preferably involving their relationship or the therapeutic situation. The possibly heightened intensity and emotionality of the used non-rupture segments, because of the focus on the relationship and on the participants themselves, in contrast to segments based upon a completely random selection criterion, may therefore have made the task of distinguishing between ruptures and non-ruptures harder for the judges in this study. It is possible that the judges may have seen the intensity and the “struggling” (in the sense of patients and therapists working hard) in some of the non-rupture segments as a signal of a rupture, and they may therefore have been less concerned with noting if the participants were actually still connecting and stayed affiliated, not exhibiting any of the typical rupture markers.

There were two “false negatives” (i.e. neither judge identified a rupture in a situation where one of the participants originally reported one). Both involved patient-reported ruptures. This seems to suggest that patients report ruptures that are harder to notice by external sources, perhaps because they are more vague and involve more internal
process with less behavioral signs. However, this touches exactly on the core issue of this thesis and subsequent dissertation, where discrepancies between perspectives are in focus. Perhaps one should not expect a 100% reliable identification of ruptures by external observers, since these situations involve interactions during which not even the participants share the same view on what is going on between them. Inter-rater reliability should of course be at a statistically significant level, otherwise there would be no solid base for the next step in this dissertation, which is the rupture process analysis. The two false negatives were therefore excluded from further study in this dissertation to ensure that the selected segments validly represented rupture situations and that they included some behavioral signs of a rupture. However, it would be surprising and unexpected if observers were always agreeing with the participant that reported a rupture and disagreeing with the other participant (that did not see a rupture) in all potential rupture situations. This study takes it starting point in a discrepancy between perspectives and is interested in throwing light on presumably very complex interpersonal situations with the aim of clarifying some of the elements that contribute to the discrepancy. The observer is yet another (third) perspective in this picture. Studies of the discrepancy between perspectives have shown us that differences exist in
terms of rating the therapeutic relationship and the working alliance (e.g. Gurman, 1977; Horvath & Greenberg, 1994; Tichenor & Hill, 1989), and we should therefore expect corresponding differences in terms of rating rupture episodes.

Outside the scope of this dissertation, however, it would be interesting to code the process in the two rupture segments that were not identified by judges. SASB coding of these segments may show interesting moment-to-moment process and may pick up subtle nuances of the interpersonal process that were perhaps hard to reflect in the single rating judges were asked to make about each segment.

In addition, the rupture verification study lends support to the rupture construct defined by Safran and his colleagues (e.g., Safran et al., 1990; Safran, 1993; Safran et al., 1994), as the guidelines given to the judges build completely on written material using these researchers' formulations.

The second verification study involved a sample of 24 rupture events from 12 patients, with 3 patients from BAP, 3 from BRT, and 6 from CBT. Results of this study yielded an intraclass reliability of .7412. There were four instances of false positives, but no false negatives in this study. In the second study, the two judges frequently met throughout the rating process to discuss and revise their initial ratings.
based upon consensus. The intraclass reliability of the corrected ratings improved to .8090. However, the false positives remained at the same level.

The aim of the verification studies was to select rupture segments to be used for a further exploration of the therapeutic alliance with the ultimate goal of building a taxonomy of alliance rupture types focusing especially on discrepancies between patients' and therapists' perception of the occurrence of ruptures.

As seen above, the performed verification studies showed that observers are able to identify reliably rupture situations from non-rupture situations. The selected segments do therefore seem to be valid representatives of ruptures, which can be used for further analysis in the next phase in my dissertation. However, as expected, some inconsistencies were found where observers were not fully in agreement with the participant reporting a rupture, and in 2 instances, out of 52 potential rupture situations, did neither judge pick up the presence of a rupture. These two segments will be excluded from further study.

Inconsistencies were also seen in non-rupture segments (none of the participants had reported a rupture) where judges in some situations reported the presence of a rupture.

Both types of inconsistencies should be viewed in light of the main
issue in this dissertation: each rater perspective, patient, therapist, and observer, represents a unique position that cannot be expected to correlate fully with the other perspectives. This has been found to be the case for ratings of the therapeutic relationship (Gurman, 1977) and the working alliance (e.g., Horvath & Greenberg, 1994; Tichenor & Hill, 1989) and corresponding discrepancies seem to exist for ratings of ruptures.

**Rating of events**

The 50 rupture events, which were reliably verified by the judges, were transcribed, and transcripts and videotapes were presented to three coders for SASB rating. The coders were graduate students in clinical psychology, who had several years of experience with SASB coding. After approximately six months training and re-calibration with this researcher, the three coders showed adequate reliability on material similar to the events used in this study. Each coder was then assigned, in increments of 5 segments, a total of 28 rupture segments for coding, which generated an overlap of approximately one third of the total material for ongoing reliability tests. Reliability checks were performed throughout the coding process and frequent re-calibration sessions were held using training material. Table 1 shows reliability for the 17
overlapping segments. Weighted kappa was used for reliability calculations, according to guidelines by Grawe-Gerber and Benjamin (1989). Only one segment showed unacceptable reliability, and at the end of the total coding process, this segment was discussed with the coders, and consensus was reached, raising the reliability for this segment from .56 to .68; this increased the mean for weighted kappa to .80 (range .68 - .95), SD = .10. The issue of disagreement for segments coded by all three coders was resolved by using the data from the "main" coder for a specific segment (according to a pre-established plan by this researcher, unknown to coders).
Table 1. Interrater reliability on SASB measures

<table>
<thead>
<tr>
<th>Segment</th>
<th>K_w</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.95</td>
</tr>
<tr>
<td>2</td>
<td>0.74</td>
</tr>
<tr>
<td>3</td>
<td>0.77</td>
</tr>
<tr>
<td>4</td>
<td>0.80</td>
</tr>
<tr>
<td>5</td>
<td>0.64</td>
</tr>
<tr>
<td>6</td>
<td>0.73</td>
</tr>
<tr>
<td>7</td>
<td>0.87</td>
</tr>
<tr>
<td>8</td>
<td>0.87</td>
</tr>
<tr>
<td>9</td>
<td>0.76</td>
</tr>
<tr>
<td>10</td>
<td>0.79</td>
</tr>
<tr>
<td>11</td>
<td>0.70</td>
</tr>
<tr>
<td>12</td>
<td>0.94</td>
</tr>
<tr>
<td>13</td>
<td>0.88</td>
</tr>
<tr>
<td>14</td>
<td>0.56</td>
</tr>
<tr>
<td>15</td>
<td>0.79</td>
</tr>
<tr>
<td>16</td>
<td>0.78</td>
</tr>
<tr>
<td>17</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Mean = 0.79 (range .56 -.95); SD = 0.10

Analyses

The coded rupture events were submitted to detailed analyses in order to test if differences existed between the patient-reported and therapist reported ruptures. For these analyses, events were categorized based upon the SASB-codes assigned. The analyses were twofold in order to explore the data as much as possible.

First, the SASB clusters for the rupture segments were compared by
looking at the relative occurrence of SASB codes in each of the eight clusters on the SASB circumplex to see if significant differences existed between the patient- versus therapist-reported ruptures. In order to also investigate any effect of treatment modality, a number of $3 \times 2$ (Treatment modality X Reporter) MANOVAs were performed. They were done separately for patient and therapist behavior. A within-subjects design was used, treating the dependent variables as repeated measures on the 26 dyads. This procedure was chosen as it effectively teases out between-group variance from within-group variance.

Secondly, a taxonomy of ruptures was developed based upon a more qualitative analysis of the SASB patterns in the coded rupture segments. The occurrence of SASB codes was examined thoroughly with the purpose of screening the material for major groupings that could constitute specific rupture types. This included a verbal description of the process with examples presented from transcripts of segments as well as a chart of assigned SASB-codes for the rupture segments mapped onto the SASB circumplex.
Chapter VI.

RESULTS

1. Introduction

The primary aim of this dissertation is to investigate whether different rupture types exist from the patient perspective versus the therapist perspective as well as analyze these rupture types at a micro-level to get a better understanding of the underlying process. For this, 50 rupture segments (24 patient-reported and 26 therapist-reported) were selected and verified by independent judges for presence of ruptures. Subsequently, the segments were coded by trained independent coders using SASB to capture the moment-to-moment therapy process on two dimensions, affiliation and dependence.

As this section will show, a complex collection of data was generated by this process, and almost every segment proved to be unique in terms of the number of SASB-codes applied, as well as the patterning of these. In order to make the data comparable and present them in a somewhat uniform format, first a simple tally of all SASB-codes was performed (see appendix F). Secondly, due to the unequal
number of SASB codes applied to each segment, a weight was calculated for each segment’s SASB scores, which made each segment load an equal amount of scores ($1/49^{th}$ of the total sum) to the data set used in this section (see appendix G). The therapist-reported segment 20 was excluded from further analyses due to its very deviant pattern, as inclusion of this segment would otherwise have contributed to very discrepant statistics without much informative value. The corresponding patient reported rupture for this dyad, as well as two therapist-reported ruptures also had to be excluded, since the repeated measures-design in MANOVA called for a matched data set. For the statistical analysis, the codes for patient behaviors have been analyzed separately from the codes for therapist behaviors, since a combination of patient and therapist behaviors would be too complex with too many dimensions. However, in the next part of the result section, I will take a look at the total segment with patient and therapist behaviors combined.

Figures 1 and 2 show the frequencies of the unweighted SASB codes for the combined 50 segments for patient behavior and therapist behavior respectively, as they map onto the SASB circumplex. Appendix H shows each separate rupture segment (unweighted). Each rupture segment corresponds to two figures, where the first one provides a map of the patient behaviors, the second one a map of therapist behaviors.
The data have been presented this way in order to facilitate readability of the data and is an alternative presentation to Appendix F.
Figure 1. SASB codes for the patient behavior in all 50 rupture segments (unweighted)
Figure 2. SASB codes for the therapist behavior in all 50 rupture segments (unweighted)
2. Data analysis

In this section, statistical analyses were performed to test for significant variances between the relative occurrence of codes on the SASB circumplex in ruptures reported by patient and therapists respectively. Subsequently, differences in the rupture segments between the three treatment modalities, Brief Adaptive Psychotherapy (BAP), Brief relational Therapy (BRT) and Cognitive-Behavioral Therapy (CBT), were teased out. The focus was on the relative occurrence of codes across rupture segments or cases in order to find tendencies for certain behaviors. This approach was chosen, since most of the codes occurred in a lot of the segments, at least once, why an alternative approach of simply checking off the occurrence of a certain code (or no-occurrence) would not provide any useful data. In comparison, the relative occurrence seems to hold more information about the process in a segment, which will be seen in the following.

In Table 2, a comparison of SASB cluster means for patient behavior in patient-reported versus therapist-reported ruptures has been done based upon weighted raw scores. Due to the small sample size, the statistical power for finding significance was limited. Consequently, effect sizes were also calculated (\(\sqrt{\text{partial eta squared}}\)), as effect size is an additional way of evaluating the strength of a finding (Minium et al.,
1993). Results will be interpreted following Cohen's recommendations that effect sizes of .2, .5, and .8 are defined as small, medium, and large effects (Ibid.).

