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CLUSTER ANALYSIS

OF PATIENT-REPORTED THERAPEUTIC ALLIANCE RUPTURES

A dissertation submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

to the faculty of the department of

PSYCHOLOGY

at

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by

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ABSTRACT

CLUSTER ANALYSIS

OF PATIENT-REPORTED THERAPEUTIC ALLIANCE RUPTURES

Robin Jilton

The notion of the therapeutic alliance derived from the early psychoanalytic literature and eventually gained appeal as a transtheoretical construct. By the 1980s, empirical evidence began to accumulate that the therapeutic alliance was one of the best predictors of psychotherapy outcome. Interest has since grown in problematic alliances, or alliance "ruptures." Investigators at Beth Israel Medical Center's Brief Psychotherapy Research Program in Manhattan are intensively studying interpersonal behavior in psychotherapy in order to better understand the nature of alliance ruptures, the process of rupture repair, and the effects of these occurrences on outcome and drop-out rates. They have made progress in developing objective criteria for identifying rupture events and a system of rupture classification based on third-party behavioral observation. Efforts have also begun at Beth Israel to incorporate the subjective experience of patients and therapists into the rupture construct. As a contribution to these efforts, the current study addressed methodological problems encountered in previous pilot studies by the author (Jilton, et al.,
1994, 1995). The current study used an exploratory approach to identify therapeutic misalliances reported by patients in their own words, and generated an empirically based typology of these rupture events using cluster analysis methodology. Written patient reports of alliance ruptures were collected from the Post-Session Questionnaires (PSQs) of 15 patients who received therapy within the research program at Beth Israel. One hundred independent raters assessed the degree of similarity between 75 paired patient statements, and these numerical values were transformed into a dissimilarity matrix and subjected to a hierarchical cluster analysis. Eight categories of ruptures were identified and named: "Feeling judged and incompetent," "Feeling attacked and defensive," "Patient is assertive and challenging toward therapist," "Feeling frustrated and angry," "Feeling misunderstood," "Difficulty trusting and being open," "Confusion about how to respond and express feelings in therapy," and "Feeling pressured to accept therapist's task or agenda." Categories were validated by five judges who matched clustered items to cluster headings with 100% accuracy. The results are examined in the context of existing theory and research, and implications for treatment and further research are discussed.
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TABLE OF CONTENTS

ACKNOWLEDGMENTS.................................................................ii

LIST OF TABLES.................................................................vii

LIST OF FIGURES.................................................................viii

LIST OF APPENDICES............................................................ix

INTRODUCTION........................................................................1

The Therapeutic Alliance.......................................................1

Therapeutic Alliance Ruptures...............................................10

Empirical Research Into Ruptures and Their Resolution.............14

Pilot Study.............................................................................25

HYPOTHESIS...........................................................................33

METHOD.................................................................................34

Participants............................................................................34

Patients.................................................................................34

Therapists..............................................................................37

Raters...................................................................................37

Materials...............................................................................38

Post-Session Questionnaires..................................................38

Item Rating Forms.................................................................39

Procedures............................................................................40

RESULTS.................................................................................42

DISCUSSION...........................................................................57

Comparison of Results with Pilot Studies...............................57
LIST OF TABLES

Table 1. Differences Among Consecutive Fusion Coefficients Associated with Number of Clusters.........................51

Table 2. Results of Post-Hoc Analysis: Percentage of 5 Raters Who Correctly Matched Patient Statements to Cluster Headings..................55
LIST OF FIGURES

Figure 1. Rational-Empirical Model 1 ......................17
Figure 2. Rational-Empirical Model 2 ......................18
Figure 3. Rational-Empirical Model 3 ......................21
Figure 4. Dendogram output from cluster analysis using Ward's method .................45
Figure 5. Agglomeration Schedule using Ward's Method ....................................46
Figure 6. Dendogram showing 6-cluster solution to cluster analysis of rupture types ......47
Figure 7. Dendogram showing 8-cluster solution to cluster analysis of rupture types ......48
Figure 8. Plot of fusion coefficients against number of clusters ..........................49
Figure 9. Dendogram showing possible 2-cluster solution to cluster analysis of rupture types ..........................60
# LIST OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix A.</th>
<th>Patient Post-Session Questionnaire...........93</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix B.</td>
<td>Excerpt from Rater Form..........................98</td>
</tr>
<tr>
<td>Appendix C.</td>
<td>Rater Demographic Sheet..........................99</td>
</tr>
<tr>
<td>Appendix D.</td>
<td>Patient-Reported Rupture Items..................100</td>
</tr>
<tr>
<td>Appendix E.</td>
<td>Cluster Naming Form..............................105</td>
</tr>
<tr>
<td>Appendix F.</td>
<td>Judges' Independent Suggestions for Cluster Names..........................112</td>
</tr>
<tr>
<td>Appendix G.</td>
<td>Cluster Headings with Corresponding Items..................114</td>
</tr>
</tbody>
</table>
Introduction

The current investigation attempts to elucidate key
types of problematic patient-therapist interactions, from
the perspective of patients within a short-term dynamically
oriented psychotherapy. In this study, an exploratory
approach was used to discover the kinds of interpersonal
difficulties in the therapy setting that are prominent or
troubling for patients. Cluster analysis methodology was
used to derive a typology of these so-called patient-
reported alliance ruptures. It is hoped that the resultant
categories will serve as a heuristic for clinicians, and
provide a basis for further research.

The Therapeutic Alliance

The concept of the therapeutic alliance originated in early
psychoanalytic literature. Writing in 1913, Sigmund Freud
said that in his experience, the technical work of
psychoanalysis could not commence until a "proper rapport"
was established between patient and analyst:

It remains the first aim of the treatment to attach him
[the patient] to it and to the person of the doctor.
... If one exhibits a serious interest in him,
carefully clears away the resistances that crop up in
the beginning and avoids making certain mistakes, he
will of himself form such an attachment. (Freud,
1913/1958, p. 139)
Freud distinguished this aspect of the patient's relationship with the therapist from what he labeled the "neurotic transference" (i.e., the fantasies and repressed wishes derived from early childhood and displaced onto the analyst). He described the former--this prerequisite rapport--as "friendly or affectionate feelings, which are admissible to consciousness, ... and which are the vehicle of success in psychoanalysis" (Freud, 1912/1958, p. 105).

The notion of a facilitative relationship is found throughout the early psychoanalytic literature, although the concept was often not clearly distinguished from what analysts termed the "transference." Sterba (1934) wrote of the necessity of a certain amount of "positive transference" toward the analyst in order for the patient to develop "intellectual contemplation" of his unconscious processes (i.e., what is known as an observing ego). On the basis of this positive transference, "a transitory strengthening of the ego takes place through identification with the analyst. ... From the outset the patient is called upon to 'co-operate' with the analyst against something in himself" (p. 121). Similarly, Fenichel (1941) referred to the "rational, aim-inhibited positive transference" that made an individual suitable for analysis. Stone also spoke of the patient-therapist rapport in terms of transference. He referred to it as the "mature transference," in contrast to
what he called the unconscious “primordial transference” (Stone, 1961, p. 106). Stone allotted great importance to this positive aspect of the relationship, claiming it was essential for a successful analysis (Stone, 1961).

Elizabeth Zetzel (1956) actually coined the term "therapeutic alliance" and elevated its importance by clarifying that the two major schools of psychoanalysis (the classical and the “British School” of object relationists) could be differentiated by their relative emphasis on this part of the transference. Greenson (1967) devoted considerable attention in his well-known text, The Technique and Practice of Psychoanalysis, to describing the importance of what he termed the "working alliance." He explained that his preference for this term stemmed from its emphasis on the patient’s ability to work in the analytic situation. He defined the working alliance as comprised of the patient’s motivation, his willingness to cooperate, and his ability to follow the instructions and insights of the analyst. He elaborated factors affecting the working alliance, which included the patient’s preconceptions, his feelings about exposing himself, and his responses to the therapist’s method and personality.

In contrast to the analysts, Rogers (1951, 1957) pioneered efforts to define the active components of the therapeutic relationship in terms of therapist behavior,
rather than in terms of patient perception, motivation or behavior. He identified the three therapist-offered conditions of empathy, unconditional positive regard, and congruence as necessary conditions for therapeutic change. His client-centered theory was influential in providing a base for empirical exploration into the effects of process variables and inspired considerable research, although the three variables he named did not correlate with change across therapies as well as it was originally thought they might (for reviews see Gelso & Carter, 1985; Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978).

Interest in the therapeutic relationship, however, has only continued to grow, becoming a dominant focus among psychotherapy theorists and researchers in the past decade and a half. Several developments in research, theory and instrument development have contributed to this trend. At the conclusion of the long-term Menninger Clinic study, Horwitz (1974) reported on data collected over a 15-year period involving 42 patients, half of whom received formal psychoanalysis, and half psychoanalytically-oriented psychotherapy. He concluded that there was no significant difference in outcome according to treatment mode, but that the major contribution of the study "is the indication that the therapeutic alliance is not only a prerequisite to therapeutic work, but often may be the main vehicle of
change." In 1977, Smith and Glass presented a much more comprehensive picture of comparative outcomes when they published a large-scale meta-analysis, which included data from nearly 400 controlled outcome studies encompassing a full diversity of modalities. Their findings revealed that while most patients benefit from psychotherapy, no particular type of treatment is consistently more effective than any other. Much of early psychotherapy research had involved comparing treatment outcomes. The finding by Smith and Glass, however, put into question the usefulness of looking for simple differences among treatment outcomes.

Around this time, Bordin (1979) published a watershed theoretical article, in which he suggested that the psychoanalytic concept of the working alliance could be generalized to encompass all approaches to psychotherapy (indeed, to encompass any type of "change situation," including teacher/student, etc.). Further, he proposed that the working alliance "is one of the keys, if not the key, to the change process" (italics his). Bordin's crucial contribution was his definition and elaboration of the working alliance in terms that made it universally applicable. In all psychotherapy, he offered, the strength of the alliance is a function of three interrelated features: "an agreement on goals, an assignment of task or a series of tasks, and the development of [interpersonal]
bonds." The agreement on tasks and goals, he said, could be either implicit or explicit. As for the bond component, he defined this as the "human relationship" between therapist and patient that includes liking or disliking, basic trust, and attachment. So, although the content may change among therapies (e.g., the tasks may vary from free association to graded exposure), Bordin argued that the elements of collaboration between patient and therapist have more to do with the effectiveness of the therapy than the particular methods chosen.

With new knowledge about equivalency of therapy outcome across modalities, and with a transtheoretical conceptualization of the therapeutic alliance, psychotherapy researchers began to focus more of their attention on the therapeutic alliance as a universal process variable. Increasingly, they turned away from the study of isolated therapist behaviors and began to study more complex interactions between treatment and other variables, including the interpersonal context of the treatment. This marked the shift towards the study of so-called "nonspecific," transtheoretical relationship factors involving both patient and therapist.

In order for the therapeutic alliance to become a candidate for intensive study, instruments first had to exist to measure it as objectively as possible. During the
1980s, different research centers developed distinctive methods of quantifying the working alliance. Examples include the California Psychotherapy Alliance Scales (CALPAS), (Marmar & Gaston, 1988); the Vanderbilt Therapeutic Alliance scale (Hartley & Strupp, 1983); the Penn Helping Alliance Rating Method (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983); and the Working Alliance Inventory (Horvath & Greenberg, 1987). Some of these measures were rating systems for therapist and observer raters, and others were formatted as patient questionnaires. The Working Alliance Inventory (WAI) is a patient questionnaire that uses Bordin's tripartite conceptualization (bond, goal and task). It has been widely adopted in research and is the self-report scale used within the Brief Psychotherapy Research Program at Beth Israel Medical Center. Fortunately for researchers who are interested in the construct of the therapeutic alliance as a process variable, numerous studies have indicated substantial intercorrelation among the different alliance measures (Bachelor, 1990; Hansell, 1990; Saburin, Hansell, Gutfreund, Gaston, & Marmar, 1990; Safran & Wallner, 1991; Tichenor & Hill, 1989).

Alliance instruments allowed for empirical exploration of the claim made by earlier theorists that a positive therapeutic alliance is prerequisite for change in therapy.
Using the alliance scales, investigators looked at the impact of the therapeutic alliance on a broad range of outcome indices, across a range of client problems, in all major forms of psychotherapy, and from different perspectives (Alexander & Luborsky, 1986; Frank & Gunderson, 1990; Greenberg & Webster, 1982; Hartley, 1985; Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990; Marmar, Weiss, & Gaston, 1989; Marziali, 1984; Rounsaville et al., 1987; Suh, O'Malley, Strupp, & Johnson, 1989; Tichenor & Hill, 1989). Empirical research began to accumulate which showed that regardless of therapy modality, the therapeutic alliance was an important predictor of outcome. For example, Hartley and Strupp (1983) showed that higher scores on alliance measures related to better outcome, with both patient and therapist scales after the first quarter of therapy discriminating good from poor outcome groups at the end of treatment. Similarly, Marmar, Gaston, Gallagher and Thompson (1989) showed that both patient and therapist rated alliance factors from the CALPAS were related to outcome across behavioral, cognitive, and brief dynamic treatments. The Penn Helping Alliance scales, measured during the third and fifth session, were found to significantly predict the outcome of psychodynamic psychotherapy (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982).
While some within the cognitive therapy tradition have de-emphasized the importance of the therapeutic alliance (e.g., Ellis, 1962), there is evidence of its prominent role within this specific form of treatment. In a study of 53 patients completing pre- and post-session ratings over 20 sessions of cognitive therapy, change in cognition and the quality of the therapeutic alliance were found by regression analyses to be the two best predictors of outcome (Muran et al., 1995). The therapeutic alliance predicted ultimate outcome (measured by eight patient and therapist-rated outcome variables) better than changes across individual sessions in anxiety, depression and optimism.

In a meta-analysis, Horvath and Symonds (1991) examined 20 data sets relating the equality of the working alliance to therapy outcome and found that the quality of the alliance was a robust variable linking therapy process to outcome. Further, Lambert, Shapiro and Bergin (1986) found that nonspecific factors (such as patient expectations and the therapeutic alliance) accounted for up to 45 percent of outcome variance, while specific factors (such as treatment intervention) contributed only about 15% of the outcome variance. (For review articles of studies predicting outcome from alliance measures, see Luborsky, Crits-Christoph, Mintz, & Auerbach, (1988), and Orlinsky & Howard, (1986).)
Therapeutic Alliance Ruptures

Given the accumulating empirical evidence in support of what theorists had suspected—that a positive therapeutic relationship is a crucial factor in successful therapy—curiosity arose among a number of theorists and researchers about the converse issue. That is, they began to look at problematic interactions for clues to what was going wrong, and how poor alliances might be improved in the service of better outcome. Thus, the concept of the therapeutic alliance "rupture" (also known as "impasse" or "breach" or "strain") began to draw attention.

As early as 1913, Freud alluded to factors that could impede the development of a positive therapeutic relationship:

It is certainly possible to forfeit . . . success if from the start one takes up any standpoint other than one of sympathetic understanding, such as a moralizing one, or if one behaves like a representative or advocate of some contending party—of the other member of a married couple, for instance. This answer of course involves a condemnation of any line of behavior which would lead us to give the patient a translation of his symptoms as soon as we have guessed it ourselves, or would even lead us to regard it as a special triumph to fling these 'solutions' in his face.
at the first interview. . . . Behavior of this sort will completely discredit oneself and the treatment in the patient's eyes and will arouse the most violent opposition in him, whether one's guess has been true or not. . . . As a rule the therapeutic effect will be nil. (Freud, 1913/1958, p. 140)

A central emphasis of self-psychology theory is the "empathic failure" of the therapist within treatment and the patient's negative response to it. Kohut (1984) articulated the importance of "empathic failures" from the viewpoint of self psychology theory. He suggested that working through and resolving such inevitable breaches constitutes a "corrective emotional experience," which is a key element in therapeutic change. Viewed this way, problems in the therapeutic relationship gain importance beyond being a source of poor therapy outcome; they can be viewed as a critical point for intervention. Use of the term "empathic failure," however, focuses attention on the therapist, as Rogers had done, and does not clearly convey the interactional nature of the process. As Safran (1993a) points out, the commonly used term "resistance" in psychoanalytic literature also fails to recognize the contributions of both parties, placing the responsibility primarily on the patient.

Safran is a leading theorist in the area of alliance
ruptures, and has made important contributions to the study of the interpersonal processes involved in the phenomenon. He defines a therapeutic alliance rupture as "a negative shift in the quality of the therapeutic alliance or an ongoing problem in establishing one" (Safran, 1990). This shift can range from subtle to intense, and can endure briefly or for a longer period. In some cases, ruptures may go undetected by the therapist or remain out of awareness for the patient and may not significantly obstruct therapeutic progress. In more extreme cases, they may lead to dropout or treatment failure.

Safran's theory integrates concepts from cognitive, interpersonal, and self psychology theories. It stresses, as did Kohut, that alliance impasses are a key aspect of therapy. Safran believes that this is because the experience of working through impasses is an important learning experience in how to negotiate relatedness, and is an opportunity for patients to clarify factors that may have impeded relatedness in the past. Specifically, repairing alliance ruptures can help the patient to develop a view of him or herself as "capable of attaining relatedness, and other people as potentially available emotionally," within the context of one's existential separateness (Safran, 1993a; Safran, 1993b; Safran & Segal, 1990). Previous research by Foreman and Marmor (1985) seems to support the
notion of the value of attending to ruptures in treatment. These researchers studied the factors distinguishing between poor therapeutic alliance cases that improved over the course of treatment and those that did not. They found that in the improved cases, therapists directly addressed problems in the therapeutic relationship, whereas in the other cases they did not.

A number of theorists have proposed methods for resolving ruptures. Safran, Crocker, McMain and Murray (1990) have outlined metacommunication principles in this regard, which stress the need for therapists to explore the rupture process collaboratively with the patient. Safran and Muran (1995) reviewed an array of strategies for rupture repair proposed by diverse theorists. They categorized these strategies into direct and indirect methods, and subdivided them further into strategies that address the bond component of the alliance and those that address the task and goal components. Direct types of interventions include providing rationales for treatment, suggesting exercises to help patients gain a concrete understanding of therapy tasks, clarifying misunderstandings, and exploring the patient's core interpersonal themes (through transference interpretations or discussion of schemas). Indirect strategies include simply changing the task or goal, reframing the meaning of
the task or goal, providing empathic reframing of the patient's behavior, and intentionally acting in a way that disconfirms the patient's expectations and provides a new, constructive interpersonal experience. It seems likely that understanding ruptures will lead to more tailored and effective clinical strategies for dealing with them, resulting in a stronger alliance and improved outcome. The various theories and strategies, however, require some verification.

**Empirical Research Into Ruptures and Their Resolution**

Investigators at Beth Israel Medical Center's Brief Psychotherapy Research Program, led by Safran and Muran, have made some of the earliest attempts in the field to construct research-based theories about the nature of alliance ruptures, the process of rupture repair, and the effects of these occurrences on outcome. The first critical tasks in this area of research have been to operationally define and classify ruptures, and develop reliable and valid methods for identifying rupture events. In Safran's early efforts to define rupture events, he and his colleagues flagged sessions in which both the patient and therapist had noted alliance problems on post-session questionnaires (Safran, 1984a; 1984b; 1990a; 1990b; Safran & Segal, 1990). Audiotapes of these sessions were then intensively studied to identify themes. From these observations, the
researchers were able to label seven prominent "markers," or types of client behaviors signifying problematic interactions. These client markers were: overt expression of negative sentiments; indirect communication of negative sentiments or hostility; disagreement about the goals or tasks of therapy; over-compliance; avoidance maneuvers; self-esteem-enhancing operations; and non-responsiveness to intervention.

These seven types of markers were eventually condensed into two main categories: (1) confrontation ruptures (in which the patient directly expresses negative sentiments toward the therapist) and (2) avoidance of confrontation ruptures (in which the patient deals with the breach through withdrawal, distancing or avoidance) (Safran et al., 1990). Based on more recent research, Safran has reported that the distinction between confrontation and avoidance ruptures is not so clear cut, and that patients often present with a combination of both markers--for instance, blaming the therapist and then feeling anxious about direct expression of needs, followed by some form of withdrawal.

Identification procedures were further developed to locate objectively sessions in which ruptures were followed by successful resolution, based on convergent patient and therapist ratings of WAI items on post-session questionnaires (see Safran, Muran, & Wallner Samstag, 1994).
Next began a microanalysis of the therapist-patient interactional patterns that denote the onset of ruptures, define their sequence, and that signify their successful resolution. Using multiple process measures, a stage model was developed for the rupture resolution process, based on explicit operational criteria (Safran et al., 1994) (see Figure 1). In the original model for withdrawal, or "avoidance of confrontation" ruptures (estimated by Safran to be the most common type), the resolution process appeared to proceed through four stages: (1) patient withdrawal rupture marker (avoidance of direct confrontation of the therapist), (2) partial expression of avoided negative sentiments, (3) patient explores avoidance (fears, beliefs, and expectations blocking the expression of negative sentiments), and (4) patient explores interpersonal schema (which generalizes to other interpersonal situations). Each of the stages also consists of therapist subcomponents, with the therapist's activity aimed at facilitating the patient's exploration and expression.

In a subsequent revised model (see Figure 2), based on further research and refinements, Stage 4 of the sequence was dropped, as it was found to occur too infrequently and did not appear essential for resolution of ruptures within session. In fact, it was found that premature interpretation linking the rupture to other situations
outside of therapy often led to defensiveness and obstruction of further exploration. Stages 2 and 3 of the model were also expanded. In the current model, the sequence ends with therapist validation of the patient's self-assertion, which is now seen as an important step in resolution.

Work continues to refine, verify and test the utility of the model, and to develop a separate model for confrontation type ruptures. Initial research support for the current model has been found (Inck, 1995; Muran, Safran, Inck, Wallner Samstag & Winston, 1995; Safran and Muran, 1996; Safran, Muran & Inck, 1995; Twining, 1995). The most recent direction in model development involves inclusion of individual patient formulations, using an objective scale called the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1990). The CCRT codes a patient's wishes, needs, expectations and responses in relation to another person. This scale has provided new insights, particularly in helping to distinguish primary, authentic emotions (related to underlying wishes and vulnerabilities, usually more focused on the self) from secondary emotions (which are internal reactions to primary emotions, can serve as defensive coping strategies, and are usually focused on the other person). Both types of emotions may be experienced and expressed in the rupture sequence.
but it is helpful to differentiate them. The original rupture marker is typically a secondary emotional response, based on an underlying wish or primary emotion. The therapeutic goal is to help the patient express the wish or primary emotion, while the therapist disconfirms the patient's maladaptive expectations of the response of other (Safran and Muran, 1996). The CCRT, then, has enriched the resolution model by including inferences about the patient's internal experience (Figure 3).

Beyond model development and testing, the rupture resolution research program focuses on treatment development and treatment evaluation. These final stages interact with and inform further model development. A pilot research project was funded by the National Institute of Mental Health (NIMH) to study the efficacy of a treatment modality specifically designed to resolve therapeutic alliance problems with patients identified as potential treatment failures (Safran, Muran, Winston, & Samstag, 1994). Patients identified as having difficulty establishing a therapeutic alliance are offered the option of transferring to another treatment condition, and are then randomly assigned to a standard treatment or the experimental treatment, the latter of which is based on the rupture resolution process research.

This and other studies within the program at Beth
Israel are noted here as examples of ways in which difficulties in the therapeutic alliance have been studied and understood. From this perspective, ruptures are seen as observable behavioral events, which can be detected and evaluated by an outside examiner. This is a useful perspective, because of its objectivity and amenability to empirical verification. It helps us to understand the sequence of observable behaviors involved in an intricate interpersonal dance, which takes place within the therapeutic dyad. To gain insight into the psychological processes underlying the behavior, however, it may be helpful to collect more subjective information from those individuals actually involved in the dance.

Inherent in the very concept of the alliance rupture is a breakdown in relations, often signaled by shut down in communications on the part of the patient. In many instances, there is a tendency for both parties to avoid discussing what they are thinking and feeling. Lacking open dialog, much must be inferred about the patient's emotional experience and evaluations of himself, the therapist, and the situation. Realizing that central to the rupture and resolution phenomena are the subjective experiences of the patient and therapist, Beth Israel researchers have made efforts to gain access to these personal experiences through various means. As described above, inclusion of idiopathic
formulations based on the CCRT is one step in this direction. As another example, Winkelman (1995) used Beth Israel data to develop a patient self-report measure of rupture resolution indices within treatment.

Beth Israel researchers have also made use of a specialized interview known as Interpersonal Process Recall (IPR). IPR has played dual and complementary roles in Beth Israel’s research, serving as a tool for both hypothesis confirmation and theory building (Batchelder & Jilton, 1994). This method was developed originally by Kagan (1980) and involves the review of videotaped session material to elicit recall of the participant’s subjective experience during a selected session. A trained interviewer sits with the patient (or in some cases the therapist) while they watch portions of the videotaped therapy session together, and then asks questions about what the participant was feeling or thinking at certain key moments in the treatment. Although colored by the passage of time and other possible influences, this method yields data that is usually more ideographic and elaborated than a likert-type self-report questionnaire or observer rating. The information gained is also quite different at times than what was predicted. For example, it may appear on the tape that the patient was sullen and angry with the therapist for a question she just asked, while during the IPR the patient instead reports
being preoccupied and upset about something that was discussed five minutes before. As Elliot (who has made extensive use of IPRs as a way to investigate insight and change) asks, "would not the perceptions of the participants be more relevant for the outcome of treatment than the narrowly trained perceptions of third party observers?" (Elliot, 1986).

Investigating alliance ruptures from the unique perspective of the patient, as the project proposed here aims to do, is an attempt to clarify the rupture construct further by adding patient input. As Safran points out, the history of psychotherapy process research testifies to the fact that the patient, therapist, and third-party observer do not always agree on ratings. "Whether one chooses to use one perspective over others depends upon one's ultimate objective." (Safran, 1993a, p. 38). More specifically, the objective of this proposed research project is to develop a patient-centered classification system for ruptures, which will augment present understanding about the reasons ruptures occur, give clues to how they can be anticipated, and inform clinical interventions. As Safran explained about his own work, classification is important mainly so that interventions can be honed. "Breaches in the alliance are likely to take place for a variety of different reasons. . . . Different processes are thus likely to be
involved in healing or resolving different rupture types" (Safran, 1993a, p. 39). He notes that research in classifying ruptures has led trainees who are involved (and even experienced therapists and supervisors) to become more sensitized to the occurrence of these fluctuations, which have taken on new meaning. Where therapists previously tended to avoid or "seal over" problems in the relationship, they became more likely to address them non-defensively, despite initial feelings of discomfort (Safran et al., 1990).

**Pilot Study**

As a contribution to exploring the nature and causes of therapeutic alliance ruptures, Jilton et al. (1994, 1995) conducted a two-phase pilot study using Beth Israel data. Its aim was to develop an empirically based system of classification for alliance ruptures, based on patient written self-reports of problems or tensions experienced in the relationship. This pilot study used content analysis procedures to identify several clusters of patient responses that appeared to represent different types of problematic therapy experiences from the patient's perspective.

The patient sample for the pilot study consisted of 32 outpatients (23 female, 9 male) receiving psychotherapy treatment through Beth Israel Medical Center's Brief Psychotherapy Research Program. All subjects participating
in the program were recruited via newspaper advertisements and were offered 40 weeks of individual psychotherapy according to a sliding fee scale. The subjects selected for the pilot study were comprised of all patients who began the study between March 1991 (when post-session questionnaires were initiated at Beth Israel) and September 1994 (when data collection for the pilot study began), and who were treated within the two main therapy modalities: Cognitive Behavioral Therapy (CBT) or a psychodynamically oriented treatment known as Brief Adaptive Psychotherapy (BAP). The mean patient age was 41 (SD = 11). Diagnostic inclusion criteria for program participants consisted of DSM-III-R Axis I Anxiety or Mood disorders excluding Bipolar Disorder, and/or Axis II Cluster C personality disorders (including Personality Disorder Not Otherwise Specified, with Cluster C features).

Exclusion criteria were intended to eliminate cases that suggested the need for medication, or for long-term or specialized treatment. These criteria included: psychotic symptoms; manic depressive illness; prominent borderline or antisocial features; history of violent behavior or poor impulse control; current alcohol or substance abuse; recent suicidal ideation; organic conditions or serious physical illness. Current use of psychotropic medication also disqualified potential subjects.
Therapists in the Brief Psychotherapy Research Program at Beth Israel included licensed staff psychologists, psychiatrists, and clinical social workers, as well as clinical trainees, all of whom volunteered to participate and attended weekly group supervision for their respective modality. For cases whose data were included in this study, there were 10 psychologists, 4 psychiatrists, 3 social workers, 1 psychology intern and 1 master’s level psychology trainee. None of the investigators for the pilot study was a therapist for the analyzed cases.

Patients in the study were instructed to complete a Post-Session Questionnaire (PSQ) after each of their 40 sessions (see Appendix A). This questionnaire was developed by Muran, Safran, Samstag, and Winston (1990) as a suboutcome measure to represent intermediate links between more molecular in-session changes and ultimate outcome. One item of the questionnaire asked patients to indicate whether there was any problem or tension with the therapist during the session. If the patient answered "yes," they were asked to rate the intensity of the problem, on a likert scale from 1 to 5. Then, an open-ended follow-up item asked them to briefly describe the problem or tension. These brief descriptions—usually a sentence or two in length—provided the data for the content analysis.

A total of 213 brief descriptions of problems were
collected from patient PSQs. The number of items was fewer than the total number of sessions (32 patients x 39 sessions = 960), because all subjects did not describe problems every week. The 213 patient responses were then reduced to 157 items, using the following criteria: items were eliminated that were close duplicates, unintelligible, or non-interpersonal in nature (i.e., non-alliance related). Five members of the senior research staff judged the items, and items were eliminated if 3 of the 5 raters (60%) believed them to be inappropriate according to the last two criteria.

The remaining 157 items in the new data set were individually printed onto separate slips of paper, coded by item number, patient number and session number. Originally, 31 raters were recruited to participate in the sorting task (Jilton et al., 1994). Eventually, a total of 102 raters participated (Jilton et al., 1995). The task took most raters at least an hour to complete. The mean age of raters was 30 (SD = 8), with 49% of these raters being therapists themselves.

Raters were each given a stack of cards containing all 157 items and were given written instructions to separate the items into categories of comments that seemed similar to one another, or that seemed to "go together." They were told they could sort them in any way that seemed reasonable or logical to them, and to make the categories as broad or
narrow as they wished, forming as few or as many categories as they wished.

Using a computer program called "Grouper," designed by Bernard Gorman, the authors recorded which items each individual rater grouped together, i.e., which statements raters placed together into piles. The Grouper program allowed for different numbers of groupings, or piles, for each rater. Using a second program, also written by Gorman, called "MDSORTB," the grouping data were converted into a similarity matrix that could be read by SPSS-PC statistical software. The numbers in the similarity matrix represented the mathematical probability of any two specified items ending up in the same group, or pile. This matrix became the data for our final analysis, which was performed through the cluster analysis module of SPSS. The output from this final analysis was a dendogram—a graphic linear display showing which items tended to cluster together most often, and to what degree. This graph was accompanied by coefficients indicating the strength of association of pairs of items located next to one another on the dendogram.

Based on this dendogram output, 10 cluster categories were identified in 1994. When the same methods were employed in a repeat analysis in 1995 using a larger number of raters, the patient-defined problems were narrowed to seven clusters. Individual items within each category were
examined for common themes, and based on this assessment the authors assigned identifying labels to the categories. The resulting named categories in the 1995 study were: (1) Difficulty with parameters and tasks of therapy; (2) Wanting to exert or maintain control (over self or session); (3) Finding therapist patronizing, insulting, objectifying, or judgmental; (4) Feeling misunderstood; (5) Wanting more from therapist; (6) Feeling threatened or angry in response to therapist; (7) Feeling vulnerable to exposure or rejection. An eighth category was provisionally identified, which was labeled "Patient's own fear of failure and incompetence." This category was not as clearly discriminated from the dendogram as the other categories.

The category titles were chosen in a subjective manner by the authors. Assigning labels was difficult, because a number of items within each cluster did not seem to conform to the predominant theme. The first author felt that the categories did not represent clear and distinct groupings, but were unduly "muddy." For this reason, these groupings were seen as "working categories," and the hope was to continue to explore the best way to capture any underlying organization of rupture types.

Because of the somewhat unique application of statistical procedures, a clear precedent did not exist for the optimum number of raters to be used and the best ratio
of raters to items. The 1995 follow-up study was conducted using the same methodology and raw data as the year before, but with twice the number of raters, to determine if a greater number of raters would produce categories that were more clear cut. The number of categories did narrow, and the authors were pleased that several of the group headings were similar to those identified earlier. However, the validity of the categories remained questionable, because the fit between items and category labels still showed some discrepancies.

In looking for possible explanations, it was noted during data entry that there was wide variability in the apparent grouping schemes and in the number of categories chosen by raters. However, there was no means for assessing rater reliability. The fact that the rater categorization strategies did not appear consistent among raters may have created undue "noise" in the statistical analysis--and thus ambiguity in the results--arising from differences in approach to the task, rather than actual disagreement among raters about the conceptual or semantic similarity of items.

Also, a number of raters complained that the large number of items was overwhelming to organize, and they found the meaning of some items confusing. The sorting task was highly time-consuming for many of the raters, taking well over an hour in some cases. The mean score reflecting how
confident raters felt in completing the sorting task was only 6.7 on a 10-point Likert scale (with 1 = not at all confident, and 10 = extremely confident).

It seemed important, therefore, to attempt this project again with an improved methodological strategy that would produce the most objective, reliable and valid results possible. An alternative methodology presented itself in a recent journal article co-authored by Mary Beth Connolly of the University of Pennsylvania, and the prominent psychotherapy researcher Hans Strupp (1996). In this article the authors explored the patient’s perspective of important psychotherapy outcomes (not alliance ruptures). Connolly and Strupp performed a cluster analysis of patient written self-reports about the most important changes patients believed they had achieved from psychotherapy. The researchers’ cluster analysis methodology represents a likely improvement over that used by Jilton et al. (1994, 1995) for two main reasons. First, it asks raters to compare pairs of items along a continuum of similarity or dissimilarity, rather than forcing them to place items in distinct categories. This allows raters to compare items without requiring them to form complex categorization schemes for large amounts of data. Using paired associations also allows for interrater reliability checks. Connolly first tried using categorical sorting in her
research, but found her results to be unsatisfactory with that method (personal communication, November 7, 1996). Another advantage of the Connolly and Strupp methodology is its reliance on the recaptured item technique (RIT), originally developed by other psychology researchers (Meehl, Lykken, Schofield, & Tellegen, 1971). RIT provides a more objective and reliable method of naming the clusters, by reducing some of the "ad hoc subjectivity" in cluster naming.

The current study attempted once again to define the types of alliance ruptures that patients experience, using a modified methodology described below.

Hypothesis

Although the scientific literature proposes rupture definitions, types and processes, these have been explored primarily from an observer perspective. Rather than aiming to confirm or disconfirm a theoretical proposition, the research project proposed here builds upon former research but is discovery-oriented in nature. It will use an exploratory approach to identify and categorize common patient-reported problems and tensions in the therapeutic relationship. The results may be used as a comparison to the types of rupture classifications derived by other means and from other perspectives. (see Mahrer (1988) for a review of discovery-oriented psychotherapy research as a "distinctly
viable alternative" to hypothesis testing, with certain advantages for scientific theory building, generating advances in psychotherapeutic practice, opening new avenues of research, and integrating theory, practice and research.)

Method

The general design for the current research study, like its preceding pilot study, is a cluster analysis of patient reported therapeutic alliance rupture events. A subset of the identical data used in the pilot project was used here. However, the procedures used to accomplish this analysis was altered from the pilot study in several important ways, in an attempt to derive results with improved validity. The specific aim remained the same: to discover the important therapeutic misalliances reported by patients, and to generate an empirically based typology of these rupture events.

Participants

Patients. Only archival data was used for the study. The patient population used to derive the data, as in the pilot (Jilton et al., 1994, 1995), consisted of outpatients who were recruited through newspaper advertisements (The New York Times and Village Voice) and who received psychotherapy treatment through Beth Israel's Brief Psychotherapy Research Program between March of 1991 and September of 1994. These patients were offered 40 weeks of individual psychotherapy
according to a sliding fee scale. The diagnostic inclusion and exclusion criteria were unchanged from the pilot study described earlier. While the pilot study consisted of data on a sample of 32 patients (i.e., all patients recruited within the 3½-year period who were assigned to either BAP or CBT treatment), the data set for the current study consisted of a subset of 15 patients from this larger group. A reduction of raw data from the original set was desirable for several reasons. The number of items used in the card sorting task for the pilot study was judged in retrospect by the researchers to be unnecessarily large. It was difficult for raters to sort that number of items in a reasonable amount of time (i.e., an hour or less). With the new sorting procedures that were be introduced in the current study, the number of item pairs given to each rater was kept to a manageable number. The total number of pairs of items rated was equal to $n(n-1)/2$, where $n$ was equal to the number of single items in the analysis. Using the Connolly and Strupp (1996) cluster analysis article as a reference, the 90 items in their analysis resulted in 4,005 possible pairs of items for 10 sets of raters to compare. It was decided that more items would represent a burdensome or confusing task for raters. As a first pass means for reducing items, those items that were reported at a low intensity level on the post-session questionnaire (i.e., 1 or 2 on a likert
scale of 5) were omitted.

Secondly, only data from patients assigned to the BAP treatment condition were included; data from CBT patients were excluded from this cluster analysis. The choice of limiting the analysis to BAP data for the current study was made for several reasons. The two modalities (BAP and CBT) were initially chosen for the pilot study on the basis of availability, rather than theoretical considerations. These two groups were the two active treatments with enough post-session questionnaire data to examine. Despite the nearly equivalent number of patient cases originally selected from the BAP and CBT conditions (18 vs. 15, respectively), the actual number of patient report items in the final 157 item pilot study was heavily skewed towards BAP. Patient reported ruptures from the BAP sample comprised 74% of the total items. The uneven distribution would have made valid comparisons between the two conditions difficult. Using a pure BAP sample provided a cluster analysis of rupture types within a psychodynamic modality, and the generalizability of the results may be examined in future studies. It may be that different modalities inspire the same basic types of ruptures, because of the transtheoretical nature of the alliance. Alternatively, different approaches may pull for different types of problems, or perhaps different frequencies of the same types of ruptures. These will be
interesting matters for further investigation.

**Therapists.** The number of therapists involved in the remaining BAP cases included 4 psychologists, 4 psychiatrists, and 1 master's level clinical trainee. These therapists participated in an ongoing, weekly group supervision meeting led by a senior staff member to review videotaped therapy sessions. The treatment modality was manualized, and adherence to technique was regularly reviewed during supervision. (The supervision and adherence checks were conducted by researchers at Beth Israel, prior to the collection of data for the cluster analysis and outside the scope of this dissertation.)

**Raters.** For the current study, 100 raters were recruited to assess the degree of similarity between pairs of patient statements. Raters were primarily master's or doctoral level psychology students or faculty affiliated with St. John's University (24% of total raters), The New School for Social Research (39%) and Beth Israel Medical Center (17%). A minority of raters (20%) were affiliated with other institutions. A small minority of raters held college degrees in areas besides psychology. Approximately half of the raters were themselves therapists or therapists in training (48%), and 67% of the total were female.

Recruitment involved the distribution of rating forms (described in Materials section, below) to individuals who
volunteered and signed informed consent to participate. It was explained to all raters that the task involved reading nearly 300 paired sets of items and judging the similarity between each pair. They were aware that the task would take close to one hour of their time, was anonymous, and presented minimal or no risk to them. Each rater was paid $5 for his or her participation.

Materials

Materials for this study included a patient Post-Session Questionnaire for collection of the original data, and Item Rating Forms for collection of similarity ratings used in the cluster analysis.

Post-Session Questionnaires. Patients whose archival responses were used in the study were instructed to complete a Post-Session Questionnaire (PSQ) after each of their 40 sessions (see Appendix A). The patients were identified only by number, and were informed their therapist would not see their responses. They were told their therapist would be completing a similar questionnaire. Most of the items on the 5-page PSQ were forced-choice or likert-type responses relating to the quality of the overall session and the therapeutic alliance, and to the interpersonal behaviors of the patient and therapist. One item of the questionnaire asked patients to indicate whether there was any problem or tension with the therapist during the session. If patients
answered "yes," they were asked to rate the degree of
tension they experienced on a 5-point likert scale. Then,
an open-ended follow-up item asked them to briefly describe
the problem or tension. These brief descriptions--usually a
sentence or two in length--provided the data for the content
analysis in the pilot study (Jilton et al., 1994). A subset
of these exact items, i.e., those reported by BAP patients
and having an intensity rating of $\geq 3$, constituted the data
for the current study. Items were taken verbatim from the
PSQ.

**Item Rating Forms.** Each rater was given a form that
listed approximately 277 pairs of items and was about 32
pages in length (see Appendix B for an excerpt). Raters
were given written instructions to rate the similarity of
each item pair according to a 7-point likert scale, with 1
being "not at all similar," 4 being "moderately similar,"
and 7 being "very similar." It was explained to raters that
the items were comments made by psychotherapy patients
following a session, and that the statements described
problems patients perceive in the relationship between
themselves and their therapist. Raters were asked to rate
the similarity of each pair using the scale provided. They
were instructed to use the entire rating scale, and informed
that some of their ratings should be high and some should be
low, while others might fall in between. The instruction to
use the entire scale was intended to maximize as much as possible the amount of variance for the eventual statistical analysis. Rating forms were distributed in stamped, self-addressed envelopes, to be returned by mail to the investigator after completion. Included in the envelope was a one-page form asking for the rater's age, gender, institutional affiliation, status as therapist or non-therapist, and degree of confidence in the ratings (see Appendix C). The mean level of confidence reported by raters in completing the rating task was 6.3 on a scale from 1 to 10.

**Procedures**

The data set for the cluster analysis was made up of 75 verbatim statements taken from PSQs, describing problems or tensions patients experienced with their therapists during their most recent session (see Appendix D). Each individual statement was paired with each of the other individual items within the data set, resulting in a total of 2,775 pairs.

The 100 raters, recruited to assess the degree of similarity between statement pairs, were divided into 10 groups of 10 raters each (Groups A through J). Approximately 277 distinct item pairs were given to each set of raters. The 2,775 pairs were randomly assigned to each of the 10 rating forms (A through J) by drawing the numbers of each pair out of a hat (without replacement).
There was no overlap of items across the ten rating groups. To control for any possible systematic differences among the groups, the rating forms were collated in alphabetical order, by group, before distribution. For example, the first rater recruited received the Group A rating form, the next a Group B form, and so on, through J. This method of distribution was continued, starting with a Group A form once again for the 11th rater. This method assured that individual raters from each of the different sites had an equal chance of ending up in any one of the ten rating groups. There was no reason to expect, therefore, that raters in one group (say, Group E) would be systematically different from raters in another group (say, Group F) on the basis of demographics or judgement style. The ratings were not necessarily based on clinical experience or theoretical perspective. However, it was possible that raters from different schools and programs might in fact behave differently on the task. The combination of random assignment of items to groups, and random assignment of raters to groups controlled carefully for the possibility of systematic bias that would affect the ultimate analysis.
Results

Prior to analysis, the SPSS data file containing the collected ratings was examined for data entry errors and the presence of any out-of-range values. Missing values were few and appeared randomly dispersed, and were replaced by the mean value derived from the remaining nine ratings for the respective item.

Interrater reliability within each of the ten rating groups was computed using the intraclass correlation (ICC; 3,k). Good reliability was observed, ranging from .83 to .86. Randomization of items and raters, as described previously, precluded the need for interrater reliability across groups. The fact that reliability coefficients were similar across the groups, however, supported the notion of rater equivalency among groups.

With reliability established, the average across all 10 raters was computed for each item pair, to one decimal place. This mean rating quantified the distance, or degree of similarity between the two items. As a way of allowing high values to reflect the distance between items, each mean rating was subtracted from 8. Therefore, a score of 1 represented the most similar items and 7 the most dissimilar items. A 75 X 75 dissimilarity matrix (lower half) was then constructed by hand from these values. Each item pair had originally been assigned a number (e.g., P1 for "Pair 1").
The number of each pair was found on a key that listed which two individual items were paired. This allowed proper placement of each value within the matrix.

The resulting dissimilarity matrix was then submitted to a nonoverlapping agglomerative hierarchical cluster analysis using SPSS for Windows (version 6.1.3). Ward’s linkage method was the cluster technique used, based on its reported accuracy in recovering true structure under various error conditions (see Schreiber and Schneider, 1985). Ward’s method is designed to optimize the minimum variance within clusters (Ward, 1963). The method works by systematically joining those groups or cases that result in the minimum increase in the error sum of squares. Compared with other popular clustering methods, Monte Carlo studies have shown that Ward’s method provides superior recovery of known cluster structure when it is desired that all cases under consideration be placed into a group (“complete coverage”) (Kuiper & Fisher, 1975; Mojena, 1977). Also, in conditions where clusters may overlap, Ward’s method has been shown to outperform most other clustering methods (Bayne, Beauchamp, Begovich, & Kane, 1980; Milligan, 1980). There is some evidence that methods such as Ward’s, which are known as “space-dilating” (because they tend to start new clusters when they encounter new points rather than join the points to existing groups), may be adversely affected by
the presence of large numbers of outliers. However, in the
data set for the current study the range of values is
restricted to 1 through 7, so that outliers are not a
possible concern.

The output from the cluster analysis was a dendogram,
which is a graphical representation of the item clusters
(see Figure 4). Accompanying this was an agglomeration
schedule listing the fusion coefficients at each stage of
the analysis (see Figure 5). As in the pilot project, the
dendogram was subjectively reviewed as a first step to
determine the appropriate number of clusters. Visual
inspection suggested either six clusters (see Figure 6), or
eight clusters (see Figure 7) would be reasonable. It was
not clear at this point which solution was more appropriate.
Aldenderfer and Blashfield (1984) suggest that as a further
heuristic to clarify the number of clusters, a plot of the
fusion coefficients versus the number of clusters may be
examined. This method is analogous to a "scree test" in
factor analysis. A flattening in the curve would indicate
that no new information would be gained by further cluster
mergers. This graph was constructed (see Figure 8), showing
a gradual and even curve with some noticeable flattening
occurring only between one and two clusters. Aldenderfer
and Blashfield (1984) also suggest examining the values of
the fusion coefficients to discover a significant "jump" in
Figure 4. Dendogram output from cluster analysis using Ward's method.
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**Figure 5. Agglomeration Schedule using Ward's Method.**
Figure 6. Dendogram showing 6-cluster solution to cluster analysis of rupture types.
Figure 7. Dendogram showing 8-cluster solution to cluster analysis of rupture types.
Figure 8. Plot of fusion coefficients against number of clusters.
the value of the coefficient. A jump would imply that two relatively dissimilar clusters have been merged, and thus the number of clusters prior to the merger is the most probable solution. The fusion coefficient associated with the number of clusters ranging from 1 to 12 was examined (see Table 1). The largest jump was between one and two clusters, suggesting that no new information would be gained from merging two clusters into one.

It was thought that dividing the total items into two groups merited attention and interpretation, but would be too broad as a final analysis. Since the fusion coefficients showed no other obvious solutions, the traditional visual inspection of the dendogram was relied upon as the primary means of identifying smaller groupings. Preliminarily, both a six-group and nine-group solution were considered.

To maximize objectivity, the clusters were named using a variation of the recaptured item technique (RIT; Meehl et al., 1971). Six judges were given the list of items for each cluster. These judges were five Ph.D. psychologists and one psychology doctoral candidate. Each judge was asked independently to name each cluster, so that the name best represented the majority of items in each cluster. The judges were asked to name clusters 1 through 6, and then to give the additional names they would suggest if cluster 1
Table 1

Differences Among Consecutive Fusion Coefficients
Associated with Number of Clusters

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were subdivided into three groups (see Appendix E). Feedback from judges indicated their preference for eight groupings rather than six. The judges' suggested names are listed in Appendix F and were used to decide on final cluster names.

The cluster names derived were as follows: "Patient feels judged by therapist and intimidated or incompetent," "Patient feels defensive with therapist who is perceived as attacking and critical," "Patient self-assertive or challenging toward therapist," "Patient feels frustration and anger towards therapist," "Patient feels misattuned with therapist and misunderstood," "Patient has difficulty trusting and being open," "Patient uncertain or confused about how to respond in therapy and express genuine feelings," and "Patient feels pressured to accept therapist's agenda, task, or interpretation."

These category names were then abbreviated to make them more concise, as follows: "Feeling judged and incompetent," "Feeling attacked and defensive," "Patient assertive and challenging toward therapist," "Feeling frustrated and angry," "Feeling misunderstood," "Difficulty trusting and being open," "Confusion about how to respond and express feelings in therapy," "Feeling pressured to accept therapist's task or agenda." (See Appendix G for list of items arranged by cluster.)
Five additional judges were selected and given the list of items for each cluster, along with the final cluster names, and asked to match names with clusters to test the reliability of the cluster names. This second set of judges matched items to cluster names with 100% accuracy.

The frequency of patients reporting items in each cluster was computed in order to evaluate which type of ruptures were most frequent in the sample, and to see whether individual patients tended to report singular or multiple types of problems. (These are questions that were not addressed in the earlier pilot study.) The greatest number of patient rupture reports in the sample (21% of items) fell within Cluster 6, "Difficulty trusting and being open," followed closely by Cluster 8 (19%), "Feeling pressured to accept therapist's task or agenda," and Cluster 5 (19%), "Feeling misunderstood." These same three clusters also received contributions from more patients than the other clusters: Cluster 6 contained items from 53% of patients, Cluster 8 from 47% of patients and Cluster 5 from 53% of patients.

The data were further examined to see how many types of alliance problems were reported by individual patients in the sample. Patients were somewhat difficult to compare with each other, because not all patients contributed the same number of items to the analysis. However, it was noted
that for patients contributing more than two items to the analysis (8 of the 15 patients), their items were dispersed among a minimum of 3 and a maximum of 6 clusters, with their responses falling in an average of 3.9 clusters. Some patients did report repeated ruptures of the same types. For patients who reported more than three ruptures, their percentage of ruptures within any one single category did not exceed 57%. This suggests that patients who reported multiple ruptures also tended to report at least a few different types on different occasions, rather than just one type.

A final post-hoc analysis was performed to test further the validity of the groupings and labels that resulted from the clustering procedures, and to identify those items with the strongest association to the category headings. For this step, five additional judges (made up of pre and post-doctoral psychology fellows who had not seen the items before) were given the category labels, along with the items, and asked to place each item into the category they believed it best fit. The results are listed in Table 2, which shows the percentage of agreement among raters who correctly placed the items. This analysis revealed that 44% of the items could be placed reliably (with 80% rater agreement or better) into the given categories.
Table 2

Results of Post-Hoc Analysis: Percentage of 5 Raters Who Correctly Matched Patient Statements to Cluster Headings

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Discussion

Comparison of Results with Pilot Studies

The current study addressed methodological problems encountered in previous pilot studies by the author (Jilton et al., 1994, 1995), and used a subset of the pilot data. When the current results are compared with those of the pilot studies, similarities are observed, as well as differences. In the current study, the items within each cluster appeared to be more clearly associated with one another than in the pilot studies. In addition to the visible clustering on the dendogram output, themes could be readily distinguished when reading through the items, providing the categories with face validity. It was not surprising, then, that the judges were able to match names to categories with complete accuracy. It is doubtful whether the clusters from the original studies could have been readily identified by independent judges at the same level of accuracy. In this regard, the new methodology of using continuous instead of categorical item ratings was considered an improvement.

The post-hoc analysis showed that raters had more difficulty matching individual items (i.e., patient statements) to the corresponding category headings. This post-hoc analysis was not performed in the pilot studies, so it is not known for sure if raters would have rated the
pilot data less reliably. The fact that less than half of the items in this study could be accurately placed into categories, however, raises some questions. It is to be expected that this task would be more difficult than matching clusters of items to their proper heading. But why was the reliability as low as it was? One explanation is that single items do not capture all aspects of the cluster's meaning—in the same way that individual symptoms do not represent all aspects of a psychiatric diagnosis. To extend this analogy, it would be difficult to place the symptom "has few or no friends" within one diagnostic heading, since it represents one facet of more than one diagnosis (e.g., schizoid personality disorder, avoidant personality disorder, etc.) However, together with other symptoms, a distinct diagnoses do emerge.

Another explanation is that the clusterings are sound, but the category labels need to be improved, perhaps being more elaborated instead of abbreviated. Still another explanation is that the clusterings represent a valid way of organizing the items, but a fair degree of overlap among categories exists. This point will be explored further, below. The author feels, in any case, that the categories are sufficiently valid, based on the interrater reliability for the similarity ratings. It may be useful, however, to rethink the category headings.
Several clusters named in the pilot studies re-emerged in the current study. In the most recent pilot study, the categories clearly similar to the new ones include: "Difficulty with parameters and tasks of therapy," "Finding therapist patronizing, insulting, objectifying, judgmental, etc.,” "Feeling misunderstood,” and "Feeling threatened or angry in response to therapist.” Pilot clusters bearing some resemblance to the new ones, but not as close a match, include: "Feeling vulnerable to exposure or rejection,” “Wanting to exert or maintain control,” "Feeling vulnerable to exposure or rejection,” and "Fear of failure and incompetence.” The only cluster from the pilot studies that failed to reemerge in any form was: "Wanting more from therapist” (from Jilton et al., 1995).

**Consideration of Two-Cluster Solution**

The dendogram from the current study, as mentioned in the results, suggested a possible two-cluster solution, which was not seen in the results of the pilot study. While these two groupings are broad, they are worth examining; the dendogram can potentially be divided at a number of levels to give a broader or narrower focus. The first broad cluster would contain clusters 1 through 5, and the second would contain clusters 6 through 8 (see Figure 9). Careful inspection reveals that the first set of items reflect more externalization of responsibility for rupture (e.g.,
**Figure 9.** Dendogram showing possible 2-cluster solution to cluster analysis of rupture types.
therapist judges, attacks, misunderstands and angers me),
and the second set of items reflects more internalization of
responsibility (e.g., I can’t trust, open up, express
myself, and I am not ready, equipped or willing to follow
the therapist’s directives). The first grouping also
appears to be more related to Bordin’s formulation of the
“bond” component of the alliance (e.g., misattunement and
negative emotions in relation to therapist), while the
second grouping is weighted more towards “disagreement on
tasks and goals” (e.g., I don’t want to open up, reveal
myself, work on certain problems, analyze transference,
etc.). One question that arises, then, is whether patients
feel less responsible for the personal bond between
themselves and their therapist, but more responsible for not
meeting the expectations of what they are “supposed” to do
in therapy. Before coming to this conclusion, these broad
categories would need to be confirmed using other data sets,
and the premise tested using alternative research designs.

Results in the Context of Former Rupture Research

As noted within the introduction, Safran and Muran
(1996) have developed and reported sequential models for
understanding ruptures and the resolution process. In
relating the current results to their models, it should
first be noted that the bulk of their work has defined
interpersonal process in terms of observable behaviors--
whereas, the current study examined patient reports of rupture experiences that were not limited to behavior.

The categories derived from the current study, in fact, are an assortment of patient reported emotions, beliefs, and behavioral observations about both patient and therapist. Most of them have a subjective, phenomenological feel. Some focus more on the therapist, some more on the patient, and some contain components of both therapist behavior and patient emotional response. In retrospect, the results took these varied forms due to the open-ended and nonspecific nature of the question on the PSQ, from which the data were gathered. The preceding question on the PSQ asked, “Did you experience any problem or tension in your relationship with your therapist during the session?” This was followed by a request to “Please describe the problem briefly.” If the question had asked the patient to describe how they were feeling or thinking, or to describe a sequence of events, the responses would have been more homogeneous in form. However, the questions were designed originally to probe broadly for patient experience. It may be useful in the future to break the open-ended question down into three or more component questions, to learn about specific aspects of the patient’s experience (i.e., either affective, cognitive, or behavioral dimensions). The positive result of not doing so was that patients were allowed to report on the aspects
of experience most salient to them.

It is difficult, then, to compare the behavioral rupture markers originally identified by Safran (Safran et al., 1990) to the current study results. Certainly, Safran’s Confrontation Marker is reflected in Cluster 3, “Patient is assertive and challenging toward therapist.” This is the only cluster in the current study that is defined explicitly in terms of patient behavior. It is unclear, for example, how patients behaved during sessions when they reported “Feeling pressured to accept therapist’s task or agenda.” Did they confront the therapist, or withdraw, or some combination? The current results must serve not as a direct confirmation (or disconfirmation) of the rupture marker findings, but as a correlate, or compliment, providing information about what the patient may be experiencing that may motivate confrontation or withdrawal.

As noted in the introduction, Safran and Muran (1996) have begun to include individual patient CCRT case formulations in their rupture resolution model, as a way of incorporating assumptions about the patient’s underlying wishes, expectations and reactions during the resolution process. While these researchers were concerned specifically with resolution processes, and the current study was concerned simply with the breakdown of the alliance, the two
approaches are related in their attention to the underlying psychology of the patient. Safran and Muran's emphasis on the division between primary and secondary emotions in rupture resolution suggests one way of viewing and making sense of the current cluster analysis results. They point out (Safran & Muran, 1996) that a feeling expressed when working through a rupture may reflect primary emotion, (i.e., an authentic feeling that the patient takes responsibility for, is associated with an underlying wish, and which provides motivational information for him or her), or a secondary emotion (which focuses on the other person and serves as a defensive coping strategy in reaction to a primary emotion). For example, anger could be a genuine, primary reaction to an event, or it could be a secondary cover for primary feelings of hurt and vulnerability.

In light of this conceptualization, the clusters from the current study that include emotional reactions may be viewed as patient states that warrant further exploration by the therapist as to whether they are primary or secondary in nature. A patient who is "frustrated and angry" may also feel disappointed without reporting this. A patient who is "confused about how to express feelings in therapy" may not understand the task or possess the skills, or instead may feel confused in response to anxiety about self revelation. It would be important for researchers and clinicians to
consider both possibilities. It is also conceivable that
the rupture types discovered in this study are not mutually
exclusive, but could be experienced simultaneously--so that
a patient feels misunderstood and angry.

The Alliance as One Instance of Interpersonal Relationship

Interpersonal relationships have been studied
intensively and described outside of the framework of the
therapeutic alliance. The therapeutic relationship can be
seen as one special case of social interaction, so that
interpersonal theory and social psychology research can give
us important clues about the factors that may impede
interpersonal relatedness.

Interpersonal theory. For Sullivan, who founded the
school of interpersonal psychology, communication between
individuals was the core of his theory, and he gave much
attention to the problems of communication (Sullivan, 1953).
He believed that each person in any relationship is involved
as a portion of an "interpersonal field," rather than as a
separate entity, so that each person is contributing to the
interaction and affecting the other. He proposed that in
early development, anxiety begins to interfere with
communication and initiates patterns of inadequate
communication which are carried into adulthood. According
to Sullivan, these patterns affect personal development,
disrupt relationships and result in difficulties in living.
He saw people as intrinsically motivated towards collaboration and mutual satisfaction, but also as needing to engage in "security operations" to lower interpersonal anxiety. These security operations often conflict with effective communication, and in Sullivan’s view a large part of mental disorder results from the faulty communication that results.

Safran’s clinical theory is heavily influenced by Sullivan’s ideas. His conceptualization of ruptures is based upon the notion that during a rupture, patients are “blocked” from communicating their true feelings because of beliefs and expectations (e.g., of retaliation, abandonment, etc.) which produce fears leading to withdrawal or in some cases preemptory attack. The categories of ruptures derived from the current study are consistent with interpersonal theory and Safran’s derivative rupture theories. Several of the categories clearly reflect the patient’s fears of opening up, trusting and expressing feelings. In others, difficulty with communication is implied; for instance, the patient is not likely to feel misunderstood for any duration if patient and therapist are communicating optimally with one another.

The interpersonal perspective reminds us, too, that it is crucial to consider ruptures in terms of the communication patterns of both parties when thinking about
the process of ruptures and resolution. It is often assumed that the patient comes to therapy with maladaptive patterns of communication, and thus initiates and maintains the rupture. However, every rupture, as with every interpersonal communication, contains contributions from both people. The relative contribution of each, however, varies from case to case (Safran & Muran, 1996). In some cases, the therapist’s contribution is greater (e.g., a poorly timed intervention), and in other cases the patient’s maladaptive patterns contribute more (e.g., expecting therapist to be unempathic without justification). For each of the rupture types delineated by the cluster analysis in this study, it is important to keep in mind that relative contribution by patient therapist is unknown in any particular instance, without further study. A patient feeling “frustrated and angry” may have felt so with every person he or she encountered that day, or may have been the recipient of inconsideration or abuse by the therapist. And of course, there may have been some combination of contributing factors.

Reactance theory. The concept of reactance (Brehm, 1966; Brehm & Brehm, 1981) has spawned much social psychology research, as well as clinical psychology theory and research. Brehm’s concept is that people attempt to maintain their freedom of action, and that when this freedom
is threatened they will attempt to restore it. Thus, people may refuse to comply with a request, or do the opposite of what is requested to maintain their freedom. Reactance is seen by some as a state, the level of which changes within different contexts. Brehm and Brehm (1981), for example, stated that the magnitude of reactance in a given situation depends on the importance to the individual of the specific freedoms threatened and the implication for future freedom of choice. Miller and Rollnick (1991) similarly contend that reactance is a normal manifestation of ambivalence, which can be diminished or heightened by the timing and content of another's response. A number of studies, however, have supported that reactance is also a persistent and measurable personality trait, which shows individual differences (Dowd, Milne, & Wise, 1991; Dowd & Sanders, 1994; Dowd, Wallbrown, Sanders, & Yesenosky, 1994; Hong, 1992) and may increase with age (Hong, Giannakopoulos, Laing, & Williams, 1994). As an example of research on this phenomenon, reactance scores have been shown to correlate with patient compliance to the advice of medical doctors to quit smoking, so that a low amount of advice is more effective with individuals who score high on reactance (Graybar, Antonuccio, Boutillier, & Varble, 1989).

It is understandable that relationships where one person is in the role of authority figure, such as physician
or therapist, may be perceived as more threatening to freedom. Reactance seems like a logical explanation for some forms of therapeutic alliance rupture. While reactance has not been studied directly in relation to ruptures, the variable has been studied in correlation with the success of therapy techniques (discussed in the treatment issues section, below) and patient anger. One study found that interpretations in therapy, both absolute and tentative, tended to cause more anger in high reactance patients (Dowd, Trutt, & Watkins, 1992). One may hypothesize that the "feeling frustrated and angry," "feeling pressured to accept therapist’s task or agenda," and "patient assertive and challenging" are reflective to some extent of reactance in response to the therapist. "Difficulty trusting and being open," may even in some instances reflect a passive resistance to therapy directives.

Anger

Other potential causes for anger, according to social psychology research, are (1) attacks by others or by aversive stimuli (Baron, 1977; Berkowitz, 1983) and (2) frustration caused by the interference with the attainment of a goal (Dollard, Doob, Miller, Mowrer, & Sears, 1939). According to attribution theory (Weiner, 1982), anger is most likely when the attack or frustration is perceived as intended by another person, i.e., being under that person's
internal control.

In the therapy situation, therapists are in the special position of evaluating patients, illuminating their problems, discussing painful topics, and inducing them to change. All of these endeavors may potentially provoke feelings of attack if delivered without sufficient empathy, with poor timing, or if the individual patient is predisposed to perceive attack.

Patients may feel angry as a response to disagreement about tasks and goals in therapy if it frustrates the attainment of their own goals. In fact, depending on the patient, any number of therapist behaviors could be experienced as interfering with the patient's goals, especially if the goals of therapy have not been explicitly contracted. The patient may have some implicit goals which seem counter-therapeutic to the therapist, such as relying on the therapist in a highly dependent way. The frustration of this type of goal may then arouse anger in the patient. On the other hand, the patient may have more legitimate preferences or goals, which are ignored by the therapist due to therapist insensitivity or poor communication on either person's part.

The rupture categories of “feeling attacked and defensive,” “patient assertive and challenging toward therapist,” and “feeling frustrated and angry,” lie next to
one another on the dendogram. The dendogram can be seen as a continuum, with items closer to one another being more related, to some extent. The proximity of these clusters implies some relation to one another, which is justified according to anger theory. In treatment, patients may feel attacked, which inspires anger, and then self-assertion or even aggressive retaliation. As mentioned earlier, since the categories are not mutually exclusive, patients may also feel angry when they think they are misunderstood, if they perceive that it is within the therapist’s power to understand them better.

Treatment Implications

The utility of the current research findings can be seen within the context of a recent trend towards specificity of treatment. Beutler (1991) and others (Gendlin, 1986; Greenberg, 1986; Kiesler, 1966) have proposed that differences in treatment outcome between modalities have been difficult to detect because general therapeutic approaches have been administered to heterogeneous groups, who are assumed to be homogeneous because of a shared diagnosis. The aim of some recent psychotherapy research has been to apply more specific techniques to subtypes of clients, based on variables that are thought to be most relevant—such as level of reactance (Beutler & Consoli, 1993; Dowd, et al., 1992; Swoboda, Dowd
& Wise, 1990), cognitive attributional style (Kirmayer, 1990), and difficulty with alliance formation (Safran & Muran, 1994).

One of the important justifications for studying alliance ruptures from the patient's perspective was to inform clinical interventions. Understanding the types of experiences patients have during problematic interactions can suggest more specific techniques for dealing with these problems in all patients, but particularly in patients with whom ruptures are frequent or intense and disruptive to the treatment. The ultimate goal is to improve treatment retention and outcome as a result.

The main heuristic that emerges from the current study is that it narrows the field of possible patient experiences to consider when a rupture occurs. Out of all possible underlying experiences, a few of the most probable can be considered and explored further. Based on the preceding interactions, therapists can speculate about the type of rupture that is occurring, and then help the patient to articulate which experience they having. For instance, a therapist may suggest to a patient who is answering questions in monosyllables: "We have been talking a lot about your role in the break-up with your wife. I wonder if you are feeling judged by me." This type of process may encourage authentic communication, since patients may never
reveal their experience otherwise. This process may also increase the likelihood of repair and promote interpersonal learning. Based on the discussion of primary and secondary emotions, above, it is important to consider that some explicit reactions may in fact mask other feelings, which also need to be addressed for full resolution of the impasse.

Overall, just knowing which category of patient rupture experience has occurred does not tell the whole story. It is still unclear who has contributed the most to the rupture, what the complete system of patient needs, feelings and beliefs are, and whether other feelings may come to the fore if explored. It is up to the therapist, especially in the early stages of therapy, to attempt to clarify these matters. Having knowledge of typical patient-reported experiences, however, is a head start for the clinician.

Limitations of the Current Study

A few limitations should be noted in relation to the current study. The patient sample from which the data were derived is limited to 15 patients involved in a short-term, manualized, psychodynamic treatment modality. This one type of treatment (BAP) may not have inspired a full range of patient complaints, and may have produced a skewed sample. Other individual modalities--such as cognitive, behavioral, or interpersonal--may have aroused other types of problems
and tensions. Group and family modalities may also yield different results than the ones seen here. In addition, the manualized and time-limited nature of the treatment may have pulled for certain rupture types, particularly the "pressure to accept therapist's tasks or agenda." In all, however, it is expected that the results from patient samples in other modalities would show considerable overlap with those found in the current study.

The 75 items used in the data analysis for this study were derived from 15 patients. The results may not generalize as well as if 75 patients had each contributed one item each to the analysis. Ideally, a larger population of patients should be used in future replication studies. The population of patients in the study were predominantly white, middle-class patients paying out-of-pocket or through insurance for treatment. The therapists, likewise, were all white professionals. Thus, ruptures influenced by significant cultural clashes would not be included in the data. Since many treatment facilities serve large numbers of low SES and minority patients, further exploration of rupture events between the staff and patients of these institutions would be informative. The current results, likewise, may not necessarily generalize to patients with more severe psychopathology, such as inpatients and those with diagnoses that were exclusionary within the study.
In conducting the study, a number of raters complained that the task of comparing so many items was difficult and frustrating, and they were not confident of their ratings. Raters often gave feedback that comparisons between items could be made on many levels, and they were not sure which level to choose. Contrary to the raters' experience, good reliability was established among raters in each group. However, it may have made the task clearer and less arduous if patient statements had been paraphrased and simplified somewhat before paired and given to raters. As it was, the results indicate that raters successfully distinguished themes. The results indicate that the items were grouped according to the most concrete, semantic similarities among items. More abstract similarities were largely washed out by medium or low similarity ratings. Although worth noting, this tendency was acceptable, as the categories that did emerge were clear and distinct.

**Future Directions**

The current research is an early step in the exploration of alliance ruptures from the patient's perspective. The results will need to be replicated using other data sets, particularly from patients in other treatment modalities and more diverse patient populations. If categories of ruptures were found to be reliable across studies, it would substantiate the findings, and differences
will augment the findings.

The next direction planned by the author is the development and validation of a scale, which will gauge type and severity of therapeutic alliance rupture from patient self-report. A preliminary scale will be constructed from the best items within each rupture category (based on the post-hoc analysis ratings reported above), and the scale validity will be assessed via factor analysis. Patients (preferably from different populations at various sites) will rate their degree of agreement with the statements on a likert scale, based on their own psychotherapy (either post-session or post-treatment). It is expected that the resulting factors will be consistent with the cluster categories. If not, future revisions in the scale may be necessary.

Once the categories are established through validation studies, other important questions can be addressed. Frequency counts can be made of rupture reports to determine which types of problems are most common. It may also be useful to correlate types of rupture report with patient gender, diagnosis, and other demographic variables to see if different types of patients report different types of ruptures.

Patterns of reports could be examined over time, to determine if there are rupture types that are more likely
early in treatment, versus the middle and towards the end. As mentioned in the previous section, future studies could determine whether cultural variables change the types of ruptures seen, or the frequencies of any given type.

The construct of reactance is closely associated with rupture. Do patients who measure high on reactance scales have a greater probability of experiencing specific types of ruptures? Or a greater number of ruptures? It is possible that both cases are true. Implications for treatment could then be discerned.

Finally, research into the model of rupture repair derived by Safran and Muran (1996) could make use of the categories derived here as tools for facilitating and expediting the exploration of rupture events, by augmenting the model with the patient’s experience. It is hoped that these findings will have practical as well as theoretical applications.
References


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Appendix A

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 helpful</td>
<td>Neutral</td>
<td>Extremely hindering</td>
<td></td>
<td></td>
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</table>

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

<table>
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<tr>
<th>1</th>
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<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>
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</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>
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</table>

4. Please describe the problem briefly:

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

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<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?

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<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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7. If this problem was at all resolved, please rate the extent to which each of the following statements reflects your experience.

a. I felt a closer connection with my therapist.

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

b. I felt more trusting of my therapist.

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</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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</table>

c. I felt able to disagree with my therapist.

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<th>5</th>
</tr>
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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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</table>

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

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

e. I saw what I was doing to avoid my therapist.

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

f. I became aware that I had been upset with my therapist without really knowing it.

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

g. I saw that my self-assertion did not drive my therapist away.

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</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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</tbody>
</table>

h. My therapist did not react as negatively as I feared he/she would when I expressed anger or vulnerability.

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

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

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

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

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<tr>
<th>1</th>
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<th>3</th>
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<th>5</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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</table>

k. I began to get a sense that I can expose risky feelings and not be abandoned by my therapist.

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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Completely</td>
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</table>

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

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

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

7. I felt that my therapist appreciates me.

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

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

1 2 3 4 5 6 7
Never Sometimes Always

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

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

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

<table>
<thead>
<tr>
<th>Adjectives</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-UNSYPATHETIC-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>Adjectives</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>
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<tr>
<td>3. UNSOCIALABLE-INTROVERTED-DISTANT-SHY</td>
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<tr>
<td>4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE</td>
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<tr>
<td>5. UNDECEPTIVE-UNARGUMENTATIVE-NONEGOTISTICAL-UNDEVIOUS</td>
<td>1 2 3 4 5 6 7</td>
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</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-UNSYPATHETIC-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>
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</table>
Appendix B

INSTRUCTIONS TO Raters

This task involves rating the similarity of items. Each item is a statement made by a psychotherapy patient following a session. These statements describe problems patients perceive in the relationship between themselves and their therapist.

You will be given approximately 277 item pairs. (Please note that you will see some individual items more than once.) For each pair, please rate the similarity of the pair using the rating scale provided below. Record your rating of each pair by writing a number in the space to the right of that pair.

Be sure to use the entire rating scale. Some of your ratings should be high and some should be low, while others may fall in between. Do not spend too much time on any pair, but just mark your impression and move on. It is okay if you do not finish all the items in one sitting, but please do not skip any items.

Any questions? Call Robin at (212) 420-2000, ext. 5796, OR (203) 221-1236. Thank you for your time.

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Example 1:
I do not like to discuss my personal problems, but my therapist keeps insisting I do so.

My therapist keeps nagging me to reveal things about myself, but I am a private person. Rating: 7

Example 2:
I wish my therapist would talk more, instead of just sitting there silently all the time.

I was preoccupied and couldn’t concentrate today, and tried to fake it to make her happy. 1

P2
I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

We seem to have a lot of trouble understanding one another. We do not “click” very well.

P3
I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

We don’t seem to connect.

P26
I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

I felt as though I was just bullshitting. I didn’t know what to say.
Appendix C

PLEASE TELL ME A FEW THINGS ABOUT YOURSELF:

Age: ___________________  Gender: M  F

School or Institutional Affiliation:  St. John’s University
                                    The New School
                                    Beth Israel Medical Center
                                    Both New School & BI
                                    Other

Program:  Master’s Level
          Clinical PhD
          Bachelor’s
          Already completed degree (please specify: )
          Other

Are you a therapist yourself now (including “in training”)?  Yes  No

How confident were you in your ratings on this questionnaire, overall?

1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10
Not at all confident  Moderately confident  Extremely Confident
Appendix D

Patient-Reported Rupture Items

1. I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

2. I wouldn’t mind working with someone with whom I felt a greater rapport.

3. We seem to have a lot of trouble understanding one another. We do not “click” very well.

4. We don’t seem to connect.

5. I don’t feel he’s hearing what I’m saying, rather fitting me into his theories.

6. He seems mildly insulting sometimes, not very supportive at other times.

7. Sometimes I feel like I need to defend myself from him.

8. I got angry at what I felt was a patronizing attitude on his part.

9. I felt uncomfortable with my feelings of sadness or concerned about whether I respond clearly or express what I really mean.

10. I just don’t flow with my thoughts (in talking) for therapist.

11. I’m just tense and uncomfortable talking about myself to therapist.

12. I just don’t feel open and comfortable talking about myself to therapist.

13. He doesn’t know anything about me. When is he going to find out?

14. I feel like I’m being examined instead of being in a space that’s conducive to solving some problems. I get the feeling that I’m a guinea pig rather than a person with a life.

15. I feel misunderstood.
16. We got into a discussion about whether or not my being tired had to do with intimacy with women.

17. She wants me to experience transference, e.g., associate her with my mother.

18. She wanted me to talk about my feelings towards her. I didn’t.

19. I thought she was twisting my words and was angry at me.

20. Annoyance from previous session.

21. She felt I was ending before the true ending.

22. I was reluctant to discuss personal things at first.

23. He is looking for personal reaction to him, which I seem not to have.

24. He says I am fighting against recognition/perception of anger, and somehow I seem not to get it.

25. I had missed a session and the therapist thought it was due to the previous session’s talk, but it was really due to outside factors.

26. I was not certain what she wanted me to say about uncertainty.

27. I felt as though I was just bullshitting. I didn’t know what to say.

28. I felt I could not be honest about my feelings towards therapist for fear that therapist would decide I could not be helped.

29. Afraid of disappointing the doctor.

30. When she tries to get me to react directly to her, or to draw a parallel between an “outside” issue and the two of us, it makes me uncomfortable.

31. Therapist tries to keep me “in the moment,” when I want to escape.

32. Therapist asks me to “stay in a feeling,” and I don’t know what to do.
33. I did not want to become emotional. I retained "control" over this, but suffered tension as a result.

34. Therapist kept asking about "topic switching," and I wasn't sure what else to say.

35. Confusion about a question.

36. I was apprehensive about telling therapist that I felt disappointed.

37. It seemed as though nothing I said or did was right.

38. Therapist hit home with the intimacy issue, and this made me uncomfortable.

39. Therapist's observations came across as criticisms.

40. It seemed we weren't on the same wavelength.

41. I had a need to keep therapist at bay.

42. I felt anger towards therapist and wasn't sure how to express it.

43. I keep getting angry at what therapist says and can't seem to keep up my end.

44. I was not feeling cooperative.

45. We couldn't seem to see eye-to-eye on anything.

46. I felt angry at her responses.

47. Frustration at process.

48. I'm frustrated and pissed off!

49. She pointed out something about me that I never realized, and it caught me off guard and I couldn't concentrate on what she had said enough to comment.

50. She kept bringing up that I thought our relationship was not valuable to her because she was 15 minutes late, and the truth was, I completely understood and it didn't bother me. It frustrated me that she didn't believe me and wouldn't drop it.
51. She was asking me questions that involved so much thought. I couldn’t give answers right away. She kept harping on things. I was annoyed and frustrated and just wanted to get up and leave.

52. She was asking questions I just didn’t want to confront and didn’t expect.

53. Reference to our relationship on a personal level -- I don’t want to rely on her more than is necessary for therapy purposes alone.

54. Discussion about which problems I still haven’t “worked on” and how they affect my relationship with therapist and therapy ending in four weeks.

55. Continued conversation about how I will feel when the sessions have been completed.

56. Discussion about my emotions regarding last sessions. I felt forced to reveal emotions that just aren’t there, and frustrated that she didn’t seem to believe I didn’t think they were there.

57. I was nervous about being honest, as it was the first time I met the therapist.

58. I wanted to know what type of therapy this was and he would not answer the question, instead asking why I needed to know this.

59. He challenged my ability to trust him and to be open to the working relationship.

60. I don’t know what to say or how to be more open and honest.

61. We get stuck on the same point: I won’t let him in. But I don’t know how to let myself “in” and to where?

62. I felt tense defending the idea that we are born different -- that some of us have a harder time emotionally because of genetic inheritance.

63. I am asserting myself. I am trying to assert myself, which doesn’t seem to sit well with my therapist.

64. I was challenging to her.
65. I anticipated that my reason for being late for session would be incorrectly interpreted.

66. I feel compelled to answer questions, and do, yet I’m not certain that if I had more time to reflect, I would answer the same way.

67. Tension around my interpretation of what therapist was saying as "critical" of me.

68. Towards the end of the session, when I seemed to run out of things to say, there were periods of silence, and I began to feel intimidated because of the silence. I also felt judged because she just stared at me and didn’t say anything.

69. Somehow feeling I am failing therapist by not pleasing her with my process.

70. It (the problem) was about the idea of giving him responsibility of starting the session and reminding me of what I said.

71. Therapist not feeling that I trust him enough because I won’t reveal intimate details about a book I’m writing.

72. Hesitancy on my part to discuss certain specific events.

73. I would take a long time to say something. Therapist would stop to talk about why I was taking so long. I’d lose track of what I was trying to say.

74. We have a conflict in the possibility of me moving from N.Y. before 30 sessions have been completed.

75. I was honest about having consulted with my former therapist during the previous week, the same week in which I had no choice but to cancel my regular appointment with therapist, and we were unable to find a suitable substitute hour. Tension arose when I stood my ground on my point of view and also because I revealed what I had done.
Appendix E

Cluster Naming Form

Cluster 1

Afraid of disappointing the doctor.

Somehow feeling I am failing therapist by not pleasing her with my process.

It seemed as though nothing I said or did was right.

Therapist’s observations came across as criticisms.

Towards the end of the session, when I seemed to run out of things to say, there were periods of silence, and I began to feel intimidated because of the silence. I also felt judged because she just stared at me and didn’t say anything.

He seems mildly insulting sometimes. not very supportive at other times.

I got angry at what I felt was a patronizing attitude on his part.

Sometimes I feel like I need to defend myself from him.

I thought she was twisting my words and was angry at me.

Tension around my interpretation of what therapist was saying as “critical” of me.

I felt tense defending the idea that we are born different — that some of us have a harder time emotionally because of genetic inheritance.

I am asserting myself. I am trying to assert myself, which doesn’t seem to sit well with my therapist.

I was challenging to her.

I was honest about having consulted with my former therapist during the previous week, the same week in which I had no choice but to cancel my regular appointment with therapist, and we were unable to find a suitable substitute hour. Tension arose when I stood my ground on my point of view and also because I revealed what I had done.

I wanted to know what type of therapy this was and he would not answer the question, instead asking why I needed to know this.

It was about the idea of giving him responsibility of starting the session and reminding me of what I said.

SUGGESTED NAME OF CLUSTER:
If Cluster 1 were divided into three parts, what names would you suggest?:

CLUSTER 1:

Afraid of disappointing the doctor.

Somehow feeling I am failing therapist by not pleasing her with my process.

It seemed as though nothing I said or did was right.

Therapist's observations came across as criticisms.

Towards the end of the session, when I seemed to run out of things to say, there were periods of silence, and I began to feel intimidated because of the silence. I also felt judged because she just stared at me and didn't say anything.

SUGGESTED NAME:

CLUSTER 2:

He seems mildly insulting sometimes, not very supportive at other times.

I got angry at what I felt was a patronizing attitude on his part.

Sometimes I feel like I need to defend myself from him.

I thought she was twisting my words and was angry at me.

Tension around my interpretation of what therapist was saying as "critical" of me.

I felt tense defending the idea that we are born different -- that some of us have a harder time emotionally because of genetic inheritance.

SUGGESTED NAME:
Cluster 3:

I am asserting myself. I am trying to assert myself, which doesn’t seem to sit well with my therapist.

I was challenging to her.

I was honest about having consulted with my former therapist during the previous week, the same week in which I had no choice but to cancel my regular appointment with therapist, and we were unable to find a suitable substitute hour. Tension arose when I stood my ground on my point of view and also because I revealed what I had done.

I wanted to know what type of therapy this was and he would not answer the question, instead asking why I needed to know this.

It was about the idea of giving him responsibility of starting the session and reminding me of what I said.

**SUGGESTED NAME:**

Cluster 4

I keep getting angry at what the therapist says and can’t seem to keep up my end.

I felt angry at her responses.

I felt anger towards therapist and wasn’t sure how to express it.

I’m frustrated and pissed off?

She was asking me questions that involved so much thought. I couldn’t give answers right away. She kept harping on things. I was annoyed and frustrated and just wanted to get up and leave.

Frustration at process.

Discussion about my emotions regarding last sessions. I felt forced to reveal emotions that just aren’t there, and frustrated that she didn’t seem to believe I didn’t think they were there.

Annoyance from previous session.

**SUGGESTED NAME OF CLUSTER:**
Cluster 5

I don’t feel he’s hearing what I’m saying, rather fitting me into his theories.

I feel like I’m being examined instead of being in a space that’s conducive to solving some problems. I get the feeling that I’m a guinea pig rather than a person with a life.

He doesn’t know anything about me. When is he going to find out?

I had missed a session and the therapist thought it was due to the previous session’s talk, but it was really due to outside factors.

I anticipated that my reason for being late for session would be incorrectly interpreted.

It seemed we weren’t on the same wavelength.

We couldn’t seem to see eye-to-eye on anything.

We seem to have a lot of trouble understanding one another. We do not “click” very well.

We don’t seem to connect.

I feel misunderstood.

I wouldn’t mind working with someone with whom I felt a greater rapport.

He says I am fighting against recognition/perception of anger, and somehow I seem not to get it.

She kept bringing up that I thought our relationship was not valuable to her because she was 15 minutes late, and the truth was, I completely understood and it didn’t bother me. It frustrated me that she didn’t believe me and wouldn’t drop it.

SUGGESTED NAME OF CLUSTER:
Cluster 6

I'm just tense and uncomfortable talking about myself to therapist.

I just don't feel open and comfortable talking about myself to therapist.

I was reluctant to discuss personal things at first.

I was nervous about being honest, as it was the first time I met the therapist.

I felt I could not be honest about my feelings towards therapist for fear that therapist would decide I could not be helped.

I was apprehensive about telling therapist that I felt disappointed.

Therapist not feeling that I trust him enough because I won't reveal intimate details about a book I'm writing.

Hesitancy on my part to discuss certain specific events.

Reference to our relationship on a personal level -- I don't want to rely on her more than is necessary for therapy purposes alone.

We get stuck on the same point: I won't let him in. But I don't know how to let myself "in" and to where?

I did not want to become emotional. I retained "control" over this but suffered tension as a result.

Therapist hit home with the intimacy issue. and this made me uncomfortable.

She wanted me to talk about my feelings towards her. I didn't.

I had a need to keep therapist at bay.

He challenged my ability to trust him and to be open to the working relationship.

I was not feeling cooperative.

**SUGGESTED NAME OF CLUSTER:**
Cluster 7

I was not certain what she wanted me to say about uncertainty.

Confusion about a question.

Therapist kept asking about “topic switching.” and I wasn’t sure what else to say.

I felt uncomfortable with my feelings of sadness or concerned about whether I respond clearly or express what I really mean.

I just don’t flow with my thoughts (in talking) for therapist.

I felt as though I was just bullshitting. I didn’t know what to say.

I don’t know what to say or how to be more open and honest.

I feel compelled to answer questions. and do, yet I’m not certain that if I had more time to reflect, I would answer the same way.

SUGGESTED NAME OF CLUSTER:
Cluster 8

Discussion about which problems I still haven’t “worked on” and how they affect my relationship with therapist and therapy ending in four weeks.

Continued conversation about how I will feel when the sessions have been completed.

We have a conflict in the possibility of me moving from N.Y. before 40 sessions have been completed.

She felt I was ending before the true ending.

He is looking for a personal reaction to him, which I seem not to have.

When she tries to get me to react directly to her, or to draw a parallel between an “outside” issue and the two of us, it makes me uncomfortable.

We got into a discussion about whether or not my being tired had to do with intimacy with women.

She wants me to experience transference. e.g., associate her with my mother.

She pointed out something about me that I never realized, and it caught me off guard and I couldn’t concentrate on what she had said enough to comment.

I would take a long time to say something. Therapist would stop to talk about why I was taking so long. I’d lose track of what I was trying to say.

I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

She was asking questions I just didn’t want to confront and didn’t expect.

Therapist tries to keep me “in the moment.” when I want to escape.

Therapist asks me to “stay in a feeling.” and I don’t know what to do.

SUGGESTED NAME OF CLUSTER:
Appendix F

Judges’ Independent Suggestions for Cluster Names

Cluster 1 as one cluster:

Feeling of disappointing therapist, being criticized or
perceiving therapist as not responding well to self-
assertion
Struggle for individuation from therapist
Patient or therapist is challenging or critical of the other
Feeling criticized by therapist
Feeling disapproval from therapist
Therapist perceived as not positive/accepting

Cluster 1 if divided into three clusters:

Cluster 1:

Feels like failing or disappointing therapist
Afraid of the therapist and his/her judgements
Patient feels self-critical or criticized by therapist
Feeling criticized by therapist
Feeling judged and intimidated
Feel criticized or judged

Cluster 2:

Feeling attacked, criticized
Feeling attacked by therapist
Patient feels attacked by therapist
Feeling defensive with therapist
Tense and uncomfortable with hostility in therapist
Angry at therapist attitude

Cluster 3:

Self-assertion and its consequences
Challenging the therapist
Patient asserting self
Feeling attacking of therapist
Opposing therapist
Patient assertive/challenging
Cluster 4:

Angry and frustrated at therapist
Anger and frustration at therapist (and process)
Patient feels angry/frustrated
Feeling anger toward therapist
Frustrated or angry with therapist
Anger and frustration at therapist

Cluster 5:

Feeling misunderstood, unrecognized, etc.
Feeling misunderstood and/or misattuned
Patient feels misunderstood
Feeling misunderstood
Feeling misunderstood, unappreciated and unconnected with therapist
Therapist doesn’t understand me

Cluster 6:

Feeling untrusting
Anxiety re intimacy and trust
Patient reluctant to engage in therapeutic process
Not feeling open to the therapeutic relationship
Discomfort with expressing feelings to therapist
Anxiety about revealing self to therapist

Cluster 7:

Confusion
Confusion, uncertainty, self-doubts
Patient confused about what to say or how to speak
Difficulty expressing genuine feelings
Confused and full of doubts about how to act/what to say
Uncertainty/confusion about what to say

Cluster 8:

Disagreement about task or goal
Disagreement about focus and formulations
Patient disagrees with the therapist’s tasks or with the therapist’s agenda
Feeling dominated by therapist
Uncomfortable with therapist interpretation/direction
Disagree/conflict about process/topic

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Appendix G

CLUSTERS HEADINGS WITH CORRESPONDING ITEMS

CLUSTER 1: Feeling Judged and Incompetent

Afraid of disappointing the doctor.

Somehow feeling I am failing therapist by not pleasing her with my process.

It seemed as though nothing I said or did was right.

Therapist’s observations came across as criticisms.

Towards the end of the session, when I seemed to run out of things to say, there were periods of silence, and I began to feel intimidated because of the silence. I also felt judged because she just stared at me and didn’t say anything.

CLUSTER 2: Feeling Attacked and Defensive

He seems mildly insulting sometimes, not very supportive at other times.

I got angry at what I felt was a patronizing attitude on his part.

Sometimes I feel like I need to defend myself from him.

I thought she was twisting my words and was angry at me.

Tension around my interpretation of what therapist was saying as “critical” of me.

I felt tense defending the idea that we are born different—that some of us have a harder time emotionally because of genetic inheritance.
CLUSTER 3: Patient Is Assertive and Challenging Toward Therapist

I am asserting myself. I am trying to assert myself, which doesn’t seem to sit well with my therapist.

I was challenging to her.

I was honest about having consulted with my former therapist during the previous week, the same week in which I had no choice but to cancel my regular appointment with therapist, and we were unable to find a suitable substitute hour. Tension arose when I stood my ground on my point of view and also because I revealed what I had done.

I wanted to know what type of therapy this was and he would not answer the question, instead asking why I needed to know this.

It was about the idea of giving him responsibility of starting the session and reminding me of what I said.

CLUSTER 4: Feeling Frustrated and Angry

I keep getting angry at what the therapist says and can’t seem to keep up my end.

I felt angry at her responses.

I felt anger towards therapist and wasn’t sure how to express it.

I’m frustrated and pissed off!

She was asking me questions that involved so much thought. I couldn’t give answers right away. She kept harping on things. I was annoyed and frustrated and just wanted to get up and leave.

Frustration at process.

Discussion about my emotions regarding last sessions. I felt forced to reveal emotions that just aren’t there, and frustrated that she didn’t seem to believe I didn’t think they were there.

Annoyance from previous session.
CLUSTER 5: Feeling Misunderstood

I don’t feel he’s hearing what I’m saying, rather fitting me into his theories.

I feel like I’m being examined instead of being in a space that’s conducive to solving some problems. I get the feeling that I’m a guinea pig rather than a person with a life.

He doesn’t know anything about me. When is he going to find out?

I had missed a session and the therapist thought it was due to the previous session’s talk, but it was really due to outside factors.

I anticipated that my reason for being late for session would be incorrectly interpreted.

It seemed we weren’t on the same wavelength.

We couldn’t seem to see eye-to-eye on anything.

We seem to have a lot of trouble understanding one another. We do not “click” very well.

We don’t seem to connect.

I feel misunderstood.

I wouldn’t mind working with someone with whom I felt a greater rapport.

He says I am fighting against recognition/perception of anger, and somehow I seem not to get it.

She kept bringing up that I thought our relationship was not valuable to her because she was 15 minutes late, and the truth was, I completely understood and it didn’t bother me. It frustrated me that she didn’t believe me and wouldn’t drop it.
CLUSTR 6: Difficulty Trusting and Being Open

I'm just tense and uncomfortable talking about myself to therapist.

I just don't feel open and comfortable talking about myself to therapist.

I was reluctant to discuss personal things at first.

I was nervous about being honest, as it was the first time I met the therapist.

I felt I could not be honest about my feelings towards therapist for fear that therapist would decide I could not be helped.

I was apprehensive about telling therapist that I felt disappointed.

Therapist not feeling that I trust him enough because I won't reveal intimate details about a book I'm writing.

Hesitancy on my part to discuss certain specific events.

Reference to our relationship on a personal level -- I don't want to rely on her more than is necessary for therapy purposes alone.

We get stuck on the same point: I won't let him in. But I don't know how to let myself "in" and to where?

I did not want to become emotional. I retained "control" over this but suffered tension as a result.

Therapist hit home with the intimacy issue, and this made me uncomfortable.

She wanted me to talk about my feelings towards her. I didn't.

I had a need to keep therapist at bay.

He challenged my ability to trust him and to be open to the working relationship.

I was not feeling cooperative.
CLUSTER 7: Confusion About How to Respond and Express Feelings in Therapy

I was not certain what she wanted me to say about uncertainty.

Confusion about a question.

Therapist kept asking about "topic switching," and I wasn't sure what else to say.

I felt uncomfortable with my feelings of sadness or concerned about whether I respond clearly or express what I really mean.

I just don't flow with my thoughts (in talking) for therapist.

I felt as though I was just bullshitting. I didn't know what to say.

I don't know what to say or how to be more open and honest.

I feel compelled to answer questions, and do, yet I'm not certain that if I had more time to reflect, I would answer the same way.
CLUSTER 8: Feeling Pressured to Accept Therapist's Task or Agenda

Discussion about which problems I still haven’t “worked on” and how they affect my relationship with therapist and therapy ending in four weeks.

Continued conversation about how I will feel when the sessions have been completed.

We have a conflict in the possibility of me moving from N.Y. before 40 sessions have been completed.

She felt I was ending before the true ending.

He is looking for a personal reaction to him, which I seem not to have.

When she tries to get me to react directly to her, or to draw a parallel between an “outside” issue and the two of us, it makes me uncomfortable.

We got into a discussion about whether or not my being tired had to do with intimacy with women.

She wants me to experience transference, e.g., associate her with my mother.

She pointed out something about me that I never realized, and it caught me off guard and I couldn’t concentrate on what she had said enough to comment.

I would take a long time to say something. Therapist would stop to talk about why I was taking so long. I’d lose track of what I was trying to say.

I don’t know if I like him. He seems to like confrontational work, which makes me nervous. I don’t necessarily want to be challenged on everything I say.

She was asking questions I just didn’t want to confront and didn’t expect.

Therapist tries to keep me “in the moment,” when I want to escape.

Therapist asks me to “stay in a feeling,” and I don’t know what to do.
VITA

Name: Robin Jilton

Date of Birth: March 29, 1963

Elementary School: Fairmont Elementary
          Johnson City, Tennessee
          June 1975

High School: Science Hill High School
          Johnson City, Tennessee
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Baccalaureate Degree: Bachelor of Science
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