The Resolution of Ruptures in the Therapeutic Alliance

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This article outlines some of the main features of a research program on ruptures in the therapeutic alliance and reports some of the major findings to date. A rupture in the therapeutic alliance is a deterioration in the quality of the relationship between patient and therapist; it is an interpersonal marker that indicates a critical opportunity for exploring and understanding the processes that maintain a maladaptive interpersonal schema. Following the task-analytic research paradigm, a preliminary model of the resolution process was developed and then tested and revised with 2 different data sets. A series of lag 1 sequential analyses were used to confirm the hypothesized sequences of events within resolution sessions and to demonstrate a difference between resolution and nonresolution sessions. This article describes the evolution of a model of rupture resolution and then discusses its implications for treatment development and evaluation.

We define ruptures in the therapeutic alliance as deteriorations in the relationship between therapist and patient. They are patient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration. Ruptures often emerge when therapists unwittingly participate in maladaptive interpersonal cycles, that resemble those characteristic of patients’ other interactions, thus confirming their patients’ dysfunctional interpersonal schemas or generalized representations of self-other interactions (Safran, 1990a, 1990b). For example, a therapist who responds to a hostile patient with counterhostility confirms the patient’s view of others as hostile and obstructs the development of a good therapeutic alliance. The therapist who responds to a withdrawn patient by distancing confirms the patient’s view of others as emotionally unavailable, thereby perpetuating a vicious cycle. Ruptures vary in intensity, duration, and frequency depending on the particular therapist–patient dyad. In some cases, they may go undetected by the therapist or remain out of conscious awareness for the patient and may not significantly obstruct therapeutic progress. In more extreme cases, they can lead to dropout or treatment failure. If properly dealt with, however, alliance ruptures can provide an important opportunity for therapeutic change. By systematically exploring, understanding, and resolving alliance ruptures, the therapist can provide patients with a new constructive interpersonal experience that will modify their maladaptive interpersonal schemas (Safran, 1993a).

A number of overlapping constructs refer to the phenomenon that we are conceptualizing as an alliance rupture, including empathic failure, resistance, and transference–countertransference. Space limitations prevent us from examining the similarities and differences among these constructs. Each one, however, provides a somewhat different conceptual lens with specific underlying assumptions and therapeutic implications. The concept of the alliance rupture has a certain heuristic value because of its link to current psychotherapy research and because of its transtheoretical status (Bordin, 1994). We understand all ruptures to be a function of both patient and therapist contributions, with the relative contribution of each varying from case...
to case. In some cases, the therapist's contribution is clear cut (e.g., poorly timed interventions). In other cases, the patient's intrapsychic processes play a greater role. For example, a patient who becomes aware of shameful feelings may view the therapist as unempathic. Resolving alliance ruptures can provide patients with opportunities to acknowledge disowned parts of themselves and to learn to negotiate the dialectically opposed needs for self-agency and relatedness in a constructive fashion (Safran, 1993b).

Our research program has been guided by the task-analytic paradigm for psychotherapy research developed by Greenberg and Rice (Greenberg, 1986; Rice & Greenberg, 1984; Safran, Rice, & Greenberg, 1988). It has also been influenced by the states-of-mind perspective articulated by Horowitz (1987) and the stage process model proposed by McCullough (e.g., McCullough & Carr, 1987). These approaches share the intuition that psychotherapy process can be seen as a sequence of recurring states that take place in identifiable patterns. By identifying these recurring states and modeling patterns of transition between them, it is possible to develop a road map that will sensitize clinicians to sequential patterns that are likely to occur. The idea here is not to develop an intervention manual that is rigidly prescriptive in nature but rather to broaden the range of options available to clinicians by providing a map that sensitizes them to a range of process states that may occur in a particular context, as well as interventions that may mediate the transition between different states.

Our program can be conceptualized as consisting of four stages: model development, model testing, treatment development, and treatment evaluation. In the first stage, a change process model is developed through a series of intensive analyses of single cases. In the second stage, the model is tested by evaluating whether the presence of the stages described in the model distinguishes between resolution and nonresolution events. In the third stage, treatment interventions are developed and refined in response to the findings emerging from the model development and model testing stages of the research program. In the final stage, the efficacy of treatment intervention is evaluated. This stage of the research serves simultaneously as a treatment outcome study and as a model verification study.

Model Development and Testing

Rational–Empirical Model 1

In the first stage of our research program, we developed a preliminary model of the processes involved in resolving therapeutic alliance ruptures from intensive observations of 15 psychotherapy sessions in which alliance ruptures had appeared to reach some degree of resolution. We selected these sessions from a pool of 29 cases that consisted of 20–session protocols of an integrative psychotherapy with features of interpersonal, experiential, and cognitive approaches (Safran & Segal, 1990). This treatment is consistent in many ways with developments in contemporary psychoanalysis associated with the relational perspective (e.g., Mitchell, 1988).

After every session, patients and therapists were asked to think of the therapy session as consisting of three parts (a beginning, a middle, and an end), and to rate each third of the session on six items that had been extracted from the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). In this fashion, we obtained perceptions independently from both therapists and patients regarding fluctuations in the quality of the therapeutic alliance over the course of each session. For example, a particular patient or therapist may rate the first portion of the session relatively high on the therapeutic alliance questions, the second portion as low, and the third portion as high. This pattern of ratings would suggest that a deterioration in the therapeutic alliance had taken place toward the middle of the session but that the quality of the alliance had improved once again toward the end of the session (see Muran et al., 1995; Safran & Wallner, 1991, for more on our postsession measures and their psychometric properties).