With cell frequencies either being small, sparse or skewed, a potential risk existed that traditional asymptotic methods of computing statistical significance would not be valid; an additional transformation of raw scores to ranks were consequently made, and ranks were then submitted to the same multi-level analyses. In general, the power of the findings decreased somewhat with the ranks-transformation. However, due to the limited sample size it was decided to report raw scores here instead of reducing the data further.

A 3 X 2 (Treatment Modality X Reporter) MANOVA for patient behavior showed only a non-significant main effect for reporter, $F(1, 9) = .818$, $p = .611$, $d = .616$, which means that the overall analysis of patient variables was unable to find statistically significant differences between the patient- and the therapist-reported ruptures.
Table 2. *Comparison of Structural Analysis of Social Behavior (SASB)*  
Cluster Means for Patient Behavior - by Reporter

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Patient*</th>
<th>Therapist*</th>
<th>$F$</th>
<th>Exact $p$-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>0.2035</td>
<td>0.0422</td>
<td>0.671</td>
<td>0.422</td>
<td>0.18</td>
</tr>
<tr>
<td>1-5</td>
<td>0.0000</td>
<td>0.0422</td>
<td>0.887</td>
<td>0.358</td>
<td>0.21</td>
</tr>
<tr>
<td>1-6</td>
<td>0.1848</td>
<td>0.3796</td>
<td>0.339</td>
<td>0.267</td>
<td>0.16</td>
</tr>
<tr>
<td>2-1</td>
<td>8.1739</td>
<td>9.2117</td>
<td>0.515</td>
<td>0.481</td>
<td>0.16</td>
</tr>
<tr>
<td>2-2</td>
<td>0.2900</td>
<td>0.1943</td>
<td>0.266</td>
<td>0.612</td>
<td>0.11</td>
</tr>
<tr>
<td>2-4</td>
<td>0.9074</td>
<td>1.6948</td>
<td>1.855</td>
<td>0.188</td>
<td>0.29</td>
</tr>
<tr>
<td>2-5</td>
<td>2.4552</td>
<td>1.8248</td>
<td>0.623</td>
<td>0.439</td>
<td>0.17</td>
</tr>
<tr>
<td>2-6</td>
<td>6.5357</td>
<td>4.9261</td>
<td>1.224</td>
<td>0.282</td>
<td>0.24</td>
</tr>
<tr>
<td>2-8</td>
<td>1.6574</td>
<td>2.0913</td>
<td>0.230</td>
<td>0.637</td>
<td>0.11</td>
</tr>
</tbody>
</table>

* Scores represent weighted mean number of SASB codes per cluster  
Effect size is calculated as $\sqrt{\text{partial ETA scores squared}}$  
$df = 1; n = 23$

Main effect for modality was also non-significant at $F(2,9) = 1.156$, $p = .36$, $d = .667$. Table 3. shows the individual cluster means for each modality along with F-values, significance and effect sizes. Individual cluster comparisons between patient-reported and therapist-reported ruptures were all non-significant with moderate to low effect sizes, with SASB codes 2-4 and 2-6 ranging highest. Although results were non-
significant, they showed an interesting tendency, since both these codes fall on the lower part of the SASB circumplex, on the submissive end of the interdependence dimension. However, therapist reported ruptures with relatively more friendly submissive behavior (2-4 “Trusting & Relying), and patients reported ruptures with the more hostile version of submissiveness (2-6 “Sulking and Appeasing”). In light of the fact that all the segments included in the data set are based on a positive report of the occurrence of a rupture by one of the parties and the simultaneous negative report by the other, this seem to indicate that therapists miss a number of rupture situations when patients are exhibiting unfriendliness or hostility, which might at first seem a bit surprising. However, it is important to remember that the hostility captured by SASB code 2-6 “Sulking and Appeasing” is somewhat covert, which by its very nature might be harder for an external party, like the therapist, to detect. The patients, however, who could be using these actions defensively, may be more likely to feel the conflict between their overt behavior, e.g. acquiescing in the therapist’s intervention, and their internal wish, e.g. stating their disagreement with the therapist. The more direct hostility that can be captured by SASB code 1-6 (“belittling & Blaming) was much more rare for patients in this data set. It was only seen in 5
Table 3. Comparison of Structural Analysis of Social Behavior (SASB) Cluster Means for Patient Behavior - by Modality

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Modality</th>
<th>Mean*</th>
<th>F</th>
<th>Exact p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>BAP</td>
<td>0.1410</td>
<td>0.433</td>
<td>0.654</td>
<td>0.20</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.1890</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>BAP</td>
<td>0.0606</td>
<td>0.932</td>
<td>0.410</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-6</td>
<td>BAP</td>
<td>0.1270</td>
<td>2.331</td>
<td>0.123</td>
<td>0.43</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.6080</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-1</td>
<td>BAP</td>
<td>7.9230</td>
<td>0.110</td>
<td>0.896</td>
<td>0.11</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>9.2950</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>8.8160</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-2</td>
<td>BAP</td>
<td>0.4700</td>
<td>0.778</td>
<td>0.473</td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.0594</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.2120</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>BAP</td>
<td>1.8010</td>
<td>0.253</td>
<td>0.779</td>
<td>0.16</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>1.0450</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>1.0180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>BAP</td>
<td>1.9430</td>
<td>9.668</td>
<td>0.001</td>
<td>0.70</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.7770</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>4.4480</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3. continued

<table>
<thead>
<tr>
<th></th>
<th>BAP</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-6</td>
<td>5.9620</td>
<td>0.019</td>
<td>0.981</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>5.7350</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.4170</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-8</td>
<td>1.9820</td>
<td>0.489</td>
<td>0.620</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td>2.6980</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.4960</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Scores represent weighted mean number of SASB codes per cluster
Effect size is calculated as $\sqrt{\text{partial ETA scores squared}}$
$df = 2; n = 23$

rupture segments, and most of the occurrences were found in therapist reported ruptures (11 out of 13 instances based upon applied, un-weighted codes).

Individual cluster comparisons between modalities showed a number of moderate to large effects. SASB cluster 2-5 (Deferring & Submitting) was significant at the $p = .001$ level. Using Tukey’s HSD statistic for post-hoc comparisons it was found that CBT patients exhibited substantially more submissive behavior than BAP and BRT patients ($p = .022$ and $p = .001$ respectively). Generally, BRT patients exhibited more direct hostility than other patients, captured on cluster 1-6 “Belittling & Blaming”. Tukey’s HSD in a post-hoc comparison showed differences between BRT and BAP and CBT at $p = .294$ and $p =$
.182, respectively. However, as already mentioned above, the occurrences of SASB code 1-6 in the whole data set were sparse and any interpretation should be used with caution.

Table 4 shows comparisons of SASB cluster means for therapist behavior in patient-reported versus therapist-reported ruptures, based upon weighted raw scores. A 3 X 2 (Treatment Modality X reporter) MANOVA for therapist behavior showed a non-significant main effect for reporter, $F(1,8) = .976$, $p = .495$ and $d = .612$. Except from SASB code 1-8 ("Ignoring & Neglecting") the cluster comparisons showed low effect sizes. However, the data for 1-8 were extremely sparse and when performing a transformation to ranks, most of this effect disappeared in the subsequent analysis.

In Table 5, the therapist behavior has been analyzed across treatment modalities. A significant main effect was found for treatment modality, $F(2,8) = 2.013$, $p = .051$, $d = .73$. Individual cluster comparisons revealed moderate to large effects. SASB cluster 1-6 ("Belittling & Blaming") was significant at the $p=.05$-level. Tukey's HSD used in post-hoc comparisons showed that BRT therapists exhibit significantly less hostile behavior of this type than BAP and CBT therapists do, with $p = .047$ and $p = .103$ respectively. SASB cluster 1-1 ("Freeing & For-
Table 4. Comparison of Structural Analysis of Social Behavior (SASB) Cluster Means for Therapist Behavior - by Reporter

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Patient*</th>
<th>Therapist*</th>
<th>F</th>
<th>Exact p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>6.7035</td>
<td>6.7122</td>
<td>0.014</td>
<td>0.907</td>
<td>0.03</td>
</tr>
<tr>
<td>1-2</td>
<td>0.1917</td>
<td>0.3017</td>
<td>0.219</td>
<td>0.645</td>
<td>0.11</td>
</tr>
<tr>
<td>1-4</td>
<td>3.0757</td>
<td>4.0870</td>
<td>0.895</td>
<td>0.355</td>
<td>0.21</td>
</tr>
<tr>
<td>1-5</td>
<td>7.7657</td>
<td>6.8909</td>
<td>0.400</td>
<td>0.534</td>
<td>0.14</td>
</tr>
<tr>
<td>1-6</td>
<td>0.9717</td>
<td>1.1626</td>
<td>0.088</td>
<td>0.770</td>
<td>0.06</td>
</tr>
<tr>
<td>1-8</td>
<td>0.2191</td>
<td>0.0000</td>
<td>2.668</td>
<td>0.118</td>
<td>0.34</td>
</tr>
<tr>
<td>2-1</td>
<td>0.1191</td>
<td>0.0000</td>
<td>0.887</td>
<td>0.358</td>
<td>0.21</td>
</tr>
<tr>
<td>2-6</td>
<td>0.1548</td>
<td>0.0491</td>
<td>0.869</td>
<td>0.362</td>
<td>0.21</td>
</tr>
</tbody>
</table>

* Scores represent weighted mean number of SASB codes per cluster
Effect size is calculated as \( \sqrt{ \text{partial ETA scores squared} } \)
\( df = 1; n = 23 \)

getting") was also approaching statistical significance \( (p = .116, d = .44) \). Post-hoc comparisons using Tukey’s HSD found that BRT therapists tended to engage in more autonomy-granting behavior, and BAP therapists in less of this type of behavior (with CBT being in the middle). BRT versus BAP for this cluster yielded \( p = .097 \).
<table>
<thead>
<tr>
<th>Cluster</th>
<th>Modality</th>
<th>Mean*</th>
<th>F</th>
<th>Exact p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>BAP</td>
<td>5.1010</td>
<td>2.405</td>
<td>0.116</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>8.1070</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>6.7520</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>BAP</td>
<td>0.0000</td>
<td>1.795</td>
<td>0.192</td>
<td>0.39</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.3410</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.4340</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>BAP</td>
<td>3.5110</td>
<td>0.524</td>
<td>0.6</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>4.3530</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>2.5180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>BAP</td>
<td>8.5340</td>
<td>1.040</td>
<td>0.372</td>
<td>0.30</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>6.0830</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>7.5880</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-6</td>
<td>BAP</td>
<td>1.7570</td>
<td>3.966</td>
<td>0.035</td>
<td>0.53</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.0889</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>1.6150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-8</td>
<td>BAP</td>
<td>0.0569</td>
<td>1.465</td>
<td>0.255</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.2290</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-1</td>
<td>BAP</td>
<td>0.1710</td>
<td>0.932</td>
<td>0.41</td>
<td>0.29</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5. continued

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-6</td>
<td>BAP</td>
<td>0.0706</td>
<td>1.126</td>
<td>0.344</td>
</tr>
<tr>
<td></td>
<td>BRT</td>
<td>0.0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>0.2970</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Scores represent weighted mean number of SASB codes per cluster
Effect size is calculated as \(\sqrt{\text{partial ETA scores squared}}\)
\(df = 2; n = 23\)

In general, in this section it was seen that the separate analyses across rupture segments of the patient and therapist behavior variables, captured on SASB, failed to find statistically significant differences between the patient-reported versus therapist-reported ruptures. Individual cluster comparisons showed low to very moderate effect sizes at best.

