


CHAPTER 10
Resolving Therapeutic Alliance Ruptures: A Task Analytic Investigation*

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The concept of the therapeutic alliance originated in early psychoanalytic literature (e.g., Sterba, 1934; Zetzel, 1956). In the past 10 years, however, it has become a topic of growing theoretical and empirical interest among psychotherapy theorists and researchers in general (e.g., Gaston, 1990). One important impetus for this development has been Bordin’s (1979) transtheoretical conceptualization of the therapeutic alliance. Bordin suggested that the development of an adequate therapeutic alliance is essential in all forms of psychotherapy, but that the particular nature of the therapeutic alliance essential for effective therapy varies from approach to approach. Accordingly, the strength of the alliance is a function of the degree of agreement between patient and therapist about the tasks and goals of psychotherapy and the quality of the relationship bond between them. These three components (i.e., bond, task, and goal) are interdependent. Thus, the quality of the bond mediates the extent to which the patient and therapist are able to negotiate an agreement about the tasks and goals of therapy, and the ability to negotiate an agreement about the tasks and goals in therapy in turn mediates the quality of the bond.

There has now been a considerable amount of research evidence indicating that the quality of the therapeutic alliance as measured from different perspectives (therapist, patient, and third-party observers) and in a number of different ways is a good predictor of therapy outcome in different forms of psychotherapy (e.g., Greenberg & Pinsof, 1986; Hartley, 1985; Horvath & Symonds, 1991; Luborsky & Auerbach, 1985). The research presented here is predicated on the assumption that it is important to move beyond predictive validity studies toward clarifying the factors that mediate the establishment of good therapeutic alliances as well as those factors involved in repairing strains or ruptures in the therapeutic alliance (Foreman & Marmar, 1985; Safran, Crocker, McMain, & Murray, 1990).

* We gratefully acknowledge the assistance of Joyce A. Marquis.
There are both practical and conceptual reasons for moving in this direction. From a practical perspective, the evidence regarding the importance of establishing and maintaining an adequate therapeutic alliance suggests that improving problematic alliances should be an important therapeutic focus. At a more conceptual level, the growing evidence of the importance of the therapeutic alliance combined with the consistent failure to find differences in the efficacy of different forms of therapy has led a number of theorists to conclude that the traditional distinction between therapy specific and alliance specific factors is conceptually problematic (e.g., Butler & Strupp, 1986; Henry, Schacht, & Strupp, 1986, 1990; Strupp, 1989). As Bordin's (1979) conceptualization of the alliance makes clear, therapy specific and alliance specific factors are completely interdependent. What we think of as the therapeutic alliance consists of both the quality of the bond between therapist and patient and the degree of agreement between therapist and patient about tasks or goals of therapy. The quality of the bond mediates agreement about tasks and goals, and vice versa. It thus becomes particularly interesting to ask what it means when there is a disagreement between therapist and patient about the tasks or goals of therapy, such that the patient construes the therapeutic task or intervention for a patient? Or what is the meaning of a particular therapeutic task or intervention for a patient? Or what is the meaning of a particular therapeutic goal?

For example, a therapist asks a patient to engage in a behavioral assignment between sessions; the patient construes this therapeutic task as condescending or manipulative, and a rupture in the therapeutic alliance ensues. Or, a therapist asks a patient what he or she is experiencing at a particular point in time; the patient construes this intervention as invasive and a slip in the alliance takes place. Or again, a patient comes to therapy and responds by suggesting that the therapist help him eliminate his phobic symptoms. The therapist responds by suggesting that the elimination of the symptoms is of second importance and that a more valuable goal of therapy would be to help the patient develop greater self-awareness. The patient construes the therapist's response as invalidating, and as a result, they cannot establish an adequate therapeutic alliance. In all the preceding cases, the disagreement about tasks or goals of therapy that impairs the therapeutic alliance also provides potentially valuable information about the patient's construal process, which can in turn lead to a better understanding of some of the patient's fundamental beliefs about self and others.

The resolution of such alliance ruptures can also provide an important corrective emotional experience for the patient—an experiential disconfirmation of core maladaptive beliefs. For example, when a patient experiences a therapist's interpretation as condescending and a rupture in the therapeutic alliance ensues, she withdraws from the therapist instead of expressing her anger. Exploration of her experience at this point reveals her feeling that she is being condescended to, as well as her fear that expressing anger is dangerous. Further exploration reveals that this is a common pattern for her. By exploring and empathizing with the patient's experience and tolerating her resentment, the therapist can provide a new, constructive interpersonal experience for her. Subsequently, the therapist can help the patient to challenge her belief that expressing anger is dangerous and that the most adaptive response is withdrawal. This emphasis on the importance of focusing on alliance ruptures is very much consistent with Kohut's (1984) assertion that working through empathic failures is an important vehicle of change. Moreover, the Mount Zion Group's (Weiss et al., 1987) research provides empirical support regarding the central role that disconfirming the patient's pathogenic beliefs through the therapeutic relationship can play in the change process.

In this chapter, we will present the results of the first phase of a task analysis of the process involved in resolving ruptures in the therapeutic alliance. We will build on the preliminary model of rupture resolution initially articulated by Safran et al. (1990). Ultimately, an empirically refined model will be presented, along with some preliminary verification data supporting its validity. It is our hope that this chapter will serve as a manual of sorts in task analytic methodology.

**A Task Analysis**

The approach we have been employing to clarify the processes involved in resolving therapeutic alliance ruptures is adapted from Rice and Greenberg's (1984) task analytic model. Task analysis consists of a combination of discovery and verification-oriented strategies. The overarching principle of ongoing oscillation between theory building and empirical analysis it employs a combination of intensive and extensive analytic procedures to develop a model of the change process for a particular psychotherapy treatment. The task is to identify recurring patterns of change that take place across cases. The model of the resolution process is initially developed and refined through the intensive observation of single cases. At different stages of development the model is tested using group data. Our task analytic methodology is represented in Figure 10.1, which identifies the steps taken to define and verify our model of rupture resolution.