We ultimately proposed a stage process model that included four stages comprising four patient states and three therapist interventions (see Figure 1). The patient states were as follows: patient withdrawal rupture marker (P1), patient expression of negative feelings (P2), patient exploration of avoidance (P3), and patient explores interpersonal schema (P4). The therapist interventions included the following: therapist focuses patient on immediate experience (T1), therapist empathizes or accepts responsibility (T2), and therapist probes for fears (T3). To detect important patient–therapist interactional sequences, each of the first three patient states was linked to a specific therapist intervention, thereby creating three patient–therapist interactional stages. To score the presence of an interactional stage, its component parts had to occur in proximity to each other. Because the fourth patient state was hypothesized to be related to the resolution process regardless of any therapist intervention, it was not linked to a therapist intervention and was scored as a stage in itself. There are, thus, a total of four stages: Stage 1 (attending to rupture marker), Stage 2 (exploration of rupture experience), Stage 3 (exploration of avoidance), and Stage 4 (exploration of interpersonal schema).

In the first patient state (P1), the patient's verbalizations or actions indicate the presence of a rupture in the alliance. Following Harper (1989a, 1989b), we categorized rupture markers into two major subtypes: confrontation and withdrawal. In confrontation rupture markers, the patient directly indicates anger, resentment, or dissatisfaction with the therapist or the therapeutic process. In withdrawal markers, the patient withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process. Because we originally found withdrawal markers to be more common in our data set, we proceeded initially to conduct our research on rupture resolution with withdrawal markers.

The first therapist intervention (T1) facilitates the exploration of the rupture by directing the patient's attention to the here and now of the therapeutic relationship or to his or her immediate experience. Common examples are statements such as “What are you experiencing?” or “I have a sense of you withdrawing from me,” or “How are you feeling about what's going on between us right now?” This intervention can lead to two parallel exploratory pathways. The first (i.e., Stage 2) involves the exploration of thoughts and feelings associated with the rupture in the alliance. For example, the patient may begin to speak about feelings of anger, dissatisfaction, or hopelessness (P2; e.g., “I feel like you're criticizing me”). The model hypothesizes that
this state will be followed by a therapist intervention (T2) of empathy, validation, or acceptance of responsibility. Interventions in which therapists accept responsibility for their own contributions to the rupture can be particularly facilitative (e.g., "You're right. I was being critical of you").

The second pathway (Stage 3) involves the exploration of interpersonal expectations, beliefs, or fears that block the exploration of the feelings associated with the rupture. For example, if a patient who believes that angry feelings will result in retaliation will have difficulty acknowledging and expressing his or her angry feelings. This exploration is typically facilitated by a therapist intervention (T3) that probes for such fears or expectations (e.g., "What do you imagine would happen if you expressed your angry feelings?" or "What's the risk?"). This exploration facilitates the patient's ability to acknowledge and express feelings and thoughts associated with the rupture experience (P2 of Stage 2). The process of articulating interpersonal expectations that are often tacit in nature helps the patient to begin acknowledging and expressing negative feelings that are avoided because of these expectations. There is typically an oscillation back and forth between the two pathways (Stages 2 and 3), with the therapist initiating the exploration of the avoidance pathway (Stage 3) when the rupture experience pathway (Stage 2) becomes blocked and with the exploration of the rupture experience pathway generating anxiety in the patient. This cues the therapist to explore the avoidance pathway.

In the final patient state (P4) and fourth stage of the model, the patient becomes aware of and articulates his or her own role in the rupture event and begins to generalize to other interpersonal situations. For example, a patient becomes aware of the way in which his or her fears of self-assertion lead to compliance, which in turn evokes domination from others. This awareness
takes place at an emotionally immediate level and is grounded in the exploration of the rupture event in the here and now.

All these patient states and therapist interventions were operationalized with specific criteria on multiple process measures. This was accomplished through a conjoint measurement procedure in which measures and constructs are developed and refined over time in a mutually influential fashion (Greenberg, 1994; Krantz & Tversky, 1971). The process measures used in this procedure included the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), the Experiencing Scales (EXP; Klein, Mathieu-Coughlan, Kiesler, 1986), and the Client Vocal Quality Scale (CVQ; Rice & Kerr, 1986). The SASB measures interpersonal behavior using three two-dimensional circumplex surfaces. The orthogonal dimensions are affiliation and interdependence. Only two of these surfaces were coded for the current research, and each surface was coded in terms of an octant version. The first surface measures interpersonal behaviors where the focus is directed toward others. The second measures behaviors that are self-reflective; the focus is on the self. The EXP Scales measure the degree of patient emotional involvement and therapist facilitation of that involvement. The CVQ Scale measures variations in patient vocal quality that are believed to reflect the way in which the speaker is processing and attempting to communicate his or her internal experience. These process measures serve both as operational criteria for measurement purposes and as markers of critical interpersonal and intrapersonal processes relevant to rupture resolution.