In comparison, the analyses of ruptures across treatment modalities yielded interesting differences on a few clusters, especially for therapist behavior.

3. Taxonomy of Ruptures

The statistical analyses performed in the prior section looked at patient and therapist behavior across segments. In this section, a more global analysis of each rupture segment was made, and the starting point
was the patient behavior. As stated earlier, the end purpose was establishing a taxonomy of ruptures.

Each segment was categorized on the SASB circumplex according to a rule of "frequency majority", i.e. the type of patient behavior (SASB cluster) that occurs with the highest frequency in a given rupture segment. Figure 3 shows the distribution of 42 rupture segments that were analyzable this way. 7 rupture segments were not placed in any category due to a very unclear/mixed process. Not surprisingly, did all the ruptures fall on the neutral to hostile part of the circumplex (left and middle part of the circumplex). It was more surprising to find a rather large number of ruptures occurring in the SASB cluster 2-1 ("Asserting & Separating"), 43%, which intuitively does not fall within "typical" rupture behavior.

Figures 4 and 5 show the data for the 42 rupture segments for patient- (20) versus therapist-reported (22) ruptures respectively. These two figures reveal a somewhat large discrepancy between the two groups, as patients tend to report relatively more ruptures with a majority of submissive patient behavior, 55% (lower half of the SASB circumplex) and the therapists reporting relatively more ruptures with a majority of independent patient behavior, 63% (upper half).
Figure 3. Majority occurrence of SASB codes for the patient behavior in 42 rupture segments. (Numbers refer to # segments)
Figure 4. Majority occurrence of SASB codes for the patient behavior in 20 rupture segments reported by patients. Type 1 and 4. ( # of segments)
Figure 5.  Majority occurrence of SASB codes for the patient behavior in 22 rupture segments reported by therapists. Type 2 and 3 (# of segments)
The SASB interdependence dimension for patient behavior thus seemed to capture a major distinction between ruptures seen from the patient perspective versus ruptures from the therapist perspective, and was consequently chosen as the primary categorization tool in the development of a taxonomy. Based upon this, it was possible to extract 4 major groupings of ruptures, which would then be combined with the corresponding therapist behavior on the next level to form a number of subtypes. The taxonomy can be found in table 6.

Due to the inclusion criteria described above, the rule of “frequency majority”, the data in table 6 should be used with some caution as they only represent a very “sketchy” picture of the data. For instance, for a rupture to be included in Subtype 2A, the majority of the patient’s behaviors should be coded as 2-1 Asserting and Separating and the majority of the therapist’s behaviors should be coded as 1-1 Freeing and Forgetting. However, the rupture may include minor occurrences of other type behavior, which will be discussed in the following.

Type 1 (1A and 1B), which involve a total of 11 segments, are cases of patient reported ruptures with more submissive behavior on patients’ part, whereas Type 2 (2A, 2B and 2C), with a total of 14 segments, are cases of therapist reported rupture with more independent patient behavior. Together these 2 types of ruptures add up to 25 segments or
<table>
<thead>
<tr>
<th>Case</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEHAVIOR</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
<td>(neutral)</td>
</tr>
<tr>
<td>THERAPIST</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
<td>Controlling</td>
</tr>
<tr>
<td>Patient</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
<td>Separating</td>
</tr>
<tr>
<td>Type A</td>
<td>Type B</td>
<td>Type C</td>
<td>Type D</td>
<td>Type E</td>
<td>Type F</td>
<td>Type G</td>
<td>Type H</td>
<td>Type I</td>
</tr>
</tbody>
</table>

Table 6. Taxonomy of Response Types
approximately half of the data. Type 1 and Type 2 follow the main
tendency seen above in terms of patient behavior for the
interdependence dimension, with patients reporting more submissive
behavior and therapists reporting more independent patient behavior.
Combining this with therapist behavior and analyzing examples of this
tendency on a molecular level in terms of the interpersonal process and
the interaction during rupture events, it may be possible to get a deeper
understanding of this finding.

The two other rupture types run somewhat counter to the main
tendency, e.g. therapist reported ruptures with a majority of submissive
patient behavior (Type 3) and patient reported ruptures with a majority
of independent behavior (Type 4). Figures 4 and 5, discussed above,
showed the major tendencies. However, the overall picture was
somewhat mixed. From Table 6 it is seen that Type 1 and Type 2 hold
11 and 14 cases versus Type 4 and Type 3, with 9 and 8 cases
respectively. In order to focus attention, in the following I will
concentrate on analyzing only type 1 and 2.

The main Type 1, which is patient reported ruptures with patients
exhibiting more submissive behavior, has been subdivided into two
subtypes. Type 1A ruptures have mainly controlling therapist behavior
(SASB code 1-5), whereas in Type 1B, the therapists, in addition to
controlling behavior, are also exhibiting blaming and belittling (SASB code 1-6). Although, the numbers are too small for any generalizations, it is noteworthy that four of the six cases in Type 1B belong to the BAP treatment condition, and two belong to CBT. Interestingly, the same tendency is seen for group 3, Type 3B (3 out of 5 are BAP cases, 1 is BRT and 1 is CBT). In the total data set, 14 segments involved therapist behavior with a SASB code of 1-6, of these 7 were BAP cases, 5 were CBT and 2 BRT. This is in line with the findings in the previous section, which showed that overall BRT therapists tend to exhibit less hostile behavior. In connection with Type 1B, BAP and CBT therapists may generally be more likely to miss their own blaming and controlling behavior than BRT, due to a higher degree of this type of behavior in their baseline behavior.

In general, Type 1 provides us with a picture of how therapist behavior contributes to the rupture. When analyzing therapist behavior separately in a previous section (see table 3), we saw no significant differences between patient and therapist reported ruptures in terms of the overall distribution of SASB codes. However, when looking at Type 1 ruptures with therapist and patient behavior combined, there seems to be a very clear connection between exertion of therapist control and submissive patient behavior.

63
An example of a patient reported rupture segment in the BAP treatment modality is seen in the following excerpt (with SASB codes in parentheses):

Therapist: “Why are you concerned about that, if I misunderstand you?” (1-5)

Patient: “Well, it is obviously a concern. Because you’re, if I’m not speaking clearly enough, I am not explaining my emotions well, the way I feel.” (2-1)

Therapist: “Well, but you see, it seems to me that your responses are impersonal, you know. It’s like your concern is about that you’re not being clear as opposed to your concern about my reaction.” (1-6) “Do you know what I’m…?” (1-5)

Patient: “Yeah” (2-6)

Therapist: “The distinction I’m making?” (1-5). “So you don’t really care, you’re saying, about how I react?” (1-5)

Patient: “Yes, I do care how you react, but…” (2-6)

Therapist: “You do” (1-5)

Patient: “Yeah” (2-5)

Therapist: “So can we look at that?” (1-5)

Patient: “Yeah” (2-5)

Therapist: “Okay, go ahead.” (1-5)

Patient: (laughs) “What do you want me to say?” (2-6)

Therapist: “Oh, you just put the ball in my court.” (1-5)

Patient: “I know, but you said, let’s look at that.” (2-6) “Well, give me something to talk about.” (2-6)
For the remainder of the segment, the process of controlling therapist behavior (1-5) and submissive patient behavior (2-5/2-6) continues.

As seen in this excerpt, the therapist is quite confrontational, which is often the case with short-term psychodynamic psychotherapies. The underlying rationale being that the therapist wants to quickly bring the patient’s attention to his or her maladaptive patterns with the ultimate goal for the patient to engage in self-exploration. However, the controlling behavior of the therapist may make it difficult for the patient to maneuver in the therapeutic relationship, and perhaps if the patient starts to feel that the therapist’s actions are a threat to the relationship, the exploration process may be hindered and the patient may stick to a pattern of submissive behavior. One could speculate that the opposite thing could happen and instead the patient might start to battle with the therapist over control, which for instance would mean that the patient moved to SASB surface 1 (codes 1-5 or 1-6). However, patient behavior of the latter type was rarely seen in this data set. This may be explained by the fact that the inclusion criteria involved ruptures reported by one part only, which probably called for more subtle situations that consequently were less likely to be picked up by both parties. In the case of Type 1 ruptures, the therapists miss the rupture, perhaps due to the
more subtle hostility.

In general, empirical studies show that hostility on part of the therapist may be associated with bad outcome (e.g. Henry & Strupp, 1994). Identifying and recognizing ruptures that belong to the Type 1A and especially the Type 1B category is therefore quite important in order for the therapist to help break the vicious cycle and re-establish a good working alliance in which exploration can take place. Type 1 ruptures seem to resemble a rupture type that Safran et al. (1990) have labeled "Compliance", although in their research the focus was solely on the patient behavior as a rupture marker and they were less concerned with the therapist's initial role in contributing to the rupture. As Safran et al. (1994) point out, exploration of a patient's avoidant behavior, in this case submissiveness, is an important step in resolving the rupture.

The other main group of ruptures is Type 2, which are all therapist-reported ruptures, where patients are exhibiting a majority of independent behavior and the therapists a mixed range of behaviors. For this type, due to the majority rule used for inclusion here, there may still be subtle occurrences of other patient behavior, which we will discuss as we go along. For subtype 2C, in addition to the majority of independent patient behavior, patients would also engage in occasional Belittling and Blaming (SASB code of 1-6), which may be what the therapists picked
up on here, when reporting the rupture. In general, there were very few instances of overt hostile behavior on the part of the patients, only 5 segments out of all 49 segments contained such (3 in Type 2C, 1 in Type 1A, and 1 was not placed in any category). As explained above, this may be due to the inclusion criteria, but it may also be explained by the fact that this behavior typically feels quite scary for patients, who may thus run the risk of alienating the therapist and damaging the relationship. It is quite noteworthy that therapists were much more prone to exhibit blaming behavior than patients were. The patient behavior of SASB code 1-6 resembles a rupture type that Safran et al. (1990) has labeled “Overt expression of negative sentiments”.