**Development of a Preliminary Model**

The first step in a task analysis involves the articulation of a preliminary model that can subsequently be used to guide the observation of the resolution process in a number of single cases. This model, which is derived from available psychotherapy theory as well as any intuitions the investigators have about the resolution process, is employed as a preliminary map that is
The preliminary model we began with was derived from psychodynamic and contemporary interpersonal theory, and can be described as follows: In the first stage, the patient enacts a maladaptive cognitive-interpersonal cycle that is characteristic of him or her. For example, the patient anticipates that others will be hostile and thus puts up a hostile defense. In the second stage, the therapist becomes hooked by the patient's behavior and responds in a complementary fashion. In this example, the therapist responds to the patient's hostility with complementary hostility. In the third stage, the therapist becomes aware of his or her role in the dysfunctional cognitive-interpersonal cycle and thus begins an unhooking process. In the fourth stage, the therapist begins to metacommunicate with the patient about their current interaction by exploring with the patient the nature of their current interaction and the patient's experience of it, rather than simply participating in it automatically. In the fifth and final stage, the therapist accepts responsibility for contributing to the interaction. For example, the therapist who becomes aware of having responded to the patient's hostility with counterhostility acknowledges this to the patient.

Selection of Events

The next step of our research program involved selecting alliance rupture events for investigation. A rupture can be identified from three perspectives (therapist, patient, and third-party observer). In the early phases of the research, we selected rupture events from therapist and patient perspectives; in the later phases, we employed third-party perspectives as well.

To select rupture events from patient and therapist perspectives, we extracted six questions from the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986): two corresponding to each of the three dimensions of the therapeutic alliance (task, goal, and bond). The six questions that were selected were chosen on the basis of demonstrated ability, in a previous data set (Safran & Wallner, 1991), to predict outcome in short-term therapy with an integrated cognitive-interpersonal focus (Safran, 1984a, 1984b, 1990a, 1990b; Safran & Segal, 1990) across a range of different dependent measures (see Table 10.1). These questions represent an important intermediate link between more molecular in-session change and ultimate outcome. Their

### Table 10.1. Mean Pearson Correlations of Six WAI Items with Outcome Measures from a Previous Data Set (Safran & Wallner, 1991)

<table>
<thead>
<tr>
<th>WAI Item</th>
<th>Pearson Mean</th>
<th>Correlations Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond Factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I believe __________ is genuinely concerned for my welfare.</td>
<td>.48</td>
<td>.47–.48</td>
</tr>
<tr>
<td>29. I have the feeling that if I say or do the wrong things, __________ will stop working with me.</td>
<td>.55</td>
<td>.50–.60</td>
</tr>
<tr>
<td>Task Factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I am clear on what my responsibilities are in therapy.</td>
<td>.50</td>
<td>.44–.55</td>
</tr>
<tr>
<td>15. I find what __________ and I are doing in therapy is unrelated to my concerns.</td>
<td>.43</td>
<td>.42–.44</td>
</tr>
<tr>
<td>Goal Factor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. __________ and I are working toward mutually agreed upon goals.</td>
<td>.51</td>
<td>.44–.62</td>
</tr>
<tr>
<td>25. As a result of these sessions, I am clearer as to how I might be able to change.</td>
<td>.52</td>
<td>.43–.67</td>
</tr>
</tbody>
</table>

*All statistics are first order correlations and are significant at p < .05.
validity as indexes of intermediate outcome was further corroborated in a study by Muran and Safran (1990).

These six alliance questions were then administered independently to patients and therapists after every session. Both therapists and patients were instructed to think of the therapy session as consisting of three parts—a beginning, a middle, and an end—and to rate each portion of the session separately on each question. In this fashion, we obtained perceptions independently from both therapists and patients regarding fluctuations in the quality of the therapeutic alliance over the course of each session. For example, a particular patient and/or therapist may rate the first portion of the session relatively high on the therapeutic alliance questions, the second portion as low, and the third portion as high. This pattern of ratings would suggest that a deterioration in the therapeutic alliance had taken place toward the middle of the session but that the quality of the alliance had improved once again toward the end of the session.

We reasoned that sessions in which both therapists and patients rated the quality of the alliance as significantly poorer in the middle phase than in both the beginning and end phases would have a reasonably high likelihood of providing events in which an alliance rupture had occurred during the session and then subsequently had been resolved. A fluctuation of at least 20 points\(^1\) was chosen as the criterion. In contrast, we reasoned that questionnaires on which both therapist and patient rated the middle portion of the session as being at least 20 points lower on the therapeutic alliance items than the first portion and did not show substantial improvement in the final portion, indicated sessions in which alliance ruptures had occurred and had not been resolved by the end of the session. In this way, we were able to select a sample of resolution and nonresolution sessions.

**Informal Empirical Analysis**

Once a procedure had been developed for selecting alliance rupture events, we began the process of refining the model of the resolution process by carefully reviewing audiotapes and transcripts of ruptures that had been successfully resolved (as indicated by therapist and patient reports on the WAI items) and by successively revising the preliminary model in response to observed discrepancies between the model and actual sessions. These sessions were drawn from a pool of 29 patients being treated in 20-session, time-limited therapy with an integrated cognitive-interpersonal approach (Safran, 1990a, 1990b; Safran & Segal, 1990). Eight therapists were involved in the study.

Through a careful step-by-step comparison with actual resolution events, the preliminary model was gradually refined. In this step of the research, the model was refined in response to actual observations of psychotherapy sessions, rather than a purely conceptual or armchair analysis. At this point, however, the empirical analysis took place at an informal level, in that no procedures were employed for ensuring the reliability and the validity of the observations.

Through this process, it became apparent that there are a number of different alliance rupture types, each following unique resolution patterns. The seven different rupture types that were distinguished were described in Safran et al. (1990). Ultimately, we grouped these seven rupture categories into two major alliance rupture types corresponding to rupture types similarly described by Harper (1989a, 1989b): (a) confrontation ruptures, and (b) withdrawal ruptures.

A confrontation rupture is characterized by an aggressive and accusatory statement of dissatisfaction by the patient regarding the therapist, the therapy, or some aspect of the therapeutic process. This is exemplified by such statements from the patient as “You’re not helping me” or “This is a stupid exercise.” A withdrawal rupture is characterized by a patient statement or behavior that distances the patient from the therapist or the therapeutic task, and/or their own internal experience. Examples would be intellectualization, shifting the topic, justification, compliance, or immediate agreement with the therapist’s statement without exploration or elaboration. To date, our research has focused more intensively on the analysis of the resolution process for withdrawal ruptures, and the rest of the chapter will thus focus on this rupture type.