Operationalizing the model components is a complex and subtle one in which provisional criteria are set on the different process measures in an attempt to capture clinical intuitions about what different resolution components should look like. The criteria were adjusted in an iterative fashion as we applied them to new clinical material and gauged how well they actually captured the model components as currently conceptualized. They were also augmented by semantic definitions. The conceptualization of the relevant constructs is modified over time in response to new observations of clinical material, as well as patterns in the process measures (Rice & Saperia, 1984). The operationalization of the model stages thus sharpens the researchers’ observations, facilitates a more rigorous interplay between empirical observation and conceptualization, and promotes the validation of the model.

Preliminary Test of the Model

We conducted a preliminary test of this model on a new sample from the original pool of 29 cases that compared resolution and nonresolution sessions selected on the basis of converging therapist and patient responses on postsession questionnaires (Safran et al., 1994). Four resolution sessions were selected from three different cases involving the same therapist; three nonresolution sessions were selected from three cases, two of which involved other therapists. The four sessions containing resolution events were selected on the basis of ratings obtained independently from both patient and therapist perspectives. As before, they were asked to rate each third of the session on six items that had been extracted from the WAIS. The four resolution sessions were then selected on the basis of an increase of at least 20 percentage points from both patient and therapist perspectives on the WAIS total score between any of the thirds of the session. Because of incomplete data on patient postsession questionnaires for the selection of nonresolution sessions, they were selected initially on the basis of therapist postsession questionnaires, which indicated that there had been unsuccessfully resolved alliance ruptures within the sessions. However, the resolution status of all eight sessions was subsequently verified by two independent raters (to whom the details of the rupture resolution model had been masked) who rated the sessions by degree of resolution on a 5-point scale; their ratings yielded an intraclass correlation coefficient (3, k) of .88 and, when averaged, discriminated the resolution from nonresolution sessions as expected.

Eight coders were trained to meet preestablished levels of acceptable interrater reliability (Fleiss, 1981; Kraemer, 1981), according to guidelines described in the manuals for each process measure (SASB, Patient EXP, Therapist EXP, CVQ), using segments of the training sessions that had been previously rated by experts with the process measures. They were then asked to rate the eight sessions of interest in this study in teams of two with the process measures on which each team demonstrated high reliability. Interrater reliability estimates were calculated on a random sample of the four resolution and four nonresolution sessions, each coded by two independent raters. On the SASB, a weighted kappa coefficient (Cohen, 1968) of .69 was obtained on the resolution sample and .84 on the nonresolution sample. On the Patient EXP, intraclass correlation coefficients (ICC; 3, k) of .89 and .70 were obtained for resolution and nonresolution samples, respectively. The ICCs for the Therapist EXP Referent and Manner subscales, based on ratings from the resolution sample, were .79 and .72, respectively; as for ratings from the nonresolution sample, referent and manner estimates were .75 and .66, respectively. On the CVQ, a kappa (Cohen, 1960) of .55 was obtained for the resolution sample, and a kappa of .43 was obtained for the nonresolution sample. After reliability estimates were calculated, any coding disagreements were resolved by group consensus.

After the eight study sessions had been coded on all process measures, the components of the rupture resolution model were identified by consensus by two raters. Their ratings on a random sample of the eight sessions yielded a kappa of .67. The beginning of the rupture events within both resolution and nonresolution sessions were identified by locating the first two consecutive patient statements receiving codes on the SASB of either 2–5 (deferring & submitting), 2–6 (sulking & appeasing), or 2–8 (wallowing off & avoiding). All sessions were then coded on all process measures from this point onward. All model components were then identified using the combination of operational criteria specified in Figure 2. The results of the verification study provided evidence of a higher frequency of interactional stages associated with the stage process model in the four therapy sessions in which alliance rupture resolution events had been identified than in the nonresolution sessions. Although the differences were generally consistent with the hypothesis, Stage 4 (exploration of interpersonal schema) was only found in two of the four resolution sessions.

Rational–Empirical Model 2

The results of the preliminary test of the model led to important refinements in our understanding of rupture resolution. By
looking for regularities in transitions between specific configurations of the process measures, we were able to further clarify certain aspects of the resolution process. For example, a decision was made to drop Stage 4 (exploration of interpersonal schema), because its occurrence, as defined by the operational criteria, was infrequent. We speculate that this may be a stage in higher order rupture resolution processes in which generalizations to other situations are made, but that it is not essential for purposes of resolving a specific rupture. In fact, at a clinical level, we consistently observe that premature attempts by the therapist to help patients explore their interpersonal schemas through interpretively linking the transference relationship to other situations can elicit defensiveness and obstruct further exploration.

In addition to eliminating the original Stage 4 (exploration of interpersonal schema) of Model 1, two other modifications were made to the rupture resolution model on the basis of further observation. First, Stage 3 (exploration of avoidance) became further differentiated, with patient disclosure or expression of block (P3a) preceding the patient state of exploration of block (P3b). The patient typically gives some indication of anxiety (P3a), and the therapist then probes for underlying fears and expectations (T3). Second, the process that had been accounted for by the patient state involving the expression of negative feelings (P2) was further differentiated into two states. In the first of these, the patient expresses negative feelings mixed with the rupture marker (P2). This takes two major forms: one in which the patient begins to express negative sentiments and then qualifies the statement or takes it back (e.g., “I’m frustrated, but it’s more with the situation than you”) or one in which the patient expresses his or her feelings in a blaming or belittling way, rather than taking responsibility for them (e.g., “I’m sick and tired of you holding out on me”). This patient state is followed by a therapist intervention (T2) that facilitates self-assertion through acknowledging his or her own contribution to the interaction, refocusing on the here and now of the therapeutic relationship, or the use of an awareness experiment. In an awareness experiment, the therapist suggests that the patient experiment with directly expressing the feelings that are being avoided to the therapist and that he or she attend to what-
ever feelings are evoked. For example, the therapist in the previous example might suggest to the patient that he or she experiment with saying the phrase, "I'm frustrated with you," while noting whatever feelings are evoked in him. If the experiment is successful, the patient's evoked feelings will deepen his or her awareness of the avoided experience.