Subtype 2D involves patient behavior that is also separating, but hostile in nature, which is captured by the SASB code 2-8 “Walling-Off and Avoiding”. For this group, therapist behaviors are mixed, but generally more neutral on the affiliation dimension (SASB codes 1-1, Freeing and Forgetting, and 1-5, Watching and Managing). Subtype 2D resembles what Safran et al. (1990) have called “Avoidance maneuvers” and/or “Nonresponsiveness to intervention”. The below rupture segment from a BAP case clearly illustrates this process, where the patient seems to work hard to stay unconnected to the therapist (as well as his own emotions):
Therapist: "Ian?" (1-1)
Therapist: "Ian?" (1-1)
Therapist: "You know you see the paradox here, which I think you find yourself in, in other situations where on the one hand…" (1-5)
Patient: "(inaudible) and?"
Therapist: "You tend to see what’s going on between you and me as kind of adversarial, you know; you need to fight me off. On the other hand, to see us as working toward some mutually agreed upon goal becomes also frightening for you, because that gets you into the whole area of closeness with someone and changes, and doing things. So that’s hard, too.” (1-5)
Patient: (sighing)
(Long pause)
Therapist: "Okay. So, what’s the way out?" (1-5) "I keep showing you all these nice paradoxes where…” (1-5)
Patient: "Paradoxes." (2-8)
Therapist: "you can’t move one way or the other” (1-5)
Patient: "Oh, you seem to like the expression, paradoxes.” (2-8)
Therapist: "Yeah” (1-1)
Patient: "Nice little…” (2-8)
Therapist: "Nice what?” (1-1)
Patient: "Nice little intellectual…” (2-8)
Therapist: "Hmm, yeah, okay, very intellectual here he says as he blows his mouth” (1-5)
Patient: (Pt laughs) "I forgot what the paradox was.” (2-8)
Therapist: "Hmm” (1-1)
Patient: "I guess it’s not necessary to, to state it in so many words.” (2-8) (pause) "It’s just that there are some things, that I hate the
idea of talking about” (2-8)

Therapist: “What?” (1-1)

Patient: “Some things I just hate the idea of talking about” (2-8)

Therapist: “Okay” (1-1)

Patient: (Sighs) “Some things that just make me feel so ugly” (2-8)

Subtype 2A involves patient behavior of mainly Separating and Asserting (2-1) and therapist behavior of mainly Freeing and Forgetting (1-1). One of the three segments included a 2-6 code for patient behavior; however, to this researcher it seemed insignificant when judging the overall segment by watching the videotape. Subtype 2B also involves patient behavior of mainly Separating and Asserting (2-1), but therapist behavior is now more controlling (1-5 and 1-6). The segments in Subtype 2B all have minor occurrences of 2-5 or 2-6 SASB codes, but only in one instance did this seem to have major significance. However, in this case, patient quickly moved away from this behavior and was again captured on the more independent part of the circumplex (SASB code 2-8 “Walling-Off & Avoiding”). For both subtypes 2A and 2B, it seems to be that case that there is a lot of benign patient behavior (2-1 Asserting and Separating), which we do not intuitively associate with ruptures. As stated earlier this is a very surprising finding, and one that we will try to explore in more detail by looking at some examples.
The following is an excerpt from a BRT case, where the therapist reported a rupture, and it illustrates the lack of a distinct patient rupture marker:

Therapist: "Uuhh" (1-1)
Patient: "And we’re at what? The 15th, 15th session?" (2-1)
Therapist: "Uh, 14th or 15th I think it’s 14." (1-1)
Patient: "14th." (2-1)
Therapist: "Uuhh" (1-1)
Patient: "(inaudible) one more" (2-1)
Therapist: "Uuhh" (1-1)
Patient: "I think, last one I mailed, I booked 14" (2-1)
Therapist: "Yeah. But uh, what’s your thought about the fact that we are the midway point because you were saying that you were thinking about, you know, what have we accomplished?" (1-5)
Patient: "Uuhh." (2-1)
Therapist: "What do you think?" (1-5)
Patient: "Uhm, that we, I feel that we haven’t touched what I primarily came here to discover about myself." (2-1)
Therapist: "Which is?" (1-5)
Patient: "Am I sabotaging relationships, and if not, or if I am, what do I need to do, not to?" (2-1)
Therapist: "Uuhh" (1-1) "And you see what we have been doing and talking about as something separate from that?" (1-4)
Patient: "Yeah. I see it separate. Uuhh." (2-1) "But that also could be because uh, I know that I’ve made it difficult for you to understand me, or my emotions, or what’s important and what’s
not important, because I seem to have an outer shell that’s totally contrary to what I actually feel” (2-1)

Therapist: "Okay” (1-1)

Patient: ”I know that for a fact” (2-1)

Therapist: ”Okay” (1-1)

Patient: ”So you’ve been very patient and a very active listener, but I haven’t made it easy for you. Cause something that makes me really angry inside you sort of have to feel your way very intensely to sort of get some sense of what I’m actually feeling” (2-1)

Therapist: ”Uuhh.” (1-1) ”So where does that leave us at this point, you think, in terms of being you know at the halfway point and using the rest of our time?” (1-4)

Patient: ”Uh, two things came to my mind when I said that we will talk about it today, obviously you will have an understanding of what my feeling is about therapy and where we are and what I feel we haven’t accomplished” (2-1)

Therapist: ”Uuhh” (1-1)

Patient: ”and start working on it” (2-1)

Therapist: ”Okay” (1-1)

Patient: ”Or it would have to go beyond what was expected, if not through here, maybe through someone else” (2-1)

Therapist: ”Uuhh.” (1-1)

Patient: ”because I do understand that this is short-term” (2-1)

Therapist: ”Right.” (1-1) ”Does it seem like uh, you know now, when you start off in therapy, someone says, “short-term, 30 sessions” it’s hard to necessarily conceptualize what that length of time is
gonna look like, and now we are at the halfway point, so it's probably easier to think about how much time we've been working together and how much more time we will have to work together. Does it feel to you, like in the time that we have left we can accomplish something, fast?” (1-4)

Patient: ”Well, possibly. Possibly” (2-1)

Therapist: ”Uhuh” (1-1)

In this excerpt, the therapist seems a little constrained. He does not explore the subtle potential defensiveness on the part of patient, e.g. where patients states that “I haven’t made it easy for you”. But this may have been what he picked up on and reported. However, the coders found the patient to be asserting and separating, and along a similar vein, the therapist states in the Post-Session Questionnaire, “The pt. felt that we have come to the midpoint of therapy without having touched on what she came to tx for, i.e. learn why past relationships have failed and how to make them work in the future. We had different viewpoints on this”. The rupture seems to be about what is not said and addressed, e.g. underlying disappointment and hostility on both sides. It appears that both parties sense a potential problem area and tread so lightly that the rupture is never allowed to fully unfold. But the observers sense it and so do the therapists who report the tension that they experience. But in the moment, the rupture seems kind of stunted and a potential
exploration process may be short-circuited.

Another example is from a BAP-case:

Patient: “So then, (inaudible) what to do with that?” (2-1)
Therapist: “What does…uh? How does control uh come into it for you?
Maybe you can talk a little bit about that.” (1-5)
Patient: “Oh, when you said control, people telling you to do things. It’s
not really somebody telling me to do something, although
sometimes that is the case.”
(2-1)
Therapist: “Uhuh” (1-1)
Patient: “Cause I work fairly independently” (2-1)
Therapist: “Uhuh” (1-1)
Patient: “fairly independently.” (2-1)
Therapist: “Uhuh” (1-1)
Patient: “Well, I just had that today, where some, where my boss told me
to break something down.” (2-1)
Therapist: “Uhuh” (1-1)
Patient: “Well, just a future report just breaking down someways. So, it’s
like, okay, that part comes out, that part comes out, too. Okay the
rest is pretty much the way he wanted it, so it’s like I’m done
(laughs) You know what I mean, my heart isn’t in it.” (2-1)
Therapist: “Uhuh” (1-1)
Patient: “Not into breaking down reports.” (2-1)
Therapist: “Uhuh. I have seen it happen in here as well. Sometimes I have
been asking you a question about something, you have often
described it as like poking” (1-4)
Patient: “Uhuh” (2-1)
Therapist: “That I’m poking you, holding you to something. And you don’t like that, it pisses you off.” (1-4) “And you withdraw.” (1-4) “And it seems to be a control issue in here with us, as well.” (1-5)

Patient: “Define control issue for me again.” (2-1)

Therapist: “If I’m, if I’m sort of controlling, uh, what’s happening in the session, like for example bringing up our relationship and you don’t like to talk about that, uh so you might change the subject or get angry and pull away from me, as a way to uh control what’s happening between us. Like it sounds like you are controlling things at work or, you know, at the gym.” (1-4)

Patient: “But I don’t feel that way about it.” (2-1) “Well, when I say, I don’t feel that way about it, specifically about work.” (2-1) “You know, the anger-guilt thing is there, too. Because I feel like I never do enough, you know. I know, I never do enough and I know my work suffers, because I can’t concentrate” (2-1)

Therapist: “Uhuh” (1-1)

Patient: “You know, just little bullshit things. You know, everybody makes mistakes, right.” (2-1)

Therapist: “Uhuh.” (1-1)

Patient: “But the problem with when I make mistakes, is that, whenever I make them, I always expect, well, this is just a proof of that, I’m not functioning correctly. You know, I can’t concentrate enough to catch little bullshit things like this.” (2-1)

Therapist: “Uhuh. But I am hearing a sort of discrepancy here. That you’re not doing enough, yet you don’t want to do this, at the same time” (1-4)
Patient: “Uh, yeah, there is a discrepancy there.” (2-4) “I go to work, because I don’t know where else to go (laughs). I don’t know here else to go with my world, to go career wise or where else to go with my life, for that matter.” (2-1)

Therapist: “Uhuh” (1-1)

Patient: “So for a long time, that’s been like, my job has been the source of everything, really.” (2-1)

Therapist: “What do you mean, source of everything?” (1-5)

Patient: “Because, I mean, nothing else is going on with my life, “ (2-1)

Therapist: “Uhuh” (1-1)

Patient: “Really, I mean, I’m not seeing anyone.” (2-1)

Therapist: “Uhuh” (1-1)

Patient: “I am not applying myself to higher learning. I’m just like floating along.” (2-1)

Therapist: “Uhuh” (1-1)

Patient: “So, the only place, where anything really happens, is at the office. So...uhm I focus all my energy there.”

In this segment, there is also a lack of a clear-cut patient rupture marker, but again one senses subtle defensiveness by the patient, in the form of avoidance, especially in the way the patient refuses to pick up the therapist’s leads about therapy situations and insists on talking about an external situation. Despite the therapist’s active and at times
confrontational stance, she is also exhibiting a kind of subtle avoidance on her part by her omitting to point out the here-and-now and instead making more general interpretations, e.g. "I have seen it happen in here as well. Sometimes I have been asking you a question about something <...>" But like the previous example, the typical rupture markers are sub-threshold, and it is only by taking in the overall sense of the segment that one sees the rupture, or rather what might be a potential rupture.