**Formal Empirical Analysis**

As regularities in patterns of rupture resolution emerged, we began to operationalize the different components of the proposed model, using a battery of process measures chosen to capture different aspects of the relevant phenomena. The use of converging measurement procedures, in this context, is important since no one measure can comprehensively capture the important features of any given aspect of clinical process. Operationalizing the model’s components in this fashion serves a number of functions (Rice & Saperia, 1984; Safran et al., 1988). First, it forces the user to articulate the hypothesized constructs more precisely. Second, using reliable coding categories ensures that the observations will be rigorous and that there is ultimately some interrater reliability to the observations. This is a prerequisite if the model is going to have any validity and generalizability. Third, specifying operational criteria allows for subsequent verification studies to test the validity of the proposed model. In other words, it allows for testing the proposed model empirically using more conventional aggregate data studies that evaluate the hypothesis that resolution and nonresolution events differ in the presence or absence of the proposed model components. Finally, the operationalization of model components with converging process measures...
Procedure provides specific markers that can be useful to the practitioner in identifying the presence or absence of processes relevant to the resolution of alliance ruptures.

Process Measures

Four measures were employed in the operationalization of the rupture resolution model components:

2. The Patient Experiencing Scale (P-EXP; Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986).
3. The Therapist Experiencing Scale (T-EXP; Klein et al., 1986).
4. The Client Vocal Quality Scale (CVQ; Rice & Kerr, 1986; Rice & Wagstaff, 1967).

In our research, which emphasizes the interpersonal aspects of therapy, the cluster version of SASB analysis was used to code process, rather than content, on Surface 1 (focus on other) and Surface 2 (focus on self) of the SASB model. Readers not familiar with these scales are directed to the references cited for detailed descriptions of them.

Procedure

A number of withdrawal ruptures were coded using the preceding process measures. This helped us discern regularities in patterns of change that occurred across cases. By tracking recurring patterns of transition between recurring configurations of process measure codings, we were able to further revise the model in an iterative fashion. The process was facilitated by charting these patterns in graphlike form (Greenberg, 1984).

Operationalizing the model components is a complex and subtle procedure in which provisional criteria are set on the different process measures in an attempt to capture clinical intuitions about what different resolution components should look like. The criteria are adjusted in an iterative fashion as we apply them to new clinical material and gauge how well they actually capture the model components as currently conceptualized.

The conceptualization of the relevant constructs and their operationalization takes place over time in a mutually influencing bootstrapping process, in response to new observations of clinical material (Rice & Saperia, 1984). The operationalization of the components of the model thus sharpened our observations and facilitated a rigorous interplay between empirical observation and conceptualization. Through this iterative, bootstrapping process, a revised model was ultimately developed in which each component was operationalized with specific criteria on multiple process measures. Where it was felt that the process measures would not completely capture the important aspects of a component, additional semantic criteria were stipulated as well.

Empirical Model I

The first empirical model consisted of four components. Each of the first three components consisted of two subcomponents: a therapist subcomponent and a patient subcomponent. This arrangement allowed us to capture important patient-therapist sequences or interaction patterns that were observed to be characteristic of resolution sessions. For example, the significance of a patient withdrawal marker that is followed by a therapist response of drawing the patient's attention to the rupture will be different from one that is followed by a therapist response of withdrawal. The final resolution component in this model consisted exclusively of a patient process. It was felt that this component was sufficiently rare, and far enough along in the resolution process to be a significant marker of resolution, regardless of the particular therapist response that either precedes or follows it.

The first empirical model, along with the operational criteria for the resolution components, is diagrammed in Figure 10.2. Although an actual resolution process tends to be complex, with many repetitions and loops, the model captures the essence of the resolution process.

Component 1. Attending to the Rupture Marker

The first component in the model consists of Subcomponent 1A: Patient Withdrawal Marker; it is followed by Subcomponent 1B: Therapist Focuses Attention on Rupture Experience in the Here and Now.

Subcomponent 1A. Patient Withdrawal Marker. The presence of a withdrawal marker is indicated by a behavior on the patient's part suggesting that he or she is in some way avoiding the exploration of certain feelings. As the operational criteria on the SASB (Figure 10.2) indicate, typical indications of this marker involve Deferring and Submitting (2-5), Sulking and Appeasing (2-6), or Walling Off and Avoiding (2-8) on the part of the patient. At least two patient statement “units” receiving this constellation of codes would have to occur in sequence (either within one speech turn or across two speech turns) to be classified as a subcomponent 1A.

In one session, for example, the therapist asked the patient to participate in the two-chair exercise from Gestalt therapy. The patient began to do so, but the therapist, sensing an odd quality in her voice, began to explore whether or not she was doing so wholeheartedly or out of deference. The patient's compliant behavior receives a code of Deferring and Submitting (2-5) on the SASB. As indicated on Figure 10.2, this process is also marked by codings of Externalized or Limited on the CVQ Scale and a coding of no more than 2 on the P-EXP Scale. These codings reflect the low level of self-exploration that is characteristic here.
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COMPONENT 1
Attesting to the Rupture Marker

Patient rupture withdrawal marker
SASB: 2-5, 2-6, or 2-8
P-EXP: < 2
CVQ: X or L

Therapist focuses patient on immediate experience
SASB: 1-4 or 1-2 (+/- 2-2)
T-EXP: ≥ 2-3

COMPONENT 2
Exploration of Rupture Experience

Patient expresses negative feelings
SASB: 2-1

Therapist empathizes and/or accepts responsibility
SASB: 1-2 or 2-2
T-EXP: ≥ 3-3

COMPONENT 3
Exploration of Avoidance

Therapist probes for fears
SASB: 1-4

Patient explores avoidance
SASB: 2-2
P-EXP: ≥ 3
CVQ: F

COMPONENT 4
Exploration of Interpersonal Schema

Patient explores interpersonal schemas
SASB: 2-2
P-EXP: ≥ 5
CVQ: F

KEY
SASB: Focus on other
1-2 Affirming and Understanding
1-4 Helping and Protecting
1-5 Watching and Managing
1-6 Blaming and Belittling