Stage 4 in this revision came to include the patient state of self-assertion (P4) followed by the therapist intervention of validating or empathizing with the patient's experience (T4). In the self-assertive state (P4), the patient directly expresses his or her feelings or needs toward the therapist in a manner that involves the acceptance of responsibility for them (e.g., "I really want your help" or "I'm angry at you" rather than "You're not helping me" or "You make me angry"). Self-assertive statements can be distinguished by their location toward the autonomous end of the interdependence dimension on the SASB. They, thus, imply a degree of autonomy or individuation not characteristic of statements that are demanding, blaming, pleading, or apologetic.

A revised model was developed that contained five patient states and four therapist interventions and that clustered into four stages. The patient states were patient withdrawal rupture marker (P1), patient expression of negative feelings mixed with rupture marker (P2), patient discloses block (P3a), patient explores block (P3b), and patient self-assertion (P4). The therapist interventions were therapist focuses patient on the immediate experience (T1), therapist facilitates self-assertion (T2), therapist probes block (T3), and therapist validates assertion (T4). The five states and four interventions were clustered into the following patient-therapist interactional stages: Stage 1 (attending to rupture marker), Stage 2 (exploration of rupture experience), Stage 3 (exploration of avoidance), and Stage 4 (self-assertion). Figure 2 illustrates this revised model, and Tables 1 and 2 present the operational criteria.

Formal empirical analysis. At this point, the original four resolution sessions were recoded for the patient states and therapist interventions of the revised Rational–Empirical Model 2. To evaluate how well the revised model described the data set on which it was developed, we conducted a series of confirmatory lag 1 sequential analyses using the program ELAG (Bakeman, 1983) to test the hypothesized sequences both within and between model states. Because these sequential analyses were conducted with the same data set on which Model 2 was based, the results constitute a formal mathematical modeling of observed patterns rather than a new verification study. The analyses proceeded in a stepwise progression, confirming first sequences within model stages and then sequences between model stages. Figure 2 presents the transitional probabilities of the tested sequences that emerged from the sequential analyses of the four resolution sessions in this formal empirical analysis. The first finding of note is that all predicted sequences within model stages emerged as statistically significant. The second major finding is that the predicted sequences between model components emerged as significant. Thus the therapist intervened in a model-consistent fashion both within and between stages. The results suggest that the new revised resolution model captures the change process in this sample reasonably well, and the lag sequential analyses provide a more rigorous description of the relevant sequences than had been previously available.

The four recoded resolution sessions were then compared with four nonresolution sessions matched from the patients from whom the resolution sessions were obtained. This was done to rule out the possibility that differences emerging between resolution and nonresolution sessions were attributable to stable patient characteristics. The first observation was that there were no occurrences of Stages 3 (exploration of avoidance) and 4 (self-assertion) in the nonresolution sessions. To clarify the extent to which model-consistent sequences that had been confirmed in rupture resolution sessions would emerge in nonresolution sessions, a parallel series of sequential analyses were conducted on the nonresolution sessions. Only the sequences within Stages 1 and 2 were found to be statistically significant in this sample (see Figure 2). Although these transitions were significant in the nonresolution sessions, they were significantly more likely to occur in the resolution sessions (Stage 1: z = 5.01, p < .001; Stage 2: z = 2.09, p < .05; based on the following formula: the difference between two z scores divided by the square root of 2; Rosenthal, 1983). Significant differences between resolution and nonresolution sessions were also noted for sequences within Stages 3 (P3a–T3: z = 2.17, p < .05; T3–P3b: z = 4.34, p < .001) and 4 (z = 8.32, p < .001) and for sequences between Stages 1 and 3 (z = 2.93, p < .01) and between Stages 2 and 4 (z = 2.39, p < .05).

Replication study. The next step of the research program involved replicating the findings in a new data set of sessions from three other cases, involving three new therapists, working in the same treatment modality as the therapist in the first study. The new data set consisted of three resolution sessions matched with three nonresolution sessions from each case, which were selected based on converging patient and therapist postsession reports.

Patients and therapists responded to questions on postsession questionnaires asking them to (a) identify the presence in the session of any problem or tension in the therapeutic relationship, (b) locate this problem in the beginning, middle, or end of the session, (c) rate the degree of tension on a 5-point scale, (d) provide an open-ended description of the problem, (e) rate the extent to which it was addressed on a 5-point scale, and (f) rate the extent to which it was resolved during the session on a 5-point scale. Some examples of alliance rupture events reported by patients included statements such as "I didn't quite understand where we were going; "tension of exposing my life to a person who is a stranger to me; "I feel we've gotten off track and are not addressing the problems I have; "it seemed as though nothing I said or did was right; "I don't feel he's hearing what I'm saying, rather fitting me into his theories; and "I felt I could not be honest about my feelings towards the therapist for fear that she would decide I could not be helped."