The final example is an excerpt from one of the CBT cases:

(They are talking about a previous session missed by patient)

Patient: "<...> I can show his work." (2-1)
Therapist: "Uhhuh" (1-1)
Patient: "If he gets the chance, he shouldn't pass it" (2-1)
Therapist: "Uhhuh, uhuh" (1-1)
Patient: "So he was saying, well if we don't get funding from the Y, I will do something, you and I will do something, he told me, we will do our duet, the two of us or something" (2-1)
Therapist: "Uhhuh, uhuh" (1-1)
Patient: "He told me, so it was good also in that way like I thought" (2-1)
Therapist: "That's excellent" (1-1)
Patient: "Yeah" (2-1)
Therapist: "It sounds like it really is, the meeting was really in a variety of ways sort of potential steps for the direction, more the direction that you want to move in." (1-4)
Patient: "Yeah, yeah" (2-4)

Therapist: "And I, I, you know. So I know a lot of things were happening and you were excited and time was somehow altered, because you stepped out of the structure you usually have." (1-4) "But uh, and all of that had something to do with what happened, but I wonder if also there was some like unconscious kind of thing happening, because I was" (1-4)

Patient: "It seemed like that?" (2-1)

Therapist: "I wonder, uh. I raise it as a question really" (1-1)

Patient: "Yeah." (2-1)

Therapist: "Because" (1-1)

Patient: "The thing is that I was really, the thing is that I was really upset because I felt like I really wanted, I felt like I really wanted to come. I mean I felt like there were, I don’t remember now. I mean I know, I know I always, I know lately more and more I have been feeling like, not a dependence, but I’m feeling like I’m really looking forward to coming and, you know coming here and talking to you and it’s like, I felt, now I was feeling like, “Oh I missed last week”, so now I feel like I have to talk about what happened" (2-1)

Therapist: "Uuhh" (1-1)

Patient: "or something and it’s, and then the time goes by and then I end up talking about something that happened before and not where I am right now" (1-1)

Therapist: "Uuhh" (1-1)

Patient: "necessarily or" (2-1)

Therapist: "So it was doubly frustrating both (inaudible)?" (1-4)

Patient: "Yeah, it was frustrating because of the responsibility with you but
also because I really wanted to come so” (2-1)

Therapist: ”Uuhh. Well, I…” (1-1)

Patient: ”If it is unconscious I wouldn’t understand why or what” (2-1)

Therapist: ”And why don’t we get like triply frustrating by spending the whole session talking about it?” (1-1) ”But I think it can be valuable to talk about it for a few minutes because I, I, you know, I totally agree with you. I mean it’s the very thing that you’re talking about in terms of often during the past weeks that you are looking forward to the therapy, valuing the therapy. I totally get that feeling from you” (1-5)

Patient: ”Yeah” (2-5)

Therapist: ”That this is, you know, a valuable important thing, and so it’s all the more surprising” (1-5)

Patient: ”Yeah” (2-5)

Therapist: ”but I mean, given that” (1-4)

Patient: ”Yeah” (2-4)

Therapist: ”If somebody is kind of devaluing or disappointed or angry you could sort of understand it” (1-4)

Patient: ”Yeah” (2-4)

Therapist: ”but it is all the more kind of surprising, you know given the value you put on this.” (1-4)

Patient: ”Yeah” (2-4)

Therapist: ”Uh, and it has felt, not only value that you have put on this, but value we both put on it, because it feels like you had really used this therapy” (1-4)

Patient: ”Yeah” (2-4)

Therapist: ”in a really serious effortful way” (1-4)

Patient: ”Yeah” (2-4)

78
Therapist: "and have really, you know, used it to get through a lot of significant changes in your life" (1-4)

Again in this excerpt, one senses the "treading lightly", the unwillingness to stir up anything negative or problematic in the relationship. The context of this situation is the patient missing the previous session, and in the Post-Session Questionnaire the therapist describes the above rupture in the following way: "Discussion of last week’s missed appointment, which requires further explanation in next session". Despite the lack of clear-cut patient rupture markers, the therapist clearly sensed the rupture, which again seems to have a lot to do with the things that weren’t said or played out.

In summary, what we have done in this section is to look at patient and therapist behavior combined with special attention given to the two different perspectives, that of the patient and that of the therapist. The whole rupture segment was approached in a global way. An interesting tendency was found at this level, with patients reporting more submissive patient behavior and therapists reporting more independent patient behavior in ruptures, and this was further explored. On this background, a grouping/taxonomy of ruptures, although sketchy, has emerged.
Chapter VII.

DISCUSSION

1. Limitations of study

The generalizability of this study may be limited by a number of factors. As seen in Appendix A, the patients in this study were mainly white (84%) and college-educated (96%), and different results might have been obtained in study with different or more diverse patient demographics.

The three treatment conditions in this study all belong to the time-limited therapy approach, which is typically characterized by very active therapists and a focus on a few problem areas. Ruptures from a more open-ended therapy might have yielded different scenarios, since the latter typically allows the therapeutic alliance longer time to develop, and the rupture process may as a result change over the course of the treatment. This study found that patients seem to report ruptures with relatively more submissive patient behavior than therapists did, which seem to indicate that the patients were very concerned about this very
aspect of their relationship with the therapist. However, there is a possibility that this might change over the course of treatment, especially in longterm therapy, when the therapeutic relationship has been more fully established and perhaps feels less tenuous for the patient.

The sample size is limited and the results as well as any conclusions should consequently be used with caution. In order to maximize generalizability, the sample included cases from three different treatment modalities. As noted in connection with the data analysis section, this study looked at relative occurrences of SASB-codes in selected rupture segments based upon a tally of all codes applied, and multiple codes were therefore included for any one segment. An alternative approach that studied occurrence/non-occurrence as a single event (single codes) would very likely have produced a very different picture.

In general, this study was constrained by the small sample size, which for the statistical analysis did not result in finding a significant difference between the patient- and therapist-reported ruptures, as is often the case in similar research. However, important tendencies (i.e. relative differences between patient-reported and therapist-reported ruptures) were found when analyzing ruptures at the segment-level, which formed the basis for a taxonomy of ruptures.
The selection criteria used in the study called for more subtle ruptures, since all the ruptures were only reported by one party (either patient or therapists), never both. This approach was necessitated by the very object of study, which was exploration of discrepancies between patients’ and therapists’ perception of ruptures. However, this may set the present study apart from other studies of ruptures, which may take the starting point in more distinct ruptures, reported by both parties, and consequently the findings here may show other features.

The SASB measure was chosen as the tool for capturing interpersonal process. This is a difficult and very time-consuming measure that requires intensive training of coders and ongoing recalibration sessions along the coding process in order to obtain and keep reliability at adequate levels. Based upon this researcher’s experience, each set of SASB-coders seem to develop their unique group consensus over time, why a different group of coders than the ones used here may have come up with slightly different coding results (at equal level of reliability). However, any variance from this is judged to be minor and would probably not alter the overall tendencies found.

2. Summary

Earlier research has shown that a good working alliance in
psychotherapy is predictive of a good outcome in psychotherapy (e.g. Horvath & Symonds, 1991). However, as discussed in earlier sections, the alliance fluctuates over time and is characterized by so-called ruptures (Safran et al., 1990). The aim of this dissertation was to investigate the interpersonal process during a selection of these ruptures with particular attention being paid to two different perspectives, that of the patient and that of the therapist. A preliminary analysis of a large pool of archival data at The Brief Psychotherapy Research Project at Beth Israel in New York by this researcher found that only in a third of the cases did patients and therapists agree on the occurrence of a rupture in a particular session. Based on this, this researcher speculated that this discrepancy might imply that different rupture types exist, with patients and therapists more likely to be aware of each their different subset of ruptures. In order to investigate this, 50 rupture segments (24 patient-reported and 26 therapist reported) from three different treatment modalities (10 BAP, 10 BRT and 6 CBT cases) were selected for coding on the process measure SASB, which is a tool for capturing the moment-to-moment therapy process on two dimensions, affiliation and dependence.

Statistical analyses of the relative occurrences of various patient and therapist variables (SASB clusters) across the rupture segments did not
demonstrate statistically significant differences in the interpersonal process in ruptures between ruptures reported by patients versus ruptures reported by therapists.

Qualitative analyses at the case-level, with categorization of ruptures into the SASB cluster that was most prevalent in a given rupture, picked up an interesting difference in patient behavior on the interdependence dimension between patient- and therapist-reported ruptures, with patients reporting relatively more ruptures with a majority of submissive patient behavior and therapists reporting relatively more ruptures with a majority of independent patient behavior. Particularly interesting is the finding that therapists in some cases would report the occurrence of a rupture despite the lack of more "typical" rupture markers, such as avoidance, defensiveness or hostility on part of the patient. This could point to a rupture type with extremely subtle features, with perhaps the only indication of alliance problems being the tension that the therapist experiences in the moment (which the observer subsequently senses, too). This researcher speculates that the occurrence of this type of ruptures may be due to the selection process that called for subtle ruptures with only one of the parties being aware of the problem. Perhaps a fuller rupture was averted or not allowed to fully surface in the segment. However, therapists' awareness of potential
alliance problems is extremely important in their work, and by reporting the ruptures the therapists in this sample seemed to have a sense of a potential rupture process. By using this awareness in the here-and-now in the session and perhaps allowing the rupture to more fully surface could lead to important exploration, resolution and ultimately change for the therapeutic relationship and the patient. The abundance of self-asserting behavior of their patients in this rupture type is perhaps a signal that the process has already moved into the resolution stage during the selected 3-4 minute segment (with very little exploration of rupture experience and avoidance).

The discrepancy between patient-reported and therapist-reported ruptures along the interdependence dimension is extremely interesting, as it touches upon the dilemma of “agency versus relatedness”. This dilemma has been described by a number of theorists as underlying, dialectically interacting, concepts of the human condition (e.g. Blatt & Ford, 1994; Mitchell, 1988, Safran, 1993). Agency is closely linked to one’s sense of self, to self-identity, and the need for the individual to feel and see him- or herself as a creative, alive subject with own will (Safran, 1993); this could be loosely associated with “independent” behaviors on the SASB interdependence dimension. Relatedness is concerned with the relationship that exists between an individual and
other human beings, and the human need for relating authentically to others; this could be associated with "submissive" behaviors on the SASB interdependence dimension. According to Safran (Ibid.), "The process of coming to accept both self and others are thus mutually dependent ones that can be facilitated by working through ruptures in the therapeutic alliance (Ibid). The tendencies found in this study may help illustrate how patients struggle with the dilemma of "agency versus relatedness" in therapy. It seems that therapists may be more attuned to the problems that arise in connection with patients' attempts at not relating (independent behavior), whereas patients may be more attuned to the problems that arise in the context of their attempts to relate maximally (submissive behavior).

The division of ruptures along the interdependence dimension is slightly different from the grouping of ruptures emphasized by others, e.g. Safran et al., 1994, that report two major groups of ruptures: 1) Confrontation ruptures and 2) Withdrawal ruptures. However, perhaps due to the subtlety of the ruptures involved in the present study, very little confrontational patient behavior was found by this researcher, which may explain why the latter distinction was less salient in this study.