Focus on self
2-1 Asserting and Separating
2-2 Disclosing and Expressing
2-5 Deferring and Submitting
2-6 Sulking and Appeasing
2-8 Walling Off and Avoiding

P-EXP: 1 to 7
T-EXP: Manner-Referent (1 to 7)
CVQ: L = Limited
X = Externalizing
E = Emotional
F = Focused

N. B. Each subcomponent includes a semantic definition as part of the operational criteria.

Subcomponent 1B. Therapist Focuses Attention on Rupture Experience in the Here and Now. It appears to be critical at this point for the therapist to draw attention to the rupture and to maintain a focus on the here and now of the therapeutic relationship. Often, the therapist needs to consistently return the focus to the here and now in the therapeutic relationship, as the patient tends to retreat into generalities or speaks about other situations. For example, a patient, who had left the previous session apparently upset about what he saw as being the therapist’s unresponsiveness, came to the current session focusing on his frustration with his supervisor’s nonresponsiveness rather than on the therapist’s. At this point, the therapist drew the patient’s attention to the similarity between the two situations and asked if he felt there were any similarities.

The therapist can do this in a number of ways. A common intervention is for the therapist simply to probe for the patient’s current experience with statements such as, “What are you experiencing right now?” This type of intervention would be coded as Helping and Protecting (1-4) on the SASB. Another intervention consists of a therapist empathizing with any negative feelings that the patient may be expressing. For example, a patient begins to express some frustration with the therapy and then withdraws. The therapist empathizes with the frustration that the patient has expressed. This would receive an Affirming and Understanding (1-2) code on the SASB. Another common intervention is for the therapist to provide feedback about his or her subjective perception of negative sentiments that the patient is directly or indirectly expressing. For example, the therapist says: “You seem kind of irritated to me. My sense is that you seem kind of frustrated.” This would receive a double code of Helping and Protecting (1-4) and Disclosing and Expressing (2-2) on the SASB. Therapist responses at this point must have a minimum of a 4-3 coding on the T-EXP Scale, indicating that the therapist is attuning to the patient’s experiences in the moment and elaborating on them in an empathically involved manner. We defined these three types of therapist interventions as a Subcomponent 1B if they occurred within a minimum of three speech turns of the patient’s rupture marker.

Component 2. Exploration of Rupture Experience

This component consists of Subcomponent 2A: Patient Expression of Negative Sentiments; and Subcomponent 2B: Therapist Empathy and/or Acceptance of Responsibility.

Subcomponent 2A. Patient Expression of Negative Sentiments. At this point, in response to a therapist intervention focusing attention on rupture experience in the here and now, the patient may begin to express negative sentiments more directly. This type of response receives a coding of Asserting and Separating (2-1) on the SASB. At least one speech unit coded as Asserting and Separating (2-1), which immediately follows a Component 1, is defined as Subcomponent 2A. For example, a patient who
has been responding to the therapist’s intervention in a different way than previously. He begins to acknowledge that he is feeling hurt by the therapist’s statements and appears to be feeling angry.

A noteworthy point here is that neither the P-EXP Scale nor the SASB Scale were found to provide reliable guidelines as to the presence or absence of the three components. Comparing resolution to nonresolution sessions, it emerged that acts of self-assertion and individuation seemed to be more important in the context than any type of deeper self-exploration. In fact, a number of resolution sessions emerged where patients engaged in a compliant fashion, as indicated by high ratings on the P-EXP Scale or CVQ Focused, in what appeared to be a compliant fashion. This underscores the importance of clarifying precisely what type of response the therapist is looking for, especially in what context (Rice & Greenberg, 1984).

Subcomponent 2B. Therapist Empathy and/or Acceptance of Responsibility. It is important for the therapist to respond to immediate expressions of negative sentiments by either empathizing (SASB: Affirming) or by accepting responsibility for his or her contribution to the interaction (SASB: Disclosing & Expressing). For example, the patient asked the therapist whether he felt critical of him or her. At first, the therapist indicated that the patient’s subjective experience was more important than whether indeed he really was being critical. However, the therapist acknowledged that indeed he was being critical through the impasse.

Component 3. Exploration of Avoidance

This component consists of Subcomponent 3A: Therapist Probe for Block; and Subcomponent 3B: Patient Exploration of the Block.

Subcomponent 3A. Therapist Probe for Block. Here, the therapist begins to probe directly for any fears the patient may be blocking their expression. For example, the patient begins to express anger at the therapist, but then appears to withdraw. In response to the therapist’s probing, she indicates that she is experiencing some anxiety, which leads the therapist then begins to explore the nature of the patient’s anxiety and what her concerns are. This type of direct question receives a Disclosing and Protecting (1-4) code on the SASB and is operationally defined as Subcomponent 3A if it occurs anytime after a Component 1 response.

Subcomponent 3B. Patient Exploration of the Block. This is when the patient explores the fears that blocking their expression of negative sentiments. For example, the patient explores his concern of being abandoned if he or she expresses any negative sentiments of response receives a Disclosing and Expressing (2-2) code on the P-EXP Scale.

Component 4. Exploration of Interpersonal Schema

This component consists of only a patient process. The exploration of the rupture experience and the fears that are blocking the acknowledgment and the expression of the rupture experience in the interaction (SASB: Disclosing & Expressing) is coded as Disclosing and Expressing (2-2) on the SASB. It is important that this exploration take place in an experiential fashion, as indicated by a CVQ coding of Focused Voice Quality (F). This is critical for the exploration of interpersonal schema as a Component 4 if it was preceded by a Component 1 and either a Component 2 or 3 sometime in the session. For example, the previously discussed patient, who was reluctant to explore his frustration about the earlier session with the therapist, eventually came to see the way in which his belief that the exploration of his emotions would be useless played a central role in terms of his feeling of his interpersonal schema.

Conceptualization of this component emerged out of the observation in some cases, patient responses that initially looked very much like Component 3B (Patient Exploration of Block), were distinguished from instances of this component by a combination of higher P-EXP ratings and CVQ ratings of Focused (F). (The criteria for Component 3B are P-EXP ≥ 3 or CVQ = F). This combination of codings suggests that there is an advanced stage of exploration taking place in these instances.