All six sessions were identified by both patient and therapist as containing tension or problems in the therapeutic relationship. We considered a resolution session as one in which both therapist and patient rated the degree of resolution as three or greater. Nonresolution sessions required a rating on this question by both therapist and patient as 2 or less. As in the first verification study, the beginning of the rupture events in each session was identified by locating the first two consecutive patient statements receiving codes on the SASB of either 2–5 (deferring & submitting), 2–6 (sulking & appeasing) or 2–8...
Table 1
Operational Criteria of Patient States for Rational–Empirical Model 2

<table>
<thead>
<tr>
<th>Patient state</th>
<th>Structural analysis of social behavior</th>
<th>Experiencing scale: patient version</th>
<th>Client vocal quality</th>
<th>Semantic definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Patient rupture withdrawal marker</td>
<td>Any of the following: 2-5, 2-6, 2-8</td>
<td>≤2</td>
<td>X or L</td>
<td>Patient evidences withdrawal behavior</td>
</tr>
<tr>
<td>P2: Patient expresses negative feelings mixed with rupture marker</td>
<td>2 or 3</td>
<td></td>
<td></td>
<td>Patient expresses negative feelings regarding the rupture experience in a qualified manner or by blaming the therapist</td>
</tr>
<tr>
<td>P3a: Patient discloses block</td>
<td>2-2</td>
<td>3</td>
<td>X or L</td>
<td>Patient discloses a block to exploring the rupture experience in the form of acknowledging fear or becoming self-doubting</td>
</tr>
<tr>
<td>3b: Patient explores block</td>
<td>≥3</td>
<td></td>
<td>F or E</td>
<td>Patient explores the implications of the block, becoming aware of how it interferes with the expression of primary emotional experience</td>
</tr>
<tr>
<td>P4: Patient self-asserts</td>
<td>≥4</td>
<td></td>
<td>F or E</td>
<td>Patient accesses primary emotional experience and assertively expresses a underlying wish or need</td>
</tr>
</tbody>
</table>

*aThe first number in the code refers to the focus of the behavior, the second number to one of the eight possible behaviors within the circumplex space. *bThe patient version of the Experiencing Scale consists of a 7-point scale ranging from low (1) to high (7) levels of experiencing. *cThe four possible vocal quality codes are externalized (X), limited (L), focused (F), and emotional (E).

(walling off & avoiding). To prepare the data for analysis, we reliably coded each of the three resolution and three nonresolution sessions on the SASB, EXP, and CVQ process measures, and we then identified the stages of the revised model by locating all instances in which operational criteria on the three process measures, as well as the semantic definition, were met.

In a manner similar to the way that we proceeded in the formal empirical analysis, six coders were trained on the process measures and then asked to rate the six sessions in teams of two: one team rated the sessions with the SASB, one with both the P-EXP and T-EXP, and one with the CVQ. Interrater reliability estimates were calculated on a random sample of the three resolution and three nonresolution sessions. On the SASB, a weighted kappa coefficient of .61 was obtained on the resolution sample and .67 on the nonresolution sample. On the Patient EXP, intraclass correlation coefficients (ICC; 3, k) of .89 and

Table 2
Operational Criteria of Therapist Interventions for Rational–Empirical Model 2

<table>
<thead>
<tr>
<th>Therapist intervention</th>
<th>Structural analysis of social behavior</th>
<th>Experiencing scale: therapist version*</th>
<th>Semantic definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1: Therapist focuses patient on immediate experience</td>
<td>1-2 (affirming &amp; understanding), 1-4 (nurturing &amp; protecting), 2-2 and either 1-2 or 1-4</td>
<td>≥2-3</td>
<td>Therapist focuses the patient on immediate experience through (a) inquiry, (b) empathic reflection, or (c) subjective feedback</td>
</tr>
<tr>
<td>T2: Therapist facilitates self-assertion</td>
<td>1-4 or both 2-2 and 1-2</td>
<td>≥3-3</td>
<td>Therapist facilitates patient self-assertion by the three strategies described above, as well as (a) awareness experiment with direct expression, (b) acceptance of own responsibility for role in rupture experience, and (c) focus on the therapeutic relationship</td>
</tr>
<tr>
<td>T3: Therapist probes block</td>
<td>1-2 or 1-4</td>
<td>≥3-3</td>
<td>Therapist probes for the meaning of the block and facilitates patient awareness of its interference</td>
</tr>
<tr>
<td>T4: Therapist validates assertion</td>
<td>1-2</td>
<td>≥4-3</td>
<td>Therapist validates and empathizes with self-assertion of the patient</td>
</tr>
</tbody>
</table>

*aThe therapist version of the Experiencing Scale consists of 7-point ratings on both the referent and manner of intervention. The referent is the first number, the manner second.
.82 were obtained for resolution and nonresolution samples, respectively. The ICCs for the Therapist EXP Referent and Man-
ter subscales, based on ratings from the resolution sample, were .82 and .75, respectively; for ratings from the nonresolution sample, referent and manner estimates were .80 and .70 respectively. On the CVQ, kappas of .41 and .36 were obtained for the resolution sample and the nonresolution sample, respectively. After the six study sessions had been coded on all process mea-
sures, the components of the rupture resolution model were then identified by the consensus of two raters. Their ratings on a random sample of the eight sessions yielded a kappa of .89.

We then conducted a series of confirmatory lag 1 sequential analyses to test for the hypothesized sequences both within and between stages. Figure 2 also presents the transitional probabilities of the tested sequences in the three resolution and three nonresolution sessions of this replication study. All predicted sequences within stages emerged as significant, thus confirming that therapists consistently followed patient states with stage-appropriate interventions. In terms of between-stage sequences, the predicted sequences between Stage 1 (attending to rupture marker) and Stage 2 (exploration of rupture experience), and between Stage 2 and Stage 4 (self-assertion), emerged as significant. The predicted sequence between Stage 1 and Stage 3 (exploration of avoidance) did not, however, emerge as significant. In nonresolution sessions, significant sequences were found within Stage 1, Stage 2, and Stage 3. As for Stage 4, there were no incidences of patient self-assertion (P4) or therapist validation of assertion (T4) and, thus, no significant within-stage sequence. In contrast to the resolution sessions, none of the between-stage sequences emerged as significant. Therefore, although therapists were significantly likely to follow patient states with appropriate interventions in three of the four stages, these interventions did not tend to facilitate model-consistent transitions between stages.

To help clarify factors underlying the failure of therapist inter-
terventions to facilitate model consistent transitions between stages, we evaluated differences between within-stage transi-
tional probabilities in resolution and nonresolution sessions. These analyses indicate that within-stage transitional probabil-
ities were significantly higher for resolution sessions in both Stages 3 (P3a-T3: z = 3.64, p < .001; T3-P3b: z = 2.86, p < .01) and 4 (z = 6.05, p < .001). These findings suggest that in nonresolution sessions both the failure of the final stage to emerge and the failure of stage-appropriate interventions to fa-
cilitate model-consistent transitions between stages may be in part attributable to therapists' failure to follow patient states with stage-appropriate interventions as consistently as they did in the resolution sessions.

Rational–Empirical Model 3

The process of intensively studying three more cases led to further revision of the model, as patterns not captured in the existing model emerged. For example, the failure to find the predicted sequence between Stages 1 (attending to rupture marker) and 3 (exploration of avoidance) led us to further clar-
ify how Stage 3 emerges. It is now our impression that such explorations seem to begin with the patient engaging in coping strategies, defensive verbalizations, or actions that function to avoid or manage the emotions associated with the rupture experience. Examples include changing the topic, speaking in a deadened voice tone, and speaking in general terms rather than the here-and-now specifics of the therapeutic relationship. The most common facilitative therapist response here is to draw the patient’s attention to the defensive operation and probe for inner experience. This leads to disclosure of the block (e.g., “I’m afraid”) that, when probed further by the therapist, leads to the exploration of the block.

In addition, it has led to a better understanding and opera-
tionalization of the patient states. It has become increasingly apparent to us that an explicit case formulation can be helpful in identifying important patient states involved in the resolution process, and we are now experimenting with the use of the Core Confictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1988) for this purpose. The components of the CCRT include (a) wish, or what the individual wants or needs from the other (coded W); (b) response from other, or how the other reacts to the self (coded RO); (c) response from other, expected, or how the other is expected to react (coded ROe); and (d) response of self, or how the self responds to the other’s reaction or to one’s expectations of the other’s reaction (coded RS). Figure 3 illustrates Rational–Empirical Model 3, with each of the patient states defined in terms of a component of the CCRT. To avoid unnecessary complexity, we omitted therapist interventions from this diagram.

One of the difficulties emerging in coding components of the model has been distinguishing between P2 (patient expresses negative feelings mixed with rupture marker) and P4 (patient self-assertion). The CCRT helps to clarify the distinction in the following fashion. Self-assertion always involves the expression of the underlying wish (coded W) or a primary emotion associ-
ated with that wish. Primary emotions are authentic feelings that provide adaptive motivational information to the individual and that are characterized by the acceptance of responsibil-
ity for one’s feelings (Greenberg & Safran, 1987). It is thus pos-
sible, for example, for P4 to be anger or sadness, depending on the patient’s CCRT. P2 is the patient’s response of self (coded RS). Emotions associated with the response of self are secondary emo-
tions that are the result of internal reactions to primary emo-
tions; in some instances, secondary emotions are defensive coping strategies in reaction to underlying primary emo-
tions (Greenberg & Safran, 1987). These secondary emotions tend to involve more of a focus on the other than the self and can result from the influence of the processes explored in Stage 3 (exploration of avoidance) on the primary emotion. Thus, for example, a patient anticipating a negative response to an under-
lying wish for nurturance may respond with a response (coded RS on the CCRT) of anger. A patient anticipating a neg-
ative response to anger may express her anger in a qualified way in P2 of Stage 2. In psychoanalytic terms, P2 is conceptualized as a wish–defense compromise or a compromise formation.

Further intensive analysis has led to the differentiation of Stage 3 (exploration of avoidance) into two forms. Whereas the first form that Stage 3 takes is the exploration of interpersonal beliefs and expectations (i.e., ROe on the CCRT) that prevent the emergence of the expression of the underlying wish in Stage 4, the second form involves the exploration of self-doubts and criticisms that block the emergence of Stage 4. For example, a
patient doubts the legitimacy of his or her angry feelings, accusing himself of being childish and feels a secondary emotion of depression. This self-criticism is coded RS on the CCRT.