A study by Twining (1995) that identified 18 variations of patient
markers of therapeutic alliance impasses based upon SAB and another measure called Patient Experiencing Scale (which assesses the level of patient involvement in the therapy process), similarly to this study found confrontation ruptures to be less frequent than withdrawal ruptures with only 4 out of 18 rupture types involving confrontation. In the remaining 14 rupture scenarios, the researcher identified a range of patient disengagement behaviors, of which some resemble the findings in the present study. However, in Twining’s study, patient behaviors of “Walling-Off & Avoiding” (SASB code 2-8) were more prevalent than in the present study, and Twining’s study did no find any ruptures that almost exclusively involved patient behavior on SASB cluster 2-1 “Asserting & Separating”. Again, these differences may be due to the subtle nature of the rupture segments included in the present study versus the ones that Twining used for her research. She stated the following in connection with her selection criteria: “The segments selected as impasse segments were those that this researcher believed included the “worst” breakdowns in the therapeutic alliance” (Ibid. p. 42).

When analyzing ruptures across treatment modalities, a number of interesting observations were made. Most of the discrepancies were found for therapist behavior, which showed significant variances in
terms of hostility, with BRT exhibiting significantly less hostile behavior
than both BAP and CBT therapists. At the same time BRT therapists
would exhibit more autonomy-encouraging behavior than both the other
modalities, with the largest discrepancy seen between BRT and BAP.
CBT patients tended to exhibit more submissive patient behavior. It is
not possible with the design of this study to determine whether these
differences tap into general underlying differences between the
modalities or are specific to rupture situations, although it seems
reasonable to assume the former. However, the identification of base-
line frequencies of modality-specific behavior would be an important
next step in this exploration (which falls outside the scope of this
dissertation). Ruptures with modality-specific features can be more
easily “masked” and be difficult for a therapist or patient to detect, since
these ruptures do not stand out very clearly from the other more
“normal” interaction. This could then lead to an even higher proportion
of undetected (and perhaps unresolved) ruptures with these modality-
specific features than the baseline behavior would indicate.

A sketchy taxonomy of ruptures was made on the basis of the
ruptures included in this data set. This mainly consisted in grouping of
ruptures based upon reporter and the combined patient/therapist
behavior captured on the two SASB dimensions. In connection with this,
it was possible to identify subgroups that resemble rupture categories identified by other researchers, e.g. Safran et al (1990), as well as add to their findings with the finding of a subtle type of therapists-reported ruptures that lack very distinct characteristics of "typical" patient rupture markers. In these situations, the therapists experience tension or sense potential alliance problems, but any defensiveness, avoidance or hostility is only picked up by a more global evaluation of the underlying sense of the rupture segments.

3. Suggestions for future research

The present study examined a number of rupture events with the intent of building a taxonomy of ruptures with a focus on the discrepancies between the patient and therapist perspective. The results were somewhat mixed, as, on the one hand, the study failed to find statistical differences when looking at patient and therapist behavior variables, and on the other hand, the study successfully was able to identify discrepancies between the two perspectives when judging the whole rupture segment more globally. Furthermore, the study picked up a number of interesting differences in the therapist behavior between treatment modalities.

Using the whole segment as the unit of analysis seems to hold a lot
of promise for finding differences between the two perspectives, and a future design of a study could try to substitute a more global rating system of the rupture segment for SASB. In this connection, it would be particularly interesting to explore the dilemma of "agency versus relatedness" further, to see how this is played out, both in ruptures and in therapy in general. Studies of this sort could be linked to semantic studies of content, and perhaps connected to semantic studies of the rupture descriptions provided by patients and therapists on the Post-Session Questionnaires.

The differences between modalities could be researched further to see if a connection exists between rupture types within different modalities and modality-specific features. For this, an examination, identification, and categorization of "baseline behavior" in different modalities outside rupture situations would need to be an integral part.
Chapter VIII.

REFERENCES


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies; "Is it true that everybody has won and all must have prizes?" Archives of General Psychiatry, 32, 995-1008.


95


Graduate School of Psychology, Yeshiva University, New York.


### Appendix A. Patient and Therapist Demographics

<table>
<thead>
<tr>
<th>Patients</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>1</td>
<td>27 Male</td>
</tr>
<tr>
<td>2</td>
<td>36 Male</td>
</tr>
<tr>
<td>3</td>
<td>28 Female</td>
</tr>
<tr>
<td>4</td>
<td>46 Male</td>
</tr>
<tr>
<td>5</td>
<td>27 Female</td>
</tr>
<tr>
<td>6</td>
<td>53 Female</td>
</tr>
<tr>
<td>7</td>
<td>33 Female</td>
</tr>
<tr>
<td>8</td>
<td>33 Female</td>
</tr>
<tr>
<td>9</td>
<td>50 Male</td>
</tr>
<tr>
<td>10</td>
<td>37 Female</td>
</tr>
<tr>
<td>11</td>
<td>31 Male</td>
</tr>
<tr>
<td>12</td>
<td>55 Female</td>
</tr>
<tr>
<td>13</td>
<td>39 Female</td>
</tr>
<tr>
<td>14</td>
<td>34 Male</td>
</tr>
<tr>
<td>15</td>
<td>52 Female</td>
</tr>
<tr>
<td>16</td>
<td>36 Male</td>
</tr>
<tr>
<td>17</td>
<td>52 Female</td>
</tr>
<tr>
<td>18</td>
<td>31 Female</td>
</tr>
<tr>
<td>19</td>
<td>43 Male</td>
</tr>
<tr>
<td>20</td>
<td>28 Female</td>
</tr>
<tr>
<td>21</td>
<td>51 Male</td>
</tr>
<tr>
<td>22</td>
<td>45 Female</td>
</tr>
<tr>
<td>23</td>
<td>48 Female</td>
</tr>
<tr>
<td>24</td>
<td>42 Male</td>
</tr>
<tr>
<td>25</td>
<td>34 Female</td>
</tr>
<tr>
<td>26</td>
<td>24 Female</td>
</tr>
</tbody>
</table>

Mean = 39.04 (Range 24 - 55)  
SD = 9.54

Mean = 37.42 (Range 27 - 60)  
SD = 9.30

Mean = 6.62 (Range 0 - 35)  
SD = 10.44

98
CONSENT FOR PARTICIPATION IN SCIENTIFIC INVESTIGATIONS

NAME OF SUBJECT: J.C. Muran, Ph.D.

NAME OF INVESTIGATOR: J.C. Muran, Ph.D.

TITLE OF PROJECT: Brief Psychotherapy Research Program

PROJECT NUMBER: 48-88 (B)

INSTRUCTIONS

Type in lay terms the nature and purposes of the study, the duration of the subject’s participation, the benefits, risks and discomforts of the procedures/tests and/or drugs/devices to be used, the requirements (sample collections, biopsies, questionnaires, etc.) and restrictions (diet, etc.) and disclose appropriate alternative treatment. Provide the names of persons to contact for questions about the study and in case of research-related injury.

Purpose and Nature of Program

You are invited to participate in a study involving three forms of short-term and time-limited psychotherapy: (a) cognitive-behavioral therapy, (b) brief adaptive psychotherapy, and (c) brief relational psychotherapy. We are attempting to learn more about different aspects of short-term psychotherapy so that you and others like you can receive the benefit of the best available treatment.

Treatment Conditions

If you decide to participate you will be randomly assigned to one of the three forms of short-term psychotherapy. All three forms of psychotherapy incorporate (a) high levels of therapist activity, (b) an approach focused on specific targeted problem areas, and (c) a treatment protocol of 30 sessions. The three psychotherapies, which have all proven to be significantly effective, differ primarily in some of the specific techniques employed; no one treatment approach has proven superiority over the others.

AUTHORIZATIONS

I have read the above and have been given a clear oral explanation of the nature, requirements, and effects of the study and satisfy answers to my inquiries. I accept the conditions of the study and authorize the above procedures/tests to be performed and investigational drugs/devices to be used. I understand that in the event of physical injury resulting from this study, only standard, essential medical treatment as determined by the hospital will be available for the injury without charge to me personally. There will be no monetary compensation. I also realize that I am free to withdraw this consent at any time without prejudice to my future treatment. I understand that records of this investigation will be kept confidential but are subject to inspection by the U.S. Food & Drug Administration.

Signature of Patient: [Signature]
Date: [Date]

Signature of Person Giving Permission: [Signature]
Date: [Date]

Committee on Scientific Activities: JUL 20 1998

Relationship to Patient: [Relationship]

I have clearly and fully explained to the above patient (or person giving consent) the nature, requirements, and foreseeable risks of the study. In my judgment he/she is fully competent to comprehend the nature of the study and the procedures involved.

Signature of Investigator: [Signature]
Date: [Date]

Signature of Auditor-Witness: [Signature]
Date: [Date]
If you decide to participate in this study you will be asked to do the following:

1. Not to participate in other psychotherapy or take psychoactive medication while receiving treatment in this program.

2. Be available for 30 sessions.

3. Take two evaluation interviews and complete a package of questionnaires to evaluate how you are doing in treatment:
   a. Before beginning treatment
   b. Midway during treatment
   c. At termination of treatment
   d. Six months after treatment is completed

4. Complete a post-session questionnaire after each session.

5. Agree to have evaluation and treatment sessions videotaped.

6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as research study, professional publication, educational presentations in transcribed, audiotaped, or videotaped format by the program staff.

Possible Risks
We know of no inherent risks associated with these treatments. Each type of treatment may cause some emotional discomfort at times, but this is generally considered a natural part of the therapeutic process.

Confidentiality
Information that is obtained in connection with this study that can be identified with you, including evaluation materials and videotaped recordings, will be held in the strictest confidence and would be voluntarily disclosed only with your explicit permission. We will share such information only with other members of our research and treatment team at Beth Israel. The only exception is the post-session questionnaire, which will not be available to your therapist and which will be identified solely by your identification number that will be provided at the outset. This exception is made because some of the material in this questionnaire pertains to your relationship with your therapist. While it is possible that at some point in the future selected excerpts from your sessions will be either presented or published for scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center.

Possible Benefits
All treatment groups offer possible benefits to you because they follow principles that have been tested and proven effective for some time. We are attempting to study what aspects of the different treatments contribute to or detract from their efficacy, particularly in terms of specific types of people and specific types of problems. Thus, your participation may be beneficial to you and others in the future.

Withdrawal
You may withdraw or cancel your participation at any time and you are under no obligation to participate. If you choose not to participate or withdraw at a later date, you will not jeopardize your future care by doing so. In this event you will be provided with standard Beth Israel care on the usual basis.

Questions
If you have any questions, you may contact J. Chris Muran, Ph.D., Program Director at 420-3819. If you have any unsatisfied complaints you may contact Jo Ann Tancer, Patient Representative at 420-3818. You may request a copy of this consent form at any time. You may also request feedback regarding aspects of the study upon your termination of treatment.
Appendix C

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER
NEW YORK NY 10003

PATIENT POST-SESSION QUESTIONNAIRE

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>
<td></td>
</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>
<td></td>
<td></td>
<td></td>
<td></td>
</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>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td></td>
<td></td>
</tr>
</tbody>
</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>
</tr>
</tbody>
</table>

6. To what degree do you feel this problem was resolved by the end of the 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>Moderately</td>
<td>Completely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

7. If there was a problem or tension in your relationship with your therapist during the session, please rate the extent to which each of the following statements reflects your experience by the end of this session.

   a. I felt a closer connection with my therapist.

      1 2 3 4 5
      Not at all  Moderately  Completely

   b. I felt more trusting of my therapist.

      1 2 3 4 5
      Not at all  Moderately  Completely

   c. I felt able to disagree with my therapist.

      1 2 3 4 5
      Not at all  Moderately  Completely

   d. I felt that my therapist can help me even if he/she is not perfect.

      1 2 3 4 5
      Not at all  Moderately  Completely

   e. I began to see how I was contributing to the difficulties my therapist and I were having.

      1 2 3 4 5
      Not at all  Moderately  Completely

   f. I discovered feelings towards my therapist that I had not been fully aware of.

      1 2 3 4 5
      Not at all  Moderately  Completely

   g. I felt more comfortable expressing anger or vulnerability to my therapist.

      1 2 3 4 5
      Not at all  Moderately  Completely

   h. I began to accept a part of myself which I had not fully acknowledged before.

      1 2 3 4 5
      Not at all  Moderately  Completely

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

      1 2 3 4 5
      Not at all  Moderately  Completely

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

      1 2 3 4 5
      Not at all  Moderately  Completely

   k. I saw that I can expose risky feelings and not be abandoned by my therapist.

      1 2 3 4 5
      Not at all  Moderately  Completely

   l. I learned that I have the ability to work things out with my therapist after a misunderstanding or conflict.

      1 2 3 4 5
      Not at all  Moderately  Completely
Appendix C

PART C

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

This session was:

Bad 1 2 3 4 5 6 7 Good
Safe 1 2 3 4 5 6 7 Dangerous
Difficult 1 2 3 4 5 6 7 Easy
Valuable 1 2 3 4 5 6 7 Worthless
Shallow 1 2 3 4 5 6 7 Deep
Relaxed 1 2 3 4 5 6 7 Tense
Unpleasant 1 2 3 4 5 6 7 Pleasant
Full 1 2 3 4 5 6 7 Empty
Weak 1 2 3 4 5 6 7 Powerful
Special 1 2 3 4 5 6 7 Ordinary
Rough 1 2 3 4 5 6 7 Smooth
Comfortable 1 2 3 4 5 6 7 Uncomfortable

PART D

The following items reflect your working relationship with your therapist based on your most recent session. Please rate each item by circling the appropriate number in terms of 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
Appendix C

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
Appendix C

PART E

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

<table>
<thead>
<tr>
<th>Adjective Set</th>
<th>Not at All</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2. TRICKY-BOASTFUL-CONCEITED-CRAFTY</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3. UNSOCIALABLE-INTROVERTED-DISTANT-SHY</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>5. UNDECEPTIVE-UNARGUMENTATIVE-NONEGOTISTICAL-UNDEVIOUS</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>6. KIND-TENDER-FORGIVING-COOPERATIVE</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>7. COLDHEARTED-IMPOLITE-UNSYMPATHETIC-UNCORDIAL</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>8. FRIENDLY-OUTGOING-CHEERFUL-APPROACHABLE</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

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>Adjective Set</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>2. TRICKY-BOASTFUL-CONCEITED-CRAFTY</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>3. UNSOCIALABLE-INTROVERTED-DISTANT-SHY</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>5. UNDECEPTIVE-UNARGUMENTATIVE-NONEGOTISTICAL-UNDEVIOUS</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>6. KIND-TENDER-FORGIVING-COOPERATIVE</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>7. COLDHEARTED-IMPOLITE-UNSYMPATHETIC-UNCORDIAL</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>8. FRIENDLY-OUTGOING-CHEERFUL-APPROACHABLE</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>
Appendix D

Instruction to independent judges on rating alliance rupture events.

Your task:
You are asked to rate the extent to which you find that the presented segments contain a rupture in the therapeutic alliance. You will be using a scale that goes from 1 to 5, with 1 representing the total absence of a rupture, 3 the presence of a minor and rather vague rupture, and 5 the presence of a severe rupture. Your decision should be guided by the definition of a rupture given below.

Definition of alliance rupture:
A rupture in the therapeutic alliance can be defined as a deterioration in the relationship between the therapist and the client (Safran & Muran, 1996). A similar "rupture" construct is discussed by other researchers, although other terms are used, e.g. "strain" (Bordin, 1994) and "impasse" (Elkind, 1992).

The intensity of ruptures can vary greatly. At one end of the scale there might be minor, hardly detectable fluctuations in the alliance, at the other end overt disagreement and hostility could be expressed by the client, or the client could be terminating therapy prematurely (Safran, Crocker, McMain, & Murray, 1990).

Generally, ruptures seem to fall in two main categories: 1) confrontation ruptures and 2) withdrawal ruptures (Safran, Muran, and Samstag, 1994). The following seven client behaviors/verbalizations have been found to be "markers" of underlying rupture situation:
1. *Overt expression of negative sentiments towards therapist*  
   (attacking and/or accusing).
2. *Indirect communication of negative sentiments or hostility*  
   (sarcasm, nonverbal behavior, passive-aggressive, negative sentiments about extratherapy situations).
3. *Disagreement about goals or tasks of therapy*  
   (questioning, rejecting goals or tasks)
4. *Compliance*
5. *Avoidance maneuvers*
   (unresponsive, shifting topic, ignoring therapist's remarks, arriving late, cancel appointment)

6. *Self-esteem-enhancing operations*
   (self-justifying, defending him- or herself, boasting)

7. *Nonresponsiveness (or minimal responsiveness) to intervention* (rejecting intervention)
   (Safran, Crocker, McMain, & Murray, 1990)

The above list of "markers" is not meant to be exhaustive, but should be used as a reference when selecting the rupture events. Although the list has its focus on the client's behavior, this should not be taken to imply that the therapist's contribution to a rupture is less important than the client's. The therapeutic alliance, as well as the alliance rupture, are constructs that stress the *interactive* elements of the therapeutic process (Horvath and Greenberg, 1986).

**References:**


## Table 1

<table>
<thead>
<tr>
<th>Patient</th>
<th>0</th>
<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>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Appendix F

Patient and therapist behaviors in routine segments. Tally of all SABS codes applied in routine segments reported by Patient and Therapist (n = 25).
<table>
<thead>
<tr>
<th>11S</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>23</th>
<th>24</th>
<th>25</th>
<th>26</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>1.71</td>
<td>1.84</td>
<td>1.90</td>
<td>1.96</td>
<td>2.02</td>
<td>2.08</td>
<td>2.14</td>
<td>2.20</td>
<td>2.26</td>
<td>2.32</td>
<td>2.38</td>
<td>2.44</td>
<td>2.50</td>
<td>2.56</td>
<td>2.62</td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>4.24</td>
<td>4.38</td>
<td>4.52</td>
<td>4.66</td>
<td>4.80</td>
<td>4.94</td>
<td>5.08</td>
<td>5.22</td>
<td>5.36</td>
<td>5.50</td>
<td>5.64</td>
<td>5.78</td>
<td>5.92</td>
<td>6.06</td>
<td>6.20</td>
<td></td>
</tr>
</tbody>
</table>

**Appendix C.** Patient and therapist behaviors in noise segments. Weighted tally of all SSS codes applied in noise segments.
<table>
<thead>
<tr>
<th>Patient</th>
<th>118</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>123</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2-6   | 2-5 |
| 2-4   | 2-3 |

---

### Appendix C. Continued
SASB codes for the patient behavior in rupture segment 1 (unweighted)
SASB codes for the therapist behavior in rupture segment 1 (unweighted)
SASB codes for the patient behavior in rupture segment 2 (unweighted)
SASB codes for the therapist behavior in rupture segment 2 (unweighted)
SASB codes for the patient behavior in rupture segment 3 (unweighted)
SASB codes for the therapist behavior in rupture segment 3 (unweighted)
SASB codes for the patient behavior in rupture segment 4 (unweighted)
SASB codes for the therapist behavior in rupture segment 4 (unweighted)
SASB codes for the patient behavior in rupture segment 5 (unweighted)
SASB codes for the therapist behavior in rupture segment 5 (unweighted)
SASB codes for the patient behavior in rupture segment 6 (unweighted)
SASB codes for the therapist behavior in rupture segment 6 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 7 (unweighted)
SASB codes for the therapist behavior in rupture segment 7 (unweighted)
SASB codes for the patient behavior in rupture segment 8 (unweighted)
SASB codes for the therapist behavior in rupture segment 8 (unweighted)
SASB codes for the patient behavior in rupture segment 9 (unweighted)
SASB codes for the therapist behavior in rupture segment 9 (unweighted)
SASB codes for the patient behavior in rupture segment 10 (unweighted)

137
Appendix H

SASB codes for the therapist behavior in rupture segment 10 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 11 (unweighted)

139
Appendix H

SASB codes for the therapist behavior in rupture segment 11 (unweighted)
SASB codes for the patient behavior in rupture segment 12 (unweighted)

141
SASB codes for the therapist behavior in rupture segment 12 (unweighted)
SASB codes for the patient behavior in rupture segment 13 (unweighted)
SASB codes for the therapist behavior in rupture segment 13 (unweighted)
SASB codes for the patient behavior in rupture segment 14 (unweighted)
SASB codes for the therapist behavior in rupture segment 14 (unweighted)
SASB codes for the patient behavior in rupture segment 15 (unweighted)
SASB codes for the therapist behavior in rupture segment 15 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 16 (unweighted)
SASB codes for the therapist behavior in rupture segment 16 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 17 (unweighted)

151
SASB codes for the therapist behavior in rupture segment 17 (unweighted)
SASB codes for the patient behavior in rupture segment 18 (unweighted)
Appendix H

4 (57%)
1-1 Freeing & Forgetting
1-8 Ignoring & Neglecting
1-2 Affirming & Understanding
1-7 Attacking & Rejecting
1-3 Nurturing & Comforting
1-6 Self-titling & Blaming
1-4 Helping & Protecting

2 (29%)
1-5 Watching & Managing

2-1 Asserting & Separating

2-8 Wailing off & Withdrawing
2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing
2-3 Approaching & Enjoying

2-6 Sulking & Appeasing
2-4 Trusting & Relying

2-5 Deferring & Submitting

SASB codes for the therapist behavior in rupture segment 18 (unweighted)
SASB codes for the patient behavior in rupture segment 19 (unweighted)
3 (13%)
1-1 Freeing & Forgetting

1-6 Ignoring & Neglecting
1-7 Attacking & Rejecting
1-3 Nurturing & Comforting

1 (4%)
1-6 Belittling & Blaming
1-4 Helping & Protecting

19 (83%)
1-5 Watching & Managing

2-1 Asserting & Separating

2-6 Walling off & Withdrawing
2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing
2-3 Approaching & Enjoying

2-5 Submitting & Submitting
2-6 Suiking & Appeasing
2-4 Trusting & Relying

SASB codes for the therapist behavior in rupture segment 19 (unweighted)
SASB codes for the patient behavior in rupture segment 20 (unweighted)
SASB codes for the therapist behavior in rupture segment 20 (unweighted)
1-1 Freeing & Forgetting

1-2 Affirming & Understanding
1-8 Ignoring & Neglecting

SURFACE 1
1-7 Attacking & Rejecting
1-6 Belittling & Blaming
1-3 Nurturing & Comforting
1-4 Helping & Protecting
1-5 Watching & Managing

22 (92%)
2-1 Asserting & Separating

SURFACE 2
2-8 Walling off & Withdrawing
2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing
2-3 Approaching & Enjoying

1 (4%)
2-6 Sucking & Appeasing
2-4 Trusting & Relying
2-5 Deferring & Submitting

SASB codes for the patient behavior in rupture segment 21 (unweighted)
SASB codes for the therapist behavior in rupture segment 21 (unweighted)
SASB codes for the patient behavior in rupture segment 22 (unweighted)
SASB codes for the therapist behavior in rupture segment 22 (unweighted)
SASB codes for the patient behavior in rupture segment 23 (unweighted)
Appendix H

SASB codes for the therapist behavior in rupture segment 23 (unweighted)

164
SASB codes for the patient behavior in rupture segment 24 (unweighted)
Appendix H

SASB codes for the therapist behavior in rupture segment 24 (unweighted)
SASB codes for the patient behavior in rupture segment 25 (unweighted)
4 (29%)
1-1 Freeing & Forgetting

1-8 Ignoring & Neglecting
1-2 Affirming & Understanding

1-7 Attacking & Rejecting
1-3 Nurturing & Comforting

1-6 Belittling & Blaming
4 (28%)
1-4 Helping & Protecting

6 (43%)
1-5 Watching & Managing

2-1 Asserting & Separating

2-8 Walling off & Withdrawing
2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing
2-3 Approaching & Enjoying

2-6 Sulking & Appeasing
2-4 Trusting & Relying

2-5 Deferring & Submitting

SASB codes for the therapist behavior in rupture segment 25 (unweighted)

168
SASB codes for the patient behavior in rupture segment 26 (unweighted)
SASB codes for the therapist behavior in rupture segment 26 (unweighted)
Appendix H

1-1 Freeing & Forgetting
1-2 Affirming & Understanding
1-3 Nurturing & Comforting
1-4 Helping & Protecting
1-5 Watching & Managing
1-6 Belittling & Blaming
1-7 Attacking & Rejecting

SURFACE 1

2-1 Asserting & Separating
2-2 Disclosing & Expressing
2-3 Approaching & Enjoying
2-4 Trusting & Relying
2-5 Deferring & Submitting
2-6 Sulking & Appeasing
2-7 Protesting & Withdrawing
2-8 Walling off & Withdrawing

SURFACE 2

SASB codes for the patient behavior in rupture segment 27 (unweighted)

171
SASB codes for the therapist behavior in rupture segment 27 (unweighted)
SASB codes for the patient behavior in rupture segment 28 (unweighted)
SASB codes for the therapist behavior in rupture segment 28 (unweighted)
SASB codes for the patient behavior in rupture segment 29 (unweighted)
SASB codes for the therapist behavior in rupture segment 29 (unweighted)
SASB codes for the patient behavior in rupture segment 30 (unweighted)
11 (50%)  
1-1 Freeing & Forgetting

1-8 Ignoring & Neglecting

1-2 Affirming & Understanding

1-7 Attacking & Rejecting

1-3 Nurturing & Comforting

1-6 Belittling & Blaming

7 (32%)  
1-4 Helping & Protecting

4 (18%)  
1-5 Watching & Managing

2-1 Asserting & Separating

2-7 Protesting & Withdrawing

2-8 Walling off & Withdrawing

2-2 Disclosing & Expressing

2-3 Approaching & Enjoying

2-6 Sulking & Appeasing

2-4 Trusting & Relying

2-5 Deferring & Submitting

SASB codes for the therapist behavior in rupture segment 30 (unweighted)
SASB codes for the patient behavior in rupture segment 31 (unweighted)
Appendix H

SASB codes for the therapist behavior in rupture segment 31 (unweighted)
SASB codes for the patient behavior in rupture segment 32 (unweighted)
SASB codes for the therapist behavior in rupture segment 32 (unweighted)
SASB codes for the patient behavior in rupture segment 33 (unweighted)
SASB codes for the therapist behavior in rupture segment 33 (unweighted)
SASB codes for the patient behavior in rupture segment 34 (unweighted)
Appendix H

24 (86%)
1-1 Freeing & Forgetting

1-8 Ignoring & Neglecting

1-2 Affirming & Understanding

1-7 Attacking & Rejecting

1-3 Nurturing & Comforting

1 (3%)
1-4 Helping & Protecting

3 (11%)
1-5 Watching & Managing

2-1 Asserting & Separating

2-6 Walling off & Withdrawing

2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing

2-3 Approaching & Enjoying

2-6 Sulking & Appeasing

2-4 Trusting & Relying

2-5 Deferring & Submitting

SASB codes for the therapist behavior in rupture segment 34 (unweighted)

186
SASB codes for the patient behavior in rupture segment 35 (unweighted)
1-1 Freeing & Forgetting
1-2 Affirming & Understanding
1-3 Nurturing & Comforting
1-4 Helping & Protecting
1-5 Watching & Managing
2-1 Asserting & Separating
2-2 Disclosing & Expressing
2-3 Approaching & Enjoying
2-4 Trusting & Relying
2-5 Deferring & Submitting
2-6 Sulking & Appeasing
2-7 Protesting & Withdrawing
2-8 Walling off & Withdrawing

7 (25%)
1-8 Ignoring & Neglecting
1-7 Attacking & Rejecting
1-6 Belittling & Blaming

13 (46%)

SASB codes for the therapist behavior in rupture segment 35 (unweighted)
SASB codes for the patient behavior in rupture segment 36 (unweighted)
SASB codes for the therapist behavior in rupture segment 36 (unweighted)
Appendix H

SURFACE 1
1-1 Freeing & Forgetting
1-2 Affirming & Understanding
1-3 Nurturing & Comforting
1-4 Helping & Protecting
1-5 Watching & Managing
1-6 Belittling & Blaming
1-7 Attacking & Rejecting

12 (75%)
2-1 Asserting & Separating

2 (12%)
2-2 Disclosing & Expressing
2-3 Approaching & Enjoying

SURFACE 2
2-4 Trusting & Relying
2-5 Deferring & Submitting
2-6 Sulking & Appeasing
2-7 Protesting & Withdrawing

2-6 Walling off & Withdrawing

SASB codes for the patient behavior in rupture segment 37 (unweighted)

191
SASB codes for the therapist behavior in rupture segment 37 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 38 (unweighted)
SASB codes for the therapist behavior in rupture segment 38 (unweighted)
Appendix H

1-1 Freeing & Forgetting
1-8 Ignoring & Neglecting
1-2 Affirming & Understanding
1-7 Attacking & Rejecting
1-3 Nurturing & Comforting
1-6 Belittling & Blaming
1-4 Helping & Protecting
1-5 Watching & Managing

18 (90%)
2-1 Asserting & Separating
2-8 Walling off & Withdrawing
2-2 Disclosing & Expressing

SURFACE 1

18 (90%)
2-1 Asserting & Separating
2-8 Walling off & Withdrawing
2-2 Disclosing & Expressing

SURFACE 2

2 (10%)
2-5 Deferring & Submitting
2-4 Trusting & Relying
2-3 Approaching & Enjoying
2-7 Protesting & Withdrawing
2-6 Sulking & Appeasing

SASB codes for the patient behavior in rupture segment 39 (unweighted)

195
SASB codes for the therapist behavior in rupture segment 39 (unweighted)
Appendix H

1-1 Freeing & Forgetting

1-8 Ignoring & Neglecting
1-2 Affirming & Understanding

1-7 Attacking & Rejecting
1-3 Nurturing & Comforting

1-6 Belittling & Blaming
1-4 Helping & Protecting

1-5 Watching & Managing

23 (79%)
2-1 Asserting & Separating

2-8 Walling off & Withdrawing
2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing
2-3 Approaching & Enjoying

6 (21%)
2-6 Sulking & Appeasing
2-4 Trusting & Relying

2-5 Deferring & Submitting

SASB codes for the patient behavior in rupture segment 40 (unweighted)

197
SASB codes for the therapist behavior in rupture segment 40 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 41 (unweighted)
SASB codes for the therapist behavior in rupture segment 41 (unweighted)
SASB codes for the patient behavior in rupture segment 42 (unweighted)
SASB codes for the therapist behavior in rupture segment 42 (unweighted)
SASB codes for the patient behavior in rupture segment 43 (unweighted)
Appendix H

12 (44%)  
1-1 Freeing & Forgetting

1-8 Ignoring & Neglecting

1 (4%)  
1-2 Affirming & Understanding

1-7 Attacking & Rejecting

SURFACE 1

1-3 Nurturing & Comforting

8 (30%)  
1-4 Helping & Protecting

1-6 Belittling & Blaming

6 (22%)  
1-5 Watching & Managing

2-1 Asserting & Separating

SURFACE 2

2-8 Walking off & Withdrawing

2-2 Disclosing & Expressing

2-7 Protesting & Withdrawing

2-3 Approaching & Enjoying

2-6 Sulking & Appeasing

2-5 Deferring & Submitting

2-4 Trusting & Relying

SASB codes for the therapist behavior in rupture segment 43 (unweighted)
SASB codes for the patient behavior in rupture segment 44 (unweighted)
SASB codes for the therapist behavior in rupture segment 44 (unweighted)
SASB codes for the patient behavior in rupture segment 45 (unweighted)
SASB codes for the therapist behavior in rupture segment 45 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 46 (unweighted)

209
SASB codes for the therapist behavior in rupture segment 46 (unweighted)
SASB codes for the patient behavior in rupture segment 47 (unweighted)

211
SASB codes for the therapist behavior in rupture segment 47 (unweighted)
SASB codes for the patient behavior in rupture segment 48 (unweighted)
SASB codes for the therapist behavior in rupture segment 48 (unweighted)
Appendix H

SASB codes for the patient behavior in rupture segment 49 (unweighted)
SASB codes for the therapist behavior in rupture segment 49 (unweighted)
SASB codes for the patient behavior in rupture segment 50 (unweighted)
SASB codes for the therapist behavior in rupture segment 50 (unweighted)