Verification Study I: Descriptive Analysis

In the next phase of the research program, four rupture resolution sessions were compared with three nonresolution sessions. The operational criteria of model components were used to evaluate the extent to which resolution contained a higher frequency of model components than nonresolution. This is not a formal test of the hypothesis since the sample is
too small to allow the use of inferential statistics. It does, however, provide a preliminary indication of the potential usefulness of the model. The four resolved rupture events can be conceptualized as a series of single-case studies. Each successful replication increases confidence about the generalizability of the model. The unresolved rupture events, while not serving as a formal control group, do facilitate the development of preliminary impressions about the extent to which various model components are found exclusively in resolved rupture events or appear to varying degrees in unresolved rupture events. Furthermore, the comparison of resolved rupture events with unresolved rupture events permits us to glean preliminary impressions about various ways in which the rupture resolution process breaks down in unresolved ruptures.

Procedure

Four resolution sessions and three nonresolution sessions were selected on the basis of converging therapist and patient responses on the postsession alliance questions (as described earlier). In addition, two independent raters, naive to the nature of the study, were asked to rate all sessions on a 5-point scale, indicating the degree to which they perceived the rupture as resolved. Both raters were PhD clinical psychology students with four years' experience as psychotherapists. They participated in a 2-hour training session that focused on the concept of therapeutic alliance ruptures and examined a number of examples of resolved and unresolved alliance rupture events. The intraclass correlation of the two raters was .88. Their ratings were then averaged, and the sessions were rank ordered on the basis of this average. The four highest ranked sessions were found to correspond to the sessions that had been identified as rupture resolution sessions on the basis of patient and therapist ratings.

All four resolution sessions (101a, 103a, 103b, 106) came from one therapist (the senior author), with two of them coming from the same patient (103). In addition, one of the nonresolution sessions (101b) came from a patient who had also provided one resolution session. The two remaining resolution sessions (1701, 1904) came from two different therapists (one woman, aged 44, with a PhD degree, and one woman, aged 38, with an MA degree).

The five patients included in the formal analysis of the rupture resolution model were two women and three men with a mean age of 37.5 years; two of the patients were married, one was single, and one was divorced (marital status information was not available for one patient). The Axis I diagnoses were as follows: Three cases presented with depression symptoms, one case with both depression and anxiety symptoms, and one case with interpersonal problems. None of the patients received an Axis II diagnosis. Four patients completed all 20 sessions of the treatment protocol, and one terminated treatment after Session 15 (this patient was in the non-resolution sample).

Reliability of Process Coding

First, transcripts of the seven sessions selected for analysis were broken into speech units according to instructions in the SASB manual (Grawe-Gerber & Benjamin, 1989). A speech unit is defined as “a complete thought or a psychologically meaningful interaction” within a speech turn (Grawe-Gerber & Benjamin, 1989, p. 6). All sessions were then coded on the SASB, P-EXP, and T-EXP Scales, and CVQ Scale. Given the labor-intensive, time-consuming nature of this coding, individual raters coded the seven sessions after adequate reliability had been established. All coded sessions were then reviewed by the research team, and any disagreements were resolved by group consensus. A similar coding and group consensus procedure was used for all instruments. The model components were then identified, using the previously described criteria, after the sessions had been coded with all the process measures.

Training for all instruments was done using sessions drawn from the general patient pool at the clinic, but these sessions were not included in the analyses. Interrater agreement of SASB coding was established between two independent raters on one therapy session. Raters were blind to session number, patient, and therapist in all training cases. A weighted kappa coefficient of .69 was obtained. This result is within the range of interrater agreement estimates reported by Benjamin (1974). After training on the P-EXP Scale was completed, interrater reliability was assessed using 34 randomly selected 2-minute segments. Two independent raters achieved adequate intraclass correlation coefficients of .83 for manner and .95 for peak ratings (see Klein et al., 1986, for a review). Interrater reliability on T-EXP ratings was calculated on a sample of 31, 2-minute segments of sessions drawn from the sample. For the two independent raters, the intraclass correlation coefficients were .72 for manner and .79 for referent ratings, suggesting adequate reliability. Interrater agreement of CVQ ratings was also calculated between two independent raters, using one 50-minute therapy session drawn from the sample. The estimate of overall rater agreement (kappa) was .55, which is consistent with previously reported indexes (Rice & Kerr, 1986).

Comparison of Resolution and Nonresolution Sessions

Table 10.2 compares resolution and nonresolution events in terms of the frequency with which each of the four model components was found. The mean number of components found in resolution versus nonresolution sessions suggests the presence of differences that are consistent with the hypothesis.

The pattern that emerges when component frequencies for each of the individual cases is examined is further illuminating. The first observation is that each of the four resolution sessions had at least one occurrence of Components 1 (Attending to the Rupture Marker), 2 (Exploration of the Rupture Experience), and 3 (Exploration of Avoidance). Component 4 (Exploration of Interpersonal Schema), however, was only found in two of the
TABLE 10.2. Component Frequency of Resolution versus Nonresolution Cases

<table>
<thead>
<tr>
<th>Component</th>
<th>Resolution</th>
<th>Nonresolution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Session</td>
<td>(Attending</td>
<td>(Exploration</td>
</tr>
<tr>
<td>101a</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>103b</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>103a</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>106</td>
<td>8</td>
<td>3</td>
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<tr>
<td>M</td>
<td>4.75</td>
<td>5.3</td>
</tr>
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</table>

four resolution cases, and none of the resolution cases was found to have more than one occurrence of this component. Inspection of component frequencies in nonresolution sessions indicates that two of the three nonresolution events contained one of the model components. The third nonresolution session (1701) contained two instances of Component 1 (Attending to Rupture) and three instances of Component 2 (Exploration of Rupture Experience). However, no instances of either Component 3 (Exploration of Avoidance) or Component 4 (Exploration of Interpersonal Schema) were found.

The results of the pilot verification study were generally encouraging. Since all four resolution sessions came from the same therapist, it seems likely that differences emerging between resolution and nonresolution sessions are attributable at least in part to a therapist effect. To provide some evaluation as to whether differences are attributable to pretreatment differences in the patients, we compared the resolution and nonresolution subjects on a battery of symptom severity measures administered prior to treatment (see Table 10.3). Although the sample size is too small to permit the use of inferential statistics, inspection of the group means reveals a consistent pattern in which subjects who provided the resolution sessions actually reported more severe symptomatology prior to treatment. This suggests that any theory-consistent differences between the two groups emerging in the resolution patterns cannot be attributed to pretreatment symptom severity.

**Empirical Model II**

The results of the Pilot Verification Study I, while not definitive, provided encouraging support for the four-component resolution model. Having formally coded seven alliance rupture events on our battery of process measures, we were now in a position to go through the next phase of refining the model. By looking for regularities in transitions between specific configurations of process measures that had been identified, we were able to further clarify certain aspects of the resolution process.

The following provides a simple example of these procedures. A repeated observation was that a number of transcript segments that had previously been identified as examples of Subcomponent 2A (Patient Expression of Negative Sentiments) were actually receiving double codings on that SASB of Asserting and Separating (2-1) and either Belittling and Blaming (1-6) or Deferring and Submitting (2-5) or Walling Off and Avoiding (2-8). An example of a 2-1 and 1-6 double code would be “You're not helping me” rather than “I'm not finding this useful,” “I'm angry at you,” or “I would like more structure.” The client is in some sense individuating from the therapist, but stops short of taking full responsibility for his or her position by blaming the therapist, rather than stating his or her position or making more of an “I-statement.” An example of a 2-1 and 2-5 double code is as follows: The patient says, “Do you think it could be useful if we worked out some kind of agenda?” rather than “I'd like a clearer idea of where we're going.” Here the patient appears to be making a move toward individuation, but the form of the statement still implies a dependency on the therapist for approval or guidance, rather than a pure act of self-assertion.

These transcript segments stood in contrast to segments that had received a pure code of Asserting and Separating (2-1). Furthermore, it appeared that the pure 2-1 codings were often preceded by one or more transcript segments that had received double codings of the type described earlier.
distinction thus began to emerge in our thinking between unambiguous acts
of self-assertion on the patient's part, which tended to occur later on in the
resolution process, versus partial acts of self-assertion that were adulterated
either by a simultaneous compliance with the therapist or by an other-
directed blaming stance, rather than showing the patient's assumption of
full responsibility for his or her feelings or needs.

Another common pattern observed was that acts of partial assertion of-
ten appeared to be followed by one of three therapist responses. In one re-
response type, the therapist asks the patient to make a direct statement. For
example, the patient says, "Do you think it could be useful if we worked out
some kind of agenda?" and the therapist says, "Are you willing to tell me
directly what you want, rather than ask a question?" This type of response
would receive a SASB code of Helping and Protecting (1-4), which suggests
that the therapist is attempting to teach or stimulate the patient in a kind or
positive manner.

In the second response type, the therapist provides either accurate empa-
thy or subjective feedback about the way in which he or she perceives or
experiences the patient's statement. An example of the first subtype is as
follows: "You seem dissatisfied with the way we are proceeding," which
would receive a SASB code of Affirming and Understanding (1-2) and a
T-EXP code reflecting a modest level of therapist contribution and involve-
ment (at least 2-3). The second subtype is exemplified by the response: "I
sense you as kind of letting me know what you want, but in a very cautious
way." This would receive a double code on the SASB of Helping and Pro-
tecting (1-4) and Disclosing and Expressing (2-2), and a T-EXP code re-
flecting a modest level of empathic involvement (at least 3-3).

The third and final type of therapist behavior involves an acknowledgment
of responsibility for his or her contribution to the interaction. For example,
in response to the patient's statement, "I feel like you're being critical of
me," the therapist responds, "I think you're right. I was being critical of
you." This behavior receives a SASB code of Disclosing and Expressing
(2-2), and a P-EXP code reflecting a higher level of therapist contribution
and involvement than the other types (at least 4-3).

Another significant refinement of the rupture resolution model involved
Component 3 (Exploration of Avoidance). In its original conceptualization,
the component included two subcomponents; however, repeated observa-
tions showed that it was important to recognize the patient's acknowledg-
ment of a block prior to the therapist's probe and subsequent exploration by
the patient. For example, in response to the therapist's probe for immediate
experience, the patient says, "I'm feeling anxious." This component, there-
fore, came to include three subcomponents with the first identified as Pa-
tient Disclosure of a Block, which receives a SASB code of Disclosing and
Expressing (2-2) and an EXP code reflecting the patient's ability to react
emotionally and acknowledge such a reaction (≥ 3).

A final refinement of the model involved Component 4 (Exploration of
Component, we reasoned that it may not be an essential part of the resolution
process as currently defined. At this point in our research, we speculate that
either the exploration of the interpersonal schema is embedded in the entire
resolution process or that it is unreasonable to expect many clear-cut in-
stances of it early in treatment, considering that our data set only includes
events occurring within the first third of a 20-session protocol. This will
need to be clarified in future research.

The refined model is presented in Figure 10.3. This consists of four com-
ponents, including five patient operations and three therapist behaviors, or
eight subcomponents taken altogether. Each of the subcomponents was op-
erationalized using criteria on multiple process measures, in the same way
as before.

To evaluate raters' ability to reliably identify these components on the ba-
sis of the operational criteria, an intrarater reliability study was conducted
using eight 6-minute segments drawn from the four resolution sessions. For
two raters blind to session number, patient, and therapist, the estimate
(kappa) was .67.

Pilot Verification Study II: Sequential Analysis

As a way of more rigorously mapping out the sequence of transitions among
the model components, we conducted confirmatory sequential analyses on
the four rupture resolution events. To test important hypothesized se-
quences, both within the components (between subcomponent therapist and
patient operations), and between components, lag one sequential analyses
were conducted using the program ELAG (Bakeman & Gottman, 1986) on
the level of the subcomponents or the eight specific patient and therapist
behaviors. Because the four rupture resolution events included only 183 coded
behaviors, the analyses proceeded in a stepwise progression, confirming first
the sequences within the components and then the sequences between each
component and the following subcomponent. A general model representing
the overall structure of rupture resolution (from component to component)
was subsequently abstracted from the results of these analyses. The study-
wise alpha levels were divided by the number of sequences for which tests
were performed (Bonferroni correction).

The first step in the analysis of resolution events evaluated the hypothe-
sized sequences within each of the four components (see Figure 10.4). This
involved a sequential analysis of the 183 coded behaviors for which seven
sequences were tested. What we found was a significant forward (z = 7.46,
( \leq 5) and backward (z = 3.01, ( \leq .05) sequence between the rupture
withdrawal marker (P1) and the therapist focusing the patient on his or her
immediate experience (T1), which confirms Component 1 (C1). In terms of

2The confirmation process entailed establishing the significance of sequences beneath...
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Component 1
Attending to the Rupture Marker

Patient rupture withdrawal marker
SASB: 2-5, 2-6, or 2-8
P-EXP: < 2
CVQ: X or L

Therapist focuses patient on immediate experience
SASB: 1-4 or 1-2 (+/- 2-2)
T-EXP: ≥ 2-3

Component 2
Exploration of Rupture Experience

Patient expresses negative feelings mixed with rupture marker
SASB: 2-2 and 1-5, 1-6, 2-5, 2-6, or 2-8

Therapist facilitates self-assertion
SASB: 1-4 or 1-2 and/or 2-2
T-EXP: ≥ 2-3

Component 3
Exploration of Avoidance

Patient discloses block
SASB: 2-2
P-EXP: 3

Therapist probes block
SASB: 1-4 or 1-2

Patient explores block
SASB: 2-2
P-EXP: ≥ 3
CVQ: F or E

Component 4
Self-Assertion

Patient self-asserts
SASB: 2-1 or 2-2

Therapist validates expression
SASB: 1-4 or 1-2 (+/- 2-2)
T-EXP: ≥ 2-3

Figure 10.4. Confirmatory lag one sequential analysis of sequences within the components (N=183).

Component 2 (C2), there was a similar forward (z = 10.06, p < .001) and backward (z = 5.04, p < .001) sequence between a patient partial assertion (P2) and a therapist facilitation of self-assertion (T2). The bidirectionality evidenced with regard to both these components is consistent with our observation that the exploratory process in both contexts often has a circular or repetitive quality that deepens as it progresses.

As for Component 3 (C3), a patient disclosure of block to exploring a rupture experience (P3) was significantly followed by a therapist probe of the block (T3) (z = 5.26, p < .001), which in turn was significantly followed by
a patient exploration of avoidance (P4) \((z = 5.56, p < .001)\). Finally, there was a significant sequence from a patient expression of self-assertion (P5) to a therapist focus on immediate experience (T1) \((z = 3.46, p < .01)\), which confirms Component 4 and supports the hypothesis that it is important for the therapist to respond to the patient’s self-assertion in a validating fashion.

The second step of the analysis involved confirming the sequences following the first three components. Because the overall number of coded behaviors was small, three separate sequential analyses were conducted, one for each of the components. For example, the first analysis only analyzed the sequences following Component 1 (C1). This involved recoding our original data set of 183 coded behaviors so that, where P1 was followed by T1, we inserted instead a single code identified as C1. The first analysis was conducted on 154 coded events (see Figure 10.5). It tested the hypothesis that Component 1 (Attending to the Rupture) would be followed by either of two patient behaviors: Patient Mixed Expression (P2) or Patient Disclosure of Block (P3). Therefore, two sequences were tested. Both sequences were significantly evidenced \((z = 2.33, p < .05\) and \(z = 4.24, p < .001\), respectively). This confirms the hypothesis that the resolution process tends to follow the two pathways of Exploration of Rupture Experience and Exploration of Avoidance.

The second analysis involved only the sequences following Component 2. It was conducted on 142 coded behaviors, which included the insertion of the code C2 where P2 was followed by T2 in the original data set (see Figure 10.6). It was found that the Exploration of Rupture Experience (C2) was significantly followed by Component 4 (Self-Assertion) \((z = 2.82, p < .01)\), thus confirming the hypothesized sequence between Components 2 and 4 in the resolution process. Exploration of Rupture Experience appears to facilitate direct self-assertion and individuation, suggested by the patient’s movement toward the independence pole of the SASB control dimension.

The third analysis analyzed only the sequences following Component 3. It was conducted on 175 coded behaviors, which included the insertion of C3 where the sequence of P3 to T3 to P4 occurred (see Figure 10.7). The exploration of Avoidance (C3) was significantly followed by the therapist focusing the patient on his or her immediate experience (P1) \((z = 2.77, p < .01)\). This result confirms the hypothesis that there is an interplay between Components 2 and 3 where the therapist behavior of focusing the patient on immediate experience is the link. This suggests a sequence in which the patient’s exploration of his or her avoidance becomes progressively deepened, as the therapist attends to any indications of this avoidance, probes for the patient’s subjective experience, and maintains a focus on the here and now, both through redirection of attention (e.g., “What are you experiencing now?”), and empathic reflection.

Although it was impossible to unequivocally confirm the overall structure of the rupture resolution model from these stepwise analyses because of the small size of the data set, it is possible to infer such a structure, working back and forth from the hypothesized model and the separate analyses. Such an inference can only be made with the realization that the model is particularly susceptible to Type I error. Therefore, we present the following overall structure as strictly preliminary in nature, but with the intent of conveying a gestalt of the entire resolution process.

In Figure 10.8, following the occurrence of attending to a rupture withdrawal marker (C1), two different directions seem to emerge: one involving Exploration of Rupture Experience and then Self-Assertion (C2 to C4); the other involving Exploration of Avoidance (C3). Both these pathways appear to be followed by therapist responses that are validating,
In this clinical illustration of the rupture resolution process, the patient began the next session without making any reference to the previous session. Instead, he talks about his frustration with his supervisor at work:

**P1: Patient Withdrawal Marker**

In this clinical illustration of the rupture resolution process, the patient began the next session without making any reference to the previous session. Instead, he talks about his frustration with his supervisor at work:

**P:** Had a little talk with the boss yesterday about things. I don’t feel terribly satisfied. I suppose I got some things said that I’ve been waiting to say for a long time, but I never got much back from her, you know, so it leaves me feeling basically unsatisfied.

**T1: Focus on Immediate Experience**

The therapist responds to the patient withdrawal marker by empathizing with his feelings about the boss and attempting to establish a focus on the here and now of the therapeutic relationship:

**T:** So. You tried to bring things out in the open with your boss. You brought out a number of things you had been reluctant to, and you were left feeling sort of confused and unsatisfied. You know, as you’re talking right now, I can’t help, I guess in my own mind thinking back to our last session. That seemed to me to be the kind of situation in which you were unhappy and frustrated, and you were kind of confronting me, and I’m wondering how that resolved for you?

By establishing and maintaining a focus on the patient’s immediate experience and on the here and now of the therapeutic relationship, the therapist facilitates the exploration of two parallel paths. One path involves the exploration of the rupture experience (e.g., negative sentiments toward the therapist), while the other path involves the exploration of fears, beliefs, and expectations that inhibit the exploration of the first path. There appears to be a shuttling back and forth between these two paths, with the exploration of inhibiting beliefs or expectations subsequently facilitating the exploration of avoided experience, and the exploration of avoided experience helping the patient to contact fears and beliefs that inhibit this exploration.

**P3: Disclosure of Block**

In this stage of the process, the patient begins to disclose his or her hesitation about exploring the avoided experience, either in anticipation of this prospect or as a result of having begun to explore and express the experience. In the current session, in response to the therapist’s inquiry about any unresolved feelings from the previous week’s session, the patient responds:

**P:** Well, I guess I sort of was putting that issue on the back burner. I mean, it was on my mind. It was there for me this morning. You know, “Well, am I going to follow through or not, or are we going to follow through on...
that?" You know—"Am I going to bring it up again—will I make an issue of it?"

3: Therapist Probes Block

his disclosure leads to an attempt on the therapist's part to clarify the na­re of the patient's avoidance, or the nature of the fears, beliefs, and/or .pections inhibiting the exploration and/or expression of avoided experi­ice. In the current session, the therapist asks the patient to elaborate on his servations about bringing it up again or "making an issues of it." The ther­ist responds to the patient's statement that "We never followed that rough" with the question: "What stopped you from pushing things further st week?" At a later phase of the session, the therapist asks him, "What could be the risk of asking Bill in now?"

4: Exploration of Block

his consists of an exploration of the fears that block the expression of neg­ive sentiments. In the current session, the patient responds, "I guess I'm \raid that if we did ask Bill in and talk about it, I wouldn't really feel any etter about it anyways." In response to further probes he indicates:

Part of the risk is that there's nothing we can really do of any substance­al nature, that I will be left with my negative feelings—and whatever we can do in the context of this thing is not really going to—resolve any negative feelings about it, and I will be left with negative feelings.

2: Mixed Expression of Feelings

he following excerpt illustrates the process of beginning to express neg­ative sentiments and then withdrawing:

When we started out, you indicated that Bill [the observer] wasn't there at the time, but that he might show up sometime during the session. It's not a big deal, though.

ere, the patient begins to express dissatisfaction with the way in which things were handled during the previous session. His use of the term "we," however, indicates his reluctance to express anger at the therapist for being responsive and also precludes the exploration of his own possible role in pushing things further. He also minimizes the importance of the issue by qualifyng, "It's not a big deal, though."

In a somewhat later section of this session, after the patient has spoken out his dissatisfaction with the preceding session, the therapist asks las him if he is currently dissatisfied. In response to this probe, the patient sponds:

P: I guess I do feel dissatisfied. I'm not sure—I don't know—maybe, maybe I'm looking to you to spoon-feed me or something. You know, tell me what is reasonable to do in this situation.

Here, the patient begins to acknowledge his dissatisfaction but, rather than taking the risk of articulating the nature of his dissatisfaction fully and making it clear what he wants, he turns to the therapist for some cue as to how he should handle the situation or what kind of demand on his part would be acceptable. There is thus some expression of negative sentiments mixed again with a withdrawal.

T2: Facilitation of Self-Assertion

In some instances, the therapist helps to sharpen the exploration of the rupture experience by directly asking the patient what he or she wants in the present moment. For example, in this illustration, he asks the patient:

T: What would satisfy you with me right now? Do you have any sense of what you want, and whether you are getting what you want right now?

In other instances, the therapist may facilitate a more direct, self-assertive response, by suggesting that the patient try an experiment of directly expressing sentiments or asking the therapist for something he or she wants. For example, a patient suggests tentatively that she may be a little irritated with the therapist, but that it's not very important (P2: Mixed Expression of Feelings), and the therapist suggests that the patient try the experiment of saying directly to the therapist "I'm angry at you" without qualifying it. This may help the patient access underlying feelings of self-assertion or alternatively may help the patient contact fears and beliefs, which may interfere with such feelings.

P5: Self-Assertion

Through a combination of exploring the avoidance to expressing the rupture experience and mixed expressions of the negative feelings that are responded to empathically by the therapist prompts designed to facilitate self-assertion, the patient eventually moves to a position of being able to express his or her feelings in a more direct, self-assertive fashion.

In the current case, the patient gradually moves increasingly toward this assertive position.

P: Is one of the options for me to say "I don't want Bill behind there"?
T: Yes.
P: Is one of the options for me to say, "I don't want anybody behind there"?
T: Yes.

P: Actually one of the thoughts that occurred to me last week was, well, OK, I suppose one of the reasons the observers are behind the mirror is because it's supposedly a nonobtrusive observation. Except that there is a lot of noise going on back there, which you know, now that it's becoming an issue, I'm very conscious of it. So in that sense it's not really unobtrusive. What would be wrong with having them in the room, so that there could be more of an ongoing relationship?

This is still one step short of directly stating what he wants, but it nevertheless constitutes a considerable risk that will test his belief that his demands are excessive and that articulating them will be futile or dangerous. The therapist's response is a direct and unequivocal "Yes." A more ambiguous response might be experienced by the patient as hedging and might be less likely to challenge his dysfunctional belief that it is futile to self-assert. The energetic and enthusiastic style with which the patient makes a suggestion likely to challenge his dysfunctional interpersonal schema.

CONCLUSION

Our findings to this point are preliminary. The pilot verification studies, while encouraging, need to be extended with a larger sample. For this purpose, it would be ideal to select one resolution and one nonresolution event or session from the same subject. In this manner, each subject can serve as his or her own control, thereby ruling out the possibility that differences between rupture resolution and nonresolution events are attributable to patient characteristics, rather than dynamic and potentially malleable features of the patient-therapist interaction. The sequential analyses provide a more rigorous way of capturing patterns of transition between resolution components than would a purely descriptive analysis, and the results are encouraging in that they are theoretically coherent and intelligible. To constitute a true test of the hypothesized model, this type of analysis will have to be replicated on new samples of patients and therapists.

REFERENCES


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