Conceptualizing the resolution process in terms of the CCRT has been helpful in a number of other ways. One of the observations that has emerged over time is that the distinction between confrontation and avoidance ruptures is not so clear cut and that patients often present with a combination of both markers. Thus, for example, a patient who begins by blaming the therapist may, at a later point in the session, become anxious about directly expressing his or her needs and withdraw from the underlying feelings of vulnerability. The rupture marker (PI) is typically some variant of the patient’s secondary emotional response or RS to the underlying wish (coded as W on the CCRT) or primary emotion. The therapeutic goal in all cases is to help the patient express the underlying wish or primary emotion in the context of a therapeutic relationship that disconfirms the patient’s maladaptive interpersonal schema.

The therapist’s task is to avoid or extricate himself or herself from responding to the patient’s response of self in a way that would confirm the patient’s expected response of other, and to help the patient access primary feelings that are not fully acknowledged and expressed. To the extent that the rupture marker tends to be more of a secondary emotion of anger, it is important for the therapist to refrain from responding with complementary hostility and to access the underlying primary emotion, which is likely to be more vulnerable in nature. To the extent that the rupture marker is more deferential or compliant, the therapist’s task is to avoid or extricate himself or herself from responding in a complementary fashion by brushing over the incident or by dominating the patient and to help the patient acknowledge and explore the underlying wish, which is more self-assertive in nature. Thus, although there may be certain differences in the resolution process, depending on the patient’s response of self, there is also a fair amount of generalizability.

Table 3 illustrates the revised resolution model, in which transcript excerpts are extracted from the beginning and middle parts of the same session. Because the resolution process in real life is often circular, repetitive, and nonlinear, the excerpts presented should be considered distilled representations of a process that is more intricate in nature. Relevant patient states, therapist interventions, and CCRT codings are also indicated (see also Figure 3).

In this situation, the patient’s underlying wish is wanting to...
Table 3
Session Segment Coded to Illustrate Rational–Empirical Model 3

<table>
<thead>
<tr>
<th>Patient and therapist dialogue</th>
<th>Patient state or therapist intervention</th>
<th>CCRT</th>
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</thead>
<tbody>
<tr>
<td><strong>Beginning of session</strong></td>
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<tr>
<td>T: Hello. Happy birthday.</td>
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<tr>
<td>P: Uh, yeah. I guess. I don’t think it’s a big deal really.</td>
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<tr>
<td>T: Mmhmm.</td>
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<tr>
<td>P: Everyone’s always nice to you when it’s your birthday, so . . .</td>
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<tr>
<td>T: Uhuh. So I’ll be nice to you. (both laugh)</td>
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<tr>
<td>P: Yeah. Don’t pull that crap you usually pull. (smiles)</td>
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<tr>
<td>T: What’s going on for you inside? I’m aware of a smile on your face as you say that, but I’m not sure if you’re joking.</td>
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<tr>
<td>P: Well. I guess I’m a little irritated.</td>
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<td></td>
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<tr>
<td>T: What are you irritated about?</td>
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<tr>
<td>P: Well, you know, we’ve talked about it before. (smiles again) You won’t tell me what I should do.</td>
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<tr>
<td>T: I’m aware of your smile again. What are you experiencing?</td>
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<tr>
<td>P: Well. I guess I’m a little uncomfortable.</td>
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<tr>
<td>T: What are you uncomfortable about?</td>
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<tr>
<td>P: Well. maybe I’m feeling a little angry.</td>
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<td></td>
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<tr>
<td>T: And your discomfort?</td>
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<tr>
<td>P: I guess I’m afraid of your reaction.</td>
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<tr>
<td>T: How might I react?</td>
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<tr>
<td>P: You might get pissed off at me.</td>
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<tr>
<td>T: Anything else?</td>
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<tr>
<td>P: Well . . . you might give up on me as a hopeless case and want to wash your hands of me.</td>
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<tr>
<td><strong>Middle of session</strong></td>
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<tr>
<td>P: I don’t see how this is helping. I want you to take charge of things rather than leaving it all up to me. (smiles)</td>
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<tr>
<td>T: What are you experiencing?</td>
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<tr>
<td>P: I feel embarrassed.</td>
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<tr>
<td>T: What are you embarrassed about?</td>
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<tr>
<td>P: It’s like I’m asking you for help.</td>
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<tr>
<td>T: Can you try this as an experiment? Try asking me for help and see what it feels like.</td>
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<tr>
<td>P: I want you to help me. I need your help. (sadness in voice)</td>
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<td>T: What are you in contact with?</td>
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<tr>
<td>P: It’s true. I feel embarrassed about it, but it’s true. I want your help. (begins to cry)</td>
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<td>T: That really touches some sadness inside of you.</td>
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<tr>
<td>P: Yeah.</td>
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<tr>
<td><strong>Note.</strong> T = therapist; P = patient; CCRT = Core Conflictual Relationship Theme.</td>
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</table>

be helped or cared for. The two internal processes (Stage 3) interfering with the direct and assertive expression of this wish are (a) the patient’s negative expectation of others responses and (b) feelings of shame and self-criticism in response to the underlying wish. The therapist begins by exploring the rupture marker. As the patient begins to explore his irritation, a feeling of anxiety emerges and the therapist explores the interpersonal expectations that underlie the anxiety.

This process of alternating back and forth between the exploration of the rupture experience and the exploration of the avoidance continues in the omitted part of the transcript, and it leads to a more forceful expression of the patient’s underlying wish, at the point where the transcript resumes (“I want you to take charge of things rather than leaving it up to me [smiles]”).

This still falls short of an assertive expression of the underlying wish and associated primary emotion, as it has a demanding tone, reflecting a focus on the other, which is more characteristic of a secondary than a primary emotion (Greenberg & Safran, 1987). Moreover, the patient’s smile suggests that he does not yet feel completely comfortable with his underlying wish. Exploring the experience associated with the patient’s smile leads to the exploration of underlying feelings of embarrassment. Further exploration of the avoidance pathway would probably lead to the articulation of self-critical attitudes inhibiting the expression of the underlying wish (e.g., “I’m being childish and immature”).

However, rather than deepening the exploration of the avoidance at this point, the therapist facilitates the patient’s self-as-
sion (T2) by suggesting an awareness experiment designed to help the patient contact the underlying wish for support and nurturance and the associated primary feeling of sadness ("Can you try this as an experiment? Try asking me for help and see what it feels like"). An equally facilitative intervention, consistent with a more traditional psychodynamic approach might have been to interpret the underlying wish for nurturance and support. The patient's emotional response to the experiment, as well as his verbal confirmation, indicates that intervention has succeeded in helping him to access his underlying wish and primary feelings.

Treatment Development and Evaluation

Currently, we are manualizing a set of task-facilitative interventions based on the process research that has taken place up to this point and developing a treatment adherence measure. To evaluate the efficacy of these interventions, we are conducting a clinical trial study at Beth Israel Medical Center; this study should also serve as a form of model verification by testing the usefulness of interventions, which have been informed by the process research. The basic research strategy involves evaluating the relative efficacy of a treatment based on the results of the process research to that of two comparative treatment conditions (psychodynamic and cognitive–behavioral therapies) in a sample of patients with whom therapists have had difficulty establishing a therapeutic alliance (Safran & Muran, 1994).

The hypothesis that guides the research strategy for evaluating the efficacy of the manualized treatment is that a major obstacle to finding new treatment differences is a lack of contextual specificity (Beutler, 1991; Gendlin, 1986; Greenberg, 1986). In the standard clinical trial study, clustering patients together on the basis of a standard diagnostic criterion and then administering a general therapeutic approach commits the error of subscribing to the uniformity assumption described by Kiesler (1966) 2 decades ago. In this type of treatment design, the patient group is sufficiently heterogeneous with respect to important characteristics so that some will always benefit whereas others will not, regardless of the particular treatment approach, thereby washing out treatment differences. To the extent, however, that patients can be grouped together on the basis of a variable that, in theory, is particularly relevant to a specific intervention, the possibility of finding treatment differences should be increased (Beutler, 1991). Following this line of reasoning, we hypothesize that selecting patients for treatment specifically on the basis of difficulties that they are having in establishing a therapeutic alliance with their therapist should increase the possibility that an intervention designed to resolve ruptures in the alliance will have more impact than one that is not. This type of patient selection strategy goes beyond the more traditional factorial design of clustering patients on the basis of a static or dispositional characteristic (e.g., diagnostic category) by selecting on the basis of a relevant in-session performance variable (i.e., failure to establish an adequate therapeutic alliance). This should increase the power of the design by reducing slippage resulting from selecting on the basis of the type of trait variable that has been shown to have limited predictive validity (Beutler, 1991).

The study consists of two phases. In the first phase, patients are randomly assigned to either a short-term dynamic or cognitive–behavioral psychotherapy in Beth Israel's Brief Psychotherapy Research Program. The patients are tracked over the first 10 sessions of treatment, and on the basis of a number of empirically derived criteria from patient, therapist, and observer perspectives, a subgroup is identified with whom therapists are having difficulty establishing an alliance and who are at risk for treatment failure or dropout. These patients are then offered the option of transferring to another treatment condition. Those who choose to be transferred are randomly reassigned to either the experimental treatment (i.e., the treatment based on the process research) or the control for their previous treatment; that is, the dynamic therapy if they are coming from the cognitive–behavioral therapy, or the cognitive–behavioral therapy if they are coming from the dynamic therapy. In the second phase of the study, they undergo a 30–session protocol. The hypothesis is that patients who are reassigned to the experimental treatment will receive greater benefits than those who have been reassigned either to the dynamic therapy or the cognitive–behavioral therapy. Empirical support of this hypothesis will provide another form of evidence regarding the validity of the resolution model. In addition, we are identifying resolution and nonresolution sessions emerging from the experimental treatment and continuing to test and refine the rupture resolution model through task analytic procedures. The next cycle in the research program will include model verification studies with larger sample sizes to increase generalizability. Further refinements in the resolution model will lead to ongoing refinements in the treatment manual that will ultimately be used to train therapists in a new cycle of treatment evaluation.

Conclusion

Our goals over the next few years are to continue to test and refine the resolution model and to evaluate the influence of different interventions on underlying change processes. For example, are there contexts within which interpretations are more useful for facilitating the emergence of Stage 4 (self-assertion) than awareness experiments? What are the different ways of intervening when Stage 3 (exploration of avoidance) emerges in the form of self-criticism? In many ways, our research program is still in its early stages. The findings at this juncture, however, are encouraging and have already provided some evidence of the clinical richness that can result from the ongoing interplay between systematic rational analysis and rigorous observation.

References


Received October 1, 1994
Revision received March 30, 1995
Accepted September 19, 